Dose Titration Trial Program for Jakafi® (ruxolitinib)

PO Box 221798 • Charlotte, NC 28222-1798 • Phone: **1-855-452-5234** • Fax: **1-855-525-7207**

- For newly prescribed patients whose physician has determined that a trial dose of Jakafi is necessary to establish a safe starting dose for either (1) polycythemia vera who have had an inadequate response to or are intolerant of hydroxyurea or (2) intermediate or high-risk myelofibrosis. Patient must be new to treatment with Jakafi and may require dose titration during therapy. Please complete, sign, and submit this form by mail or fax
- Eligible patients will receive 120 free tablets (5 mg each), dispensed in two 60-count bottles. The provision of product under this *Dose Titration Trial Program (DTTP)* is not contingent on any purchase requirement
- Limit 1 prescription for Jakafi under the *DTTP* per patient. No refills are allowed. Free product may not be sold, traded, returned for credit, or billed to insurance or patients
- Incyte has the right at any time, and without notice, to modify or discontinue the *DTTP* or any assistance provided to the patient

1 Prescription for Jakafi

Patient Name: _____

Date: _____

Indication (check one)

This program is only for adult patients who are prescribed Jakafi for either of these uses.

- ☐ Polycythemia vera (PV) in adults who have had an inadequate response to or are intolerant of hydroxyurea (HU)
- ☐ Intermediate or high-risk myelofibrosis (MF), including primary MF, post-polycythemia vera MF or post-essential thrombocythemia MF in adults

Starting Dosage (only 5-mg tablets are available under the *DTTP*)

- ☐ 5 mg bid → (One 5-mg tablet po bid)
- ☐ 10 mg bid → (Two 5-mg tablets po bid)
- ☐ 15 mg bid → (Three 5-mg tablets po bid)
- ☐ 20 mg bid → (Four 5-mg tablets po bid)
- ☐ Other (describe below):

po = orally bid = twice daily

Directions: _____

_____

The patient's healthcare professional may adjust the dosage after treatment has begun.

Quantity: 120

Refills: *NO REFILLS ALLOWED*

Ship to: ☐ Patient's Home ☐ Doctor's Office

NOTE: Prescribers must submit a separate completed prescription form if required by state law. This separate prescription is only valid if received by fax.

2 Additional Patient Information

Shipping Address: _____

City: _____ State: _____ ZIP: _____

Email Address: _____

Phone # (s): _____ Date of Birth: ____ /____ /____

Alternate Contact Name: _____

Relationship: _____ Phone #: _____

3 Prescriber Information

Name: _____

State License: _____ NPI: _____

Site Facility Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Office Contact: _____

Phone #: _____ Fax #: _____

4 OPTIONAL: Patient Insurance Information for Benefit Verification

Primary Insurer: _____ Phone #: _____

Policy ID #: _____ Group #: _____

Subscriber Name: _____ Date of Birth: ____ /____ /____

Secondary Insurer: _____ Phone #: _____

Policy ID #: _____ Group #: _____

Subscriber Name: _____ Date of Birth: ____ /____ /____

Please include a photocopy of the patient's insurance card(s), if possible.

☐ **Request Insurance Verification**

By checking the above box, I authorize and request IncyteCARES for Jakafi to contact my office to obtain additional information required to perform an insurance status verification for the above-named patient, to assist in identifying additional access options.

Physician or Licensed Prescriber & Patient Declarations

Physician or Licensed Prescriber Authorization:

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Jakafi based on my professional judgment of medical necessity. I am under no obligation to continue to prescribe Jakafi after this initial dosage, but may do so if, in my professional judgment, there is continued medical necessity. I understand that the medication provided under the *Dose Titration Trial Program (DTTP)* is complimentary and that no claim may be made to any patient or third-party payer (eg, Medicare, Medicaid, and/or private insurance) for payment for Jakafi provided under the *DTTP* and that such product cannot be sold, traded, or returned for credit. I understand and agree that IncyteCARES will convey to the pharmacy chosen by or for the named patient the prescription described herein. I understand and agree that IncyteCARES will perform an eligibility assessment for the *DTTP* for Jakafi tablets for the named patient. I verify that this patient has not previously received Jakafi tablets of any dose and I will not seek further product under the *DTTP* for this patient. I understand and agree that use of the *DTTP* is not contingent on any purchase requirement. I further agree that the patient listed in this enrollment form is under my care and supervision and I will monitor any titration of Jakafi during the use of the *DTTP* or changes from Jakafi to another therapy that may be necessary based on my professional judgment.

Physician or Licensed Prescriber Signature: _____ Date: _____

Patient Authorization

I understand that my healthcare professional has requested the IncyteCARES Program to determine my eligibility for the *Dose Titration Trial Program (DTTP)* for Jakafi® (ruxolitinib) tablets. I authorize my healthcare professional and my health insurer(s) to disclose personal health information about me (my "PHI") that is relevant to treatment with Jakafi to Incyte, its agents, and IncyteCARES (collectively, "Incyte") so that Incyte may assess my eligibility for the *DTTP* and coordinate delivery of Jakafi to me or my healthcare professional. I authorize Incyte to use and disclose such PHI for those purposes and in order to (I) provide me with education and information related to the *DTTP*, IncyteCARES, Jakafi, and insurance coverage options; (II) gather feedback on my therapy and/or disease state; and (III) contact me by mail, email, phone, or fax for any of the above purposes. I understand that, once disclosed pursuant to this authorization, my PHI may no longer be protected under federal or state law and could be re-disclosed to others, but that Incyte intends to make reasonable efforts to keep it private.

I understand that I do not have to sign this authorization to obtain healthcare treatment or benefits; however, I must sign the authorization in order to receive any free drug through the *DTTP* as well as agree to accept delivery of *DTTP* product or receive any of the services and communications described above. I understand that the provision of any free drug to me through IncyteCARES is contingent upon my meeting certain eligibility criteria and that Incyte has the right, at any time and without notice to me, to modify or discontinue the *DTTP* or any assistance provided to me.

I understand that I may cancel this authorization by contacting IncyteCARES at 1-855-452-5234, by fax at 1-855-525-7207, or by mail at PO Box 221798, Charlotte, NC 28222-1798. My cancellation of this authorization will be effective as to my Healthcare Professionals and insurance companies when they are notified by Incyte of the cancellation, but the cancellation will not affect uses or disclosures of PHI made before that time.

I understand that I have a right to receive a copy of this authorization once signed.

This authorization expires 1 year after the date I sign it as shown below.

Name of Patient	Signature	Date
Name of Personal Representative	Signature	Date

If signed by Personal Representative, describe the nature of relationship with patient: