

IncyteCARES for PEMAZYRE Form

(Page 1 of 3)

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 IncyteCARES.com.

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 IncyteCARES.com 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.
- 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

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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