Daiichi-Sankyo | access central 4U™

Patient Enrollment Form

- Completing this form allows your patient's eligibility to be assessed for Daiichi Sankyo product support programs. If your patient is deemed eligible for a support program, the patient will be informed and automatically enrolled in that particular program.
- The Physician Attestation on page 4 and Patient Consent on page 5 outline the terms and conditions associated with the completion of this form. Please ensure the patient receives a copy of the Patient Consent, and that both the physician and patient review all information provided before signing this form.

How to use this form:

1. **Be sure to complete all required fields marked with a green asterisk (*)**
2. **Print the form then obtain the physician's and patient's (or patient representative's) signatures**
3. **Fax the form**

Patient Enrollment Form

1 SERVICES REQUESTED (Select all that apply.)

TURALIO® (pexidartinib)

- ❑ QuickStart Program assessment for coverage delay of ≥5 business days
- ❑ Patient Assistance Program assessment
- ❑ Specialty pharmacy services provided exclusively by **Biologics**

Biologics by McKesson can conduct a benefits investigation, prior authorization support, and assess eligibility for the patient assistance program or PAP.

For TURALIO patients, fax the completed form to this REMS certified specialty pharmacy

Biologics by McKesson	**Fax: 1-800-823-4506** **Phone: 1-800-850-4306**

For TURALIO patients who you feel may be eligible for PAP

Daiichi Sankyo AccessCentral4U	**Fax: 1-833-471-9988** **Phone: 1-866-4-DSI-NOW (1-866-437-4669)**

VANFLYTA® (quizartinib)

- ❑ QuickStart Program assessment for coverage delay of ≥5 business days
- ❑ Patient Assistance Program assessment
- ❑ Specialty pharmacy services provided by **Biologics** or **Onco360**

Your preferred specialty pharmacy can conduct a benefits investigation, prior authorization support, and assess eligibility for the patient assistance program or PAP.

In addition to the specialty pharmacies mentioned above, you may also choose to use a non-specialty pharmacy (eg, hospital outpatient pharmacy or in-office pharmacy).

For VANFLYTA patients, fax the completed form to your preferred REMS certified specialty pharmacy

Biologics by McKesson	**Fax: 1-800-823-4506** **Phone: 1-800-850-4306**
Onco360® Oncology Pharmacy	**Fax: 1-877-662-6355** **Phone: 1-877-662-6633**

For VANFLYTA patients who you feel may be eligible for PAP or if using non-specialty pharmacy (eg, a hospital outpatient pharmacy or in-office pharmacy)

Daiichi Sankyo AccessCentral4U	**Fax: 1-833-471-9988** **Phone: 1-866-4-DSI-NOW (1-866-437-4669)**

Note: If you are licensed to practice in the state of New York, you must also submit the prescription via ePrescribing.

Questions regarding the patient's prescription or need help with patient support services? Contact the entity that will be receiving this completed Patient Enrollment Form.

Patient Enrollment Form

This form is not required for commercially insured patients to enroll in the Patient Savings Program. Please visit DSAccessCentral4U.com to apply.

*Required Fields

2 PATIENT INFORMATION

*First Name: _____ *Last Name: _____ *Patient Date of Birth: ___/___/___ (MM/DD/YYYY) *Gender: ❑ M ❑ F

*Address: _____ *City: _____ *State: _____ *ZIP: _____

*Preferred Phone: ❑ Home ❑ Mobile _____ Email: _____

Alternate Contact Name: _____ Relationship to Patient: _____

Alternate Contact Phone: _____ Patient Preferred language (if other than English): _____

Permission to Contact Patient?: ❑ Yes ❑ No

3 PATIENT INSURANCE INFORMATION

Please include front and back copies of all medical and pharmacy cards or complete this section.

***Insurance Type:** (If the patient has both Medicaid and Medicare coverage, check both.)

❑ Uninsured ❑ Commercial/Private ❑ Medicare ❑ Medicaid ❑ Other: _____

Has the patient's employer, insurance plan, or their appointed representative directed you or the patient to seek enrollment in our PAP as a requirement of their drug coverage? ❑ Yes ❑ No

	*Primary Medical Insurance	Secondary/Supplemental Medical Insurance (Including Medicare)	Pharmacy Insurance
*Insurance Plan Name			
*Insurance Phone			
*Cardholder Name (if not the patient)			
*Cardholder Date of Birth			
*Policy ID			
Group #			
BIN/PCN			

4 INCOME

If applying for the Patient Assistance Program, what is the total combined household income before taxes? (Include yourself, all adults, and all dependents)

Income Verification: The Program and its authorized third-party agents will use your date of birth or social security number and/or additional demographic information as needed to access your credit information and information derived from public and other sources to estimate your income in conjunction with the eligibility determination process. As a soft credit inquiry, this option will not impact your credit score. The Program and its authorized third-p arty agents reserve the right to ask for additional documents and information at any time.

$ _____ Monthly OR $ _____ Yearly

If you have coverage under Medicare, how much have you spent on medicines during the current year? $ _____

Number of people in your household: _____ Number of dependents in your household under age 18: _____
(Include yourself, all adults, and all dependents)

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*Required Fields

5 PRESCRIPTION INFORMATION

*Patient Name: _____ *Patient Date of Birth: _____ *Diagnosis Code (ICD-10-CM): _____
MM/DD/YYYY

❑ TURALIO® (pexidartinib)

TURALIO PRESCRIPTION INFORMATION (please fill in all blank fields for TURALIO patients only):

Product Name: TURALIO (pexidartinib)

If applying for the Patient Assistance Program:

***Total Daily Dose:** _____ mg *Dispense 30-day supply.*
**Refills:* _____.*

***Instructions:** TURALIO 125 mg capsules: Take ___ capsule(s) orally twice daily with a low-fat meal (approximately 11-14 grams of total fat).

If applying for the QuickStart Prescription (optional):

***Total Daily Dose:** _____ mg *Dispense 14-day supply. No Refills.*

Instructions: TURALIO 125 mg capsules: Take ___ capsule(s) orally twice daily with a low-fat meal (approximately 11-14 grams of total fat).

❑ VANFLYTA® (quizartinib)

VANFLYTA PRESCRIPTION INFORMATION (please fill in all blank fields for VANFLYTA patients only):

Product Name: VANFLYTA (quizartinib)

If applying for the Patient Assistance Program:

***DOSING INSTRUCTIONS**

*Take ___ tablet(s) of ❑ **17.7 mg** ❑ **26.5 mg** *once daily.

*Quantity: ___ *Refills: ___

If applying for the QuickStart Prescription (optional):

*Take ___ tablet(s). Please fill in blank fields for quantity.
Dispense 14-day supply. No refills.

Take ❑ **17.7 mg** tablet(s) once daily for 14 days.

Take ❑ **26.5 mg** tablet(s) once daily for 14 days.

6 PROVIDER INFORMATION

*Provider Name: _____ Specialty: _____

*Practice Name: _____ Office Contact Name: _____

*Address: _____ *City: _____ *State: _____ *ZIP: _____

*Shipping Address (if applicable): _____ *City: _____ *State: _____ *ZIP: _____

*Phone: _____ *Fax: _____ Email: _____

*Provider NPI #: _____ State Tax ID #: _____

Other Provider ID (if applicable): _____

Alt. Office Contact Name: _____ Alt. Office Contact Phone: _____ Alt. Office Contact Email: _____

7 PHYSICIAN ATTESTATION

By providing my signature on page 5 of this form, I attest that I am the prescribing healthcare provider and have determined that prescribing said product is medically appropriate and have explained the reasons for doing so to my patient.

I also agree to submit requests to Daiichi Sankyo AccessCentral4U on behalf of my patient so that his or her eligibility can be evaluated to determine access to various assistance programs. I certify that I have received the necessary consent from my patient to release the information referenced above and other protected health information (as defined by the Health Insurance Portability and Accountability Act [HIPAA] of 1996) to Daiichi Sankyo AccessCentral4U and/or its service providers. The patient has confirmed his or her consent by reading page 6 of this form and providing his or her signature on page 6 of this form.

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*Required Fields

7 PHYSICIAN ATTESTATION (continued)

I authorize Daiichi Sankyo AccessCentral4U and its service providers, on behalf of my patients, to forward a prescription by fax or another mode of delivery to a pharmacy that Daiichi Sankyo has authorized to dispense said product. I also certify that this prescription complies with all applicable state and local laws. I agree to notify Daiichi Sankyo AccessCentral4U or its service providers if I become aware at any time of changes in my patient's circumstances that would affect his or her eligibility for any Daiichi Sankyo AccessCentral4U programs, including but not limited to changes in health insurance status or coverage, financial status, residency status in the United States, or the indication for which said product has been prescribed for my patient.

I understand that Daiichi Sankyo reserves the right to change or terminate any Daiichi Sankyo AccessCentral4U services (including the Patient Savings Program or Patient Assistance Program) at any time or to refuse to provide said product to any patient under the Patient Assistance Program.

If my patient obtains said product via the Patient Assistance Program, I attest that I understand the following:

- No third party or patient can be charged for said product under such program
- No free product should be sold, traded, or distributed for sale
- Any free drug provided is not contingent upon future purchase or prescribing of said product

By signing page 5 of this form, I certify that a copy of the Patient Consent has been given to the patient named on page 3 or his or her representative.

*I confirm I have read and understood the Physician Attestation of this form and agree to the terms explained therein.

Provider Name: _____

*PROVIDER SIGNATURE: _____ *DATE: _____

8 PATIENT CONSENT

Release of personal information

By providing my signature on page 6 of this form, I authorize my physician(s), healthcare provider(s), health insurance company, and my pharmacy to disclose information about me (for example, my name, address, and insurance policy number) and my medical condition (for example, my diagnosis or medications) to Daiichi Sankyo and its third-party vendors, suppliers, and other service providers supporting Daiichi Sankyo AccessCentral4U (herein described collectively as "service providers").

I authorize my specialty pharmacy and other service providers supporting Daiichi Sankyo AccessCentral4U to share information about me with each other. I recognize that this type of personally identifiable information (PII) could include spoken or written facts about my health or healthcare or copies of records about my health and insurance benefits provided by my healthcare provider(s) or health plan. My decision to sign this form (or to not sign this form) will not affect the treatment I receive from any healthcare professional or entity involved in my care or coverage.

Use of personal information

I understand that the service providers or pharmacy could use or provide my information in one or more of the following ways:

- Assess my eligibility and assist with my enrollment in a Daiichi Sankyo support program, including the Patient Savings Program or Patient Assistance Program, and contact me (and/or my legal representative) about my eligibility and enrollment status
- Verify, investigate, and help coordinate my coverage for said product with my health insurance company
- Make referrals to other independent programs or alternate funding sources that may be able to provide me with assistance as allowed under the law, if necessary
- Assist with analyses of the efficiencies and performance of the services provided by service providers
- Provide me (and/or my legal representative) with educational materials, information, and support relating to the Daiichi Sankyo AccessCentral4U services
- Provide support to appeal any insurance denials

Patient Enrollment Form

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*Required Fields

8 PATIENT CONSENT (continued)

In some instances, the service providers may de-identify my information and use or disclose the de-identified information (in individual or aggregated form) for any legitimate business purposes. I understand that the service providers will make reasonable efforts to keep my information private; however, I understand that once my information has been disclosed to the service providers, how the service providers further disclose my information may no longer be protected under federal and state privacy laws.
I understand that Daiichi Sankyo AccessCentral4U is a component of Daiichi Sankyo and that the service providers may be compensated by Daiichi Sankyo. My healthcare providers and my pharmacy may also receive remuneration, or payment, for disclosing my information pursuant to this consent.

Consent terms

This consent will last for 3 years from the date on this form or until I am no longer receiving said product or enrolled in any Daiichi Sankyo AccessCentral4U services. I recognize that I do not have to sign the consent on page 6, but if I do not, I will not be given referrals for alternative funding source, or have access to other services provided by or on behalf of Daiichi Sankyo AccessCentral4U. My decision to sign this form will not affect the treatment I receive from any healthcare professional or entity involved in my care or coverage. I may cancel this consent at any time by contacting Daiichi Sankyo AccessCentral4U at 1-866-4-DSI-NOW. By doing so, I revoke my consent for my healthcare provider to disclose my health information to Daiichi Sankyo or its service providers as well as discontinue my participation in the support program. I recognize that revoking my consent will not affect the use or the disclosure of health information that was already disclosed before my cancellation.
I confirm that I have received a copy of this consent, and I know I have a right to see or copy the information my healthcare providers or payers have given to the service providers.

Additional information to assess eligibility for the Patient Assistance Program

I agree to allow Daiichi Sankyo and its associated service providers to use my demographic information, including but not limited to my name, date of birth, and/or address as needed to access my credit information and information derived from public and other sources. This includes information from a consumer reporting agency (credit bureau) to estimate my income in conjunction with the eligibility determination process performed to determine my eligibility under the Patient Assistance Program. I do not have any prescription drug coverage that helps pay for or potentially helps pay for the requested medication (except Medicare for applicable products), even if that coverage includes an alternate funding program that requires you to first try to obtain your medicine from a third party or patient assistance program. I understand I may be required to apply for prescription assistance through a government assistance program to maintain eligibility for this program. Daiichi Sankyo and its associated service providers reserve the right to request additional documents and information at any time. I agree to notify my healthcare providers if I undergo any changes that would, to my knowledge, affect my eligibility, including, but not limited to, changes in health insurance status or coverage, financial status, and my residing status in the United States. The terms of this document are governed by and interpreted in accordance with the laws of the state of New Jersey, excluding New Jersey conflict of law rules, and applicable federal law.

*I confirm I have read and understood the Patient Consent of this form and agree to the terms explained therein.

Patient Name: _____

*PATIENT SIGNATURE: _____ *DATE: _____

For Representatives: If a representative for the patient needs to sign this form, please indicate the representative's authority to sign on behalf of the patient (eg, healthcare power of attorney, healthcare proxy, court-appointed legal guardian). Healthcare office staff cannot sign on behalf of the patient.

Reason for Authority: _____

Representative Attestation: I confirm that I have the legal right to sign this form (as stated above) on behalf of the patient. I confirm that I have read and understood the Patient Consent of this form and agree to the terms explained therein.

Representative Signature: _____ **Date:** _____