

## IncyteCARES for PEMAZYRE Form

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### Use this form to:

- Enroll your patient in the IncyteCARES for PEMAZYRE Patient Assistance Program or Temporary Access Program
- Write a prescription for PEMAZYRE® (pemigatinib)

Please legibly complete all required fields. **Fax completed form to 1-888-714-0016.**

We will contact you within 2 business days for program applications. For questions, call **1-855-452-5234**.

For more information, see [HCP.IncyteCARES.com/PEMAZYRE](http://HCP.IncyteCARES.com/PEMAZYRE).

### PATIENT INFORMATION

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Social Security Number (Optional) \_\_\_\_\_ 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 a US territory?  Yes  No

### ALTERNATE CONTACT (Optional)

Full Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

**FINANCIAL INFORMATION (Optional)**—Required only to apply for the Patient Assistance Program.  
See [HCP.IncyteCARES.com/PEMAZYRE](http://HCP.IncyteCARES.com/PEMAZYRE) for details.

Current Annual Household Income \_\_\_\_\_ Number of People in Household \_\_\_\_\_

### INSURANCE INFORMATION

Primary Prescription Insurer \_\_\_\_\_ Phone (Optional) \_\_\_\_\_

Policy ID Number \_\_\_\_\_ Group Number (Optional) \_\_\_\_\_

If patient is the policy subscriber, check here and skip fields below.

Subscriber Name \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Secondary Prescription Insurer (Optional) \_\_\_\_\_ 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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**CLINICAL INFORMATION**

Indication for which you are prescribing PEMAZYRE® (pemigatinib) tablets for this patient:

- Previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test.
- Relapsed or refractory myeloid/lymphoid neoplasms (MLNs) with FGFR1 rearrangement.
- Other (include description and diagnosis code) \_\_\_\_\_

Treatment status:  New to PEMAZYRE  Currently on PEMAZYRE  Restarting PEMAZYRE

**PRESCRIPTION FOR PEMAZYRE**

Use this section to write your patient's prescription. (No Patient Authorization signature is required.)

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

Patient Name \_\_\_\_\_

Allergies \_\_\_\_\_

Concurrent Medications (Optional) \_\_\_\_\_

Medication Name: PEMAZYRE® (pemigatinib) tablets Dosage:  4.5 mg  9 mg  13.5 mg

Directions \_\_\_\_\_

Quantity \_\_\_\_\_ Days Supply \_\_\_\_\_ Refill(s) \_\_\_\_\_

Prescriber Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Ship medication to:  Patient's Home  Doctor's Office  Other \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Full Name \_\_\_\_\_

Please provide at least one of the following:

State License Number \_\_\_\_\_ Payer-Specific ID Number \_\_\_\_\_

Tax ID Number \_\_\_\_\_ NPI Number \_\_\_\_\_

Site/Facility Name (Optional) \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ ZIP \_\_\_\_\_

Office Contact Name \_\_\_\_\_ Email (Optional) \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

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**PRESCRIBER DECLARATION**

I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed PEMAZYRE based on my professional judgment of medical necessity.

I represent and warrant that I have my patient’s authorization on file to (i) disclose his/her health information and to transfer such information to Incyte and its agents to use and disclose as necessary to provide reimbursement services and (ii) to forward this prescription to a dispensing pharmacy on behalf of my patient.

I appoint IncyteCARES solely to convey on my behalf, to the pharmacy chosen by or for the patient, the prescription described herein.

I authorize IncyteCARES to perform a preliminary assessment of insurance verification for the patient, and I further authorize and request that the program provide to me any and all information necessary for completing a Letter of Medical Necessity as may be required as a result of such insurance verification assessment.

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

Prescriber Name \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**PATIENT AUTHORIZATION**

All fields are required unless noted.

I authorize my Healthcare Professionals (eg, physicians, pharmacies) and my insurance company to 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 Program (collectively, “Incyte”) so that Incyte may use the information for purposes of: (i) assessing my eligibility for copay assistance or free drug or referring me to other programs or sources of funding and financial support; (ii) coordinating delivery of PEMAZYRE® (pemigatinib) to me or my Healthcare Professional; (iii) providing education, information on Incyte products and services, and ongoing support services to me related to PEMAZYRE; (iv) gathering feedback on my therapy and/or disease state; (v) contacting me by mail, email, phone, or fax for any of the above purposes; and (vi) creating information that does not identify me personally for use for other legitimate purposes. I understand that my pharmacy providers may receive remuneration for making such disclosures. I also authorize my Healthcare Professionals and my insurance company to use my

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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.

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 at 1-855-452-5234 or by mail at 11800 Weston Parkway, Cary, NC 27513. My cancellation of this authorization will be effective when my Healthcare Professionals 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 and that it expires one year after the date below unless I cancel it before then.

Patient's Full Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Patient's Legal Representative (*Optional*) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Relationship with patient \_\_\_\_\_

This Patient Authorization expires one year after signature date. Please keep a copy for your records.

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