IncyteCARES | ZYNYZ® retifanlimab-dlwr Injection 500 mg

IncyteCARES for ZYNYZ Program Enrollment Form

Please legibly complete all fields not marked optional, for timely processing. **Fax completed form to 1-855-525-7207.**
We will contact you within 2 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/ZYNYZ**.*

☐ **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 _____

FINANCIAL INFORMATION *(Optional)*—Required only to apply for the Patient Assistance Program.
See ***HCP.IncyteCARES.com/ZYNYZ*** for details.

Current Annual Household Income _____ Number of People in Household _____

INSURANCE INFORMATION

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

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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For complete program details, visit ***HCP.IncyteCARES.com/ZYNYZ***.
Please see Full Prescribing Information for ZYNYZ® (retifanlimab-dlwr) at ZYNYZ.com.

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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 ZYNYZ® (retifanlimab-dlwr) 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 ZYNYZ.

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 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 ZYNYZ 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 ZYNYZ

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 ____/____/____

Medication Name: ZYNYZ® (retifanlimab-dlwr)

Directions: 500 mg administered as an intravenous infusion over 30 minutes every 4 weeks

Number of Treatments: _____ DEA Number _____

Concurrent Medications ☐ None _____

Allergies ☐ None _____

Prescriber Signature _____ Date ____/____/____

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

☐ Adult patient with metastatic or recurrent locally advanced Merkel cell carcinoma (MCC)

☐ Adult patient with locally recurrent or metastatic squamous cell carcinoma of the anal canal (SCAC)

☐ Other _____

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

Description _____

Previous Therapy Given

Dates _____ Dose _____

Therapy Given _____ Frequency _____

PATIENT AUTHORIZATION

All fields are required unless noted.

I authorize my healthcare providers (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 for ZYNYZ program (collectively, "Incyte") so that Incyte may use the information for purposes of: (i) assisting in my enrollment in IncyteCARES for ZYNYZ; (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 ZYNYZ® (retifanlimab-dlwr) to me or my healthcare provider; (iv) providing education, information on Incyte products and services, and ongoing support services to me related to ZYNYZ; (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 ZYNYZ. 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.

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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 for ZYNYZ at 1-855-452-5234 or by mail at PO Box 221798, Charlotte, NC 28222-1798. 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**.

☐ **For patients eligible for IncyteCARES education and support program (which includes occasional emails and outbound calls):** I agree to be contacted by Incyte, its agents, and the IncyteCARES 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 Full Name _____

Signature _____ Date ____/____/____

Patient's Legal Representative *(Optional)* _____

Signature _____ Date ____/____/____

Relationship _____

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