IncyteCARES | Niktimvo™ (axatilimab-csfr) 50 mg/mL for injection, for intravenous use

IncyteCARES for Niktimvo Program Enrollment Form

Please legibly complete all fields not marked optional, for timely processing. **Fax completed form to 1-866-870-6241.**
We will contact you within 3 business days. For questions, call **1-855-452-5234**.
*For details about all program services your patient can receive upon enrollment, see **HCP.IncyteCARES.com/Niktimvo**.*

☐ **Check here to request only a Benefits Investigation for your patient.**

PATIENT INFORMATION

Full Name _____ Date of Birth ____ /____ /____

Home Address _____

City _____ State _____ ZIP _____

Medicare ID *(Required for patients with Medicare)* _____

Email *(Optional)* _____

Phone Number _____ Alternate Phone Number *(Optional)* _____

Best Time to Call *(Optional)* ☐ Morning ☐ Afternoon ☐ Evening

Primary Language *(Optional)* ☐ English ☐ Spanish ☐ Other _____

Is patient a resident of the United States or Puerto Rico? ☐ Yes ☐ No

ALTERNATE CONTACT *(Optional)*

Full Name _____ Relationship _____ Phone _____

INSURANCE INFORMATION

☐ **Patient does not have medical insurance.**

Please attach a copy of Insurance Card(s) (front and back).

Primary Insurer _____ **Type of insurance:** ☐ Commercial ☐ Government ☐ Other

Policy ID Number _____ Group Number _____

Phone _____ *If patient is the policy subscriber, check here and skip fields below.* ☐

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

Secondary Insurer *(If applicable)* _____ Phone _____

Policy ID Number _____ Group Number _____

*If patient is **not** the policy subscriber, check here and complete fields below.* ☐

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

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PRESCRIBER DECLARATION

(Patient's enrollment request cannot be processed without signed Prescriber Declaration.) I certify that the Patient and Prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed Niktimvo™ (axatilimab-csfr) based on my judgment of medical necessity and I will be supervising the patient's treatment.

I have received the necessary patient authorization prior to the transmittal of health information to Incyte Corporation or their respective third-party contractors, agents or designees, to initiate patient enrollment into IncyteCARES for Niktimvo.

If requested, I authorize the forwarding of the prescription to an infusion site on behalf of myself and the Patient. I agree that I will not seek reimbursement for any free product received under the Patient Assistance Program (PAP) for this Patient or for any other patient. I further agree that the Patient should also not seek reimbursement for any free product received under the PAP. In addition to not seeking reimbursement, I agree to notify IncyteCARES for Niktimvo immediately if the Patient is no longer receiving product through the PAP and agree to return unused donated PAP product.

I certify that I will comply with all applicable state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. I understand that non-compliance with state specific requirements could result in outreach.

☐ **I have read and agree to the declaration above.**

Prescriber Name _____ Date ____ /____ /____

PRESCRIPTION FOR NIKTIMVO

Use this section to write your patient's prescription.

A separate prescription form is not needed, unless required by state law. Date ____ /____ /____

Patient Name _____ Date of Birth ____ /____ /____ Patient Weight (kg) _____

Medication Name: Niktimvo™ (axatilimab-csfr)

Directions: For patients weighing at least 40 kg, administer Niktimvo 0.3 mg/kg, up to a maximum dose of 35 mg, as an intravenous infusion over 30 minutes every 2 weeks until progression or unacceptable toxicity. For patients weighing less than 40 kg, provide directions below.

☐ **9 mg/0.18 mL (50 mg/mL)** in a single-dose vial _____ **Vials per month**

☐ **22 mg/0.44 mL (50 mg/mL)** in a single-dose vial _____ **Vials per month**

(Refills: _____ months)

Additional Directions _____

_____

Concurrent Medications *(Optional)* ■ None _____

Allergies *(Optional)* ■ None _____

Prescriber Signature _____ DEA Number *(Optional)* _____

PRESCRIBER INFORMATION

Prescriber Full Name _____ State License Number _____

Payer-Specific ID Number _____ Tax ID Number _____

NPI Number _____ Site/Facility Name _____

Street Address _____ City _____ State _____ ZIP _____

Office Contact Name _____ Email *(Optional)* _____

Phone Number _____ Fax Number _____

Site of Infusion *(If different from above)* _____

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CLINICAL INFORMATION

☐ Chronic graft-versus-host disease (cGVHD) after failure of at least two prior lines of systemic therapy in adult and pediatric patients weighing at least 40 kg.

☐ Other _____

Patient Diagnosis (Primary ICD-10-CM Code) _____

Description _____

Previous Therapy Given

Dates _____ Dose _____

Therapy Given _____ Frequency _____

HIPAA AUTHORIZATION

All fields are required unless noted.

I authorize my healthcare providers (eg, physicians, pharmacies) and my insurance company to disclose and re-disclose personal health information about me, including information related to my medical condition and treatment, my health insurance coverage, and my address, email address, and telephone number (collectively, my "PHI") to Incyte, its agents, and the IncyteCARES for Niktimvo program (collectively, "Incyte") so that Incyte may use the information for purposes of: (i) assisting in my enrollment in IncyteCARES for Niktimvo; (ii) assessing my eligibility for out-of-pocket cost assistance or free drug or referring me to other programs or sources of funding and financial support; (iii) coordinating delivery of Niktimvo™ (axatilimab-csfr) to me or my healthcare provider; (iv) providing education, information on Incyte products and services, and ongoing support services to me related to Niktimvo; (v) gathering feedback on my therapy and/or disease state; (vi) contacting me by mail, email, phone, or fax for any of the above purposes; and (vii) creating information that does not identify me personally for use for other purposes related to Niktimvo. I understand that my pharmacy providers may receive remuneration for making such disclosures. I also authorize my healthcare providers and my insurance company to use my PHI to communicate with me about Incyte products and services and I understand that they may receive remuneration for making such communications.

I understand that, once disclosed pursuant to this authorization, my PHI may no longer be protected under federal or state law and could be disclosed by Incyte to others, but I understand that Incyte will make reasonable efforts to keep it private and to disclose it only for the purposes set forth in this authorization.

Continued on next page

I understand that I do not have to sign this authorization to obtain healthcare treatment or benefits; however, in order to receive the services and communications described above, I must sign the authorization. I understand that I may cancel my authorization at any time by contacting IncyteCARES for Niktimvo at 1-855-452-5234 or by mail at IncyteCARES, PO Box 10, Columbus, OH 43216. My cancellation of this authorization will be effective when my healthcare providers and insurance companies are notified of its receipt by Incyte but will not apply to PHI already used or disclosed in reliance upon this authorization.

I understand that I have a right to receive a copy of this authorization. This authorization expires one year after the date below unless I cancel it before then. To review Incyte's Privacy Policy, please visit **https://incyte.com/privacy-policy**.

Patient's Signature _____ Date _____ /_____ /_____
(If the patient is under 18 years of age, a legal representative should sign and print name.)

_____ _____ _____
Legal Representative Name (Print) Legal Representative Signature Relationship

FINANCIAL INFORMATION *(Optional)*—Required only to apply for the Patient Assistance Program.

See **HCP.IncyteCARES.com/Niktimvo** for details.

Current Annual Household Income _____ Number of People in Household _____

AUTHORIZATION FOR ELECTRONIC INCOME VERIFICATION

I understand that I am providing written instructions to Incyte under the Fair Credit Reporting Act authorizing Incyte to obtain information from my credit profile or other information from Experian Health. I give consent to Incyte to obtain such information solely to determine if my income meets eligibility standards of the patient assistance program.

Patient's Signature _____ Date _____ /_____ /_____
(If the patient is under 18 years of age, a legal representative should sign and print name.)

_____ _____ _____
Legal Representative Name (Print) Legal Representative Signature Relationship

PATIENT OPT-IN FOR EDUCATION AND SUPPORT *(OPTIONAL)*

☐ **For patients eligible for IncyteCARES for Niktimvo education and support program (which includes occasional emails and outbound calls):** I agree to be contacted by Incyte, its agents, and the IncyteCARES for Niktimvo program representatives about information on Incyte products and services at the email address and phone number(s) provided in my enrollment form. I can cancel this authorization at any time by emailing privacy@incyte.com.

Patient's Signature _____ Date _____ /_____ /_____
(If the patient is under 18 years of age, a legal representative should sign and print name.)

_____ _____ _____
Legal Representative Name (Print) Legal Representative Signature Relationship

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