Opzelura™
(ruxolitinib) cream 1.5%

COMMERCIAL ACCESS PROGRAM FOR OPZELURA

Some patients with commercial prescription drug insurance may initially be denied coverage for OPZELURA after prior authorization (PA) submission. If a prior authorization is denied, your patient may be eligible for the Commercial Access Program. Through this Program, patients may be eligible to receive OPZELURA at no out-of-pocket cost.

PROGRAM CRITERIA

To qualify, the patient must:

- ✔ Have commercial prescription drug insurance
- ✔ Have been denied coverage by their payer
- ✔ Have been prescribed OPZELURA for an FDA-approved indication
- ✔ Be considered clinically appropriate for OPZELURA based on product prescribing information

HOW TO ENROLL YOUR PATIENT

Complete the Prescription and Enrollment Form.
Be sure to include:

- The ICD-10 code(s) in section 2
- Whether the patient has tried and failed another topical prescription therapy in section 2
- Prescriber signatures in sections 2 and 3
- Patient signature in section 7

FAX the completed form to IncyteCARES for OPZELURA at 1-877-801-3840.

PRESCRIPTION FULFILLMENT

PRESCRIPTION FILLED BY THE DESIGNATED PROGRAM PHARMACY

Eligible patients will be shipped one tube of OPZELURA by the designated Program pharmacy.

If a second tube of OPZELURA is requested, an appeal **must** first be submitted to the patient's health plan. See below for information on appeals support.

APPEALS SUPPORT

To appeal the PA denial from the patient's health plan, a Case Manager can provide appeals support as outlined below:

- We will contact the health plan to obtain information on how to submit an appeal and will provide that information to you
- You submit the appeal directly to the health plan
- We follow up with the plan to obtain the appeal outcome

Appeal Denied: If the appeal is denied, the patient may be eligible for an additional tube of OPZELURA at no out-of-pocket cost. The patient must call IncyteCARES for OPZELURA to request the second tube.

Appeal Approved: If the appeal is approved, the prescription will be triaged to the patient's preferred pharmacy where the patient can use a copay savings card.

We will follow up with the patient's health plan at 45 and 90 days post-enrollment to determine if access to OPZELURA may be covered under the plan and will notify your team accordingly.

Please see the Full Prescribing Information, including Boxed Warning.

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COMMERCIAL ACCESS PROGRAM PRESCRIPTION AND ENROLLMENT FORM

Fax completed form to 1-877-801-3840. For questions, call 1-800-932-1720.

PRESCRIBER TO COMPLETE

1 PRESCRIBER INFORMATION

Prescriber First Name ______________________ Prescriber Last Name ______________________

State License Number ______________________ NPI Number ______________________

Practice Name ______________________

Address ______________________ City ____________ State ______ ZIP ______

Office Contact Name ______________________ Phone ____________ Fax ____________

2 PRESCRIPTION FOR OPZELURA

Patient First Name ______________________ Patient Last Name ______________________

Medication Name: OPZELURA™ (ruxolitinib) cream, 1.5% Tube Size: 60 g Number of Tubes: 1 Refills ________

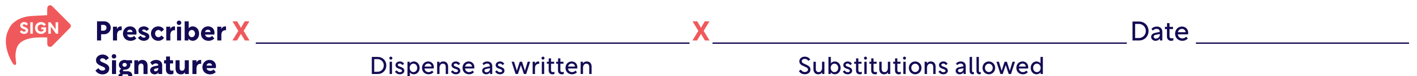
Directions ______________________

Primary Diagnosis ______________________ ICD-10 Code(s) ______________________

Tried and Failed Another Topical Prescription Therapy? ☐ Yes ☐ No

I certify that I am the Healthcare Professional who has prescribed this medication, that it is medically necessary for the patient, and that the information provided is accurate to the best of my knowledge. I further certify that the information provided on the prior authorization (PA) denial is accurate to the best of my knowledge. I authorize Incyte, and its affiliates, agents, and service providers to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

If you are a prescriber based in New York state, please use a New York state prescription form.



SIGN **Prescriber Signature** X ______________________ X ______________________ Date ____________

Dispense as written Substitutions allowed

3 PRESCRIBER DECLARATION

By my signature, I certify that I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Incyte and its employees or agents for purposes relating to Incyte's patient support programs, including assessing eligibility, assisting the patient with benefits verification, prior authorization/appeals information, financial assistance resources and information, such as copay savings or free drug programs, for which the patient may be eligible.

I certify that I have obtained consent from the patient or the patient's caregiver to be contacted by IncyteCARES for OPZELURA and/or parties acting on their behalf using phone, email, text, or an autodialer or prerecorded voice using the information provided to enable fulfillment of the services described previously. I also give my permission to receive calls related to these services from IncyteCARES for OPZELURA, and parties acting on their behalf, including phone, email, fax, or calls made with an autodialer or prerecorded voice using the information provided.

I can learn more about how Incyte processes my personal information at www.incyte.com/privacy-policy.

SIGN **Prescriber Signature** X ______________________ Date ____________

4 PAYER DENIAL INFORMATION (including prior authorizations or non-formulary exceptions)

Denial Date ______________________

Denial Reason ______________________

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COMMERCIAL ACCESS PROGRAM PRESCRIPTION AND ENROLLMENT FORM

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PATIENT INFORMATION

5 PATIENT INFORMATION

First Name ________________ Last Name ________________

Address ________________ City ________________ State ________ ZIP ________

Email ________________ Date of Birth ________________

Phone ________________ ☐ Mobile ☐ Landline Best time to call ☐ 8 AM–12 PM ☐ 12–4 PM ☐ 4–8 PM

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

Caregiver Contact (If Applicable) Full Name ________________

Relationship ________________ Phone ________________

6 INSURANCE INFORMATION

Primary Prescription Insurer ________________ Phone ________________

Policy ID Number ________________ Group Number ________________

Policyholder Name ________________ Policyholder Date of Birth ________________

PATIENT TO SIGN

7 PATIENT AUTHORIZATION

By signing this form, I authorize IncyteCARES for OPZELURA, and/or parties acting on their behalf to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, financial assistance resources and information, and for other non-marketing purposes. I further agree to be contacted by IncyteCARES for OPZELURA or parties acting on their behalf using phone, email, text, or an autodialer or prerecorded voice using the information provided to enable fulfillment services described.

☐ I also consent to Incyte and its agents to use my contact information (phone and email) to provide education and ongoing support services related to product, disease, and other related areas of interest. I understand that I may revoke my consent to be contacted for any of these purposes at any time by emailing privacy@incyte.com.

SIGN **Patient Signature X** ________________ Date ________________
(Legal representative should sign if patient is <18 years)

(If patient is <18 years, print name if signed by legal representative)

8 PRIVACY NOTICE (Patient should keep a copy for their records.)

By signing this form, you have previously given your permission to your physicians, pharmacies, laboratories, and other healthcare providers ("Healthcare Professionals") and your health insurers to share your health information with Incyte, its agents, and the IncyteCARES for OPZELURA program (collectively, "Incyte"). You understand that your health information includes information relating to your medical condition, treatment, and insurance coverage, as well as identifying information about you (including, for example, your name, address, and date of birth). Your health information will be shared with Incyte so that Incyte may provide you with various support and information to help you access OPZELURA, which may include the following (collectively, "Patient Support Activities"):

- Providing benefits investigations/verification and reimbursement support, including assisting with identification of your insurer's prior authorization requirements and requirements for appealing a denied claim
- Determining your eligibility for and helping you access copay savings for OPZELURA
- Communicating with your Healthcare Professionals about OPZELURA and Patient Support Activities
- Providing you with financial assistance resources and information if you are eligible

You understand that you do not have to sign this form and choosing not to sign will not affect your ability to receive treatment from your Healthcare Professionals or payment from your health insurer. However, if you do not sign this form, IncyteCARES for OPZELURA will not be able to provide you with assistance.

You understand that once your health information is shared, it may no longer be protected by federal privacy law. However, Incyte agrees to protect your health information and to use it for the purposes described in this form or as required or permitted by law.

You understand that this form will remain in effect for 1 year from the date of your signature unless you provide written notice that you would like to withdraw your authorization to share your health information sooner.

If you would like to withdraw your authorization, you may contact IncyteCARES for OPZELURA at 1-800-932-1720 or 6000 Park Lane, Pittsburgh, PA 15275. You understand that if you withdraw your authorization, no new information will be collected from you; however, information collected prior to your withdrawal of authorization may continue to be used or kept to provide services previously described. You understand you may receive a copy of this form.

Incyte also may use your health information for quality assurance purposes and to evaluate and improve its operations and services. You also understand that the information you provide may be combined with that of other registrants to create aggregated, anonymized data and to use and share only the anonymized data for any legitimate business purpose.

You can learn more about how Incyte processes your personal information at www.incyte.com/privacy-policy.

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