ILUMYA™ tildrakizumab-asmn Injection 100 mg/mL

ILUMYA SUPPORT™

Patient Services Enrollment Form

ILUMYA SUPPORT™ Patient Services
PO Box 29051
Phoenix, AZ 85038-9051

Fax: 877-872-6575
Phone: 855-4ILUMYA (855-445-8692)

Version 4: Updated October 2019

REQUIRED SECTIONS (Sections 1-5)

1. Requested Services

☐ **All services listed at right are requested** ☐ **Benefits investigation and prior authorization assistance** ☐ **Financial assistance (EAP, co-pay, PAP)** ☐ **Claim denial assistance** ☐ **Sending to SPP**

2. Patient Information

First name _____ MI _____ Last name _____ DOB (MM/DD/YYYY) ____/____/____ Gender ☐ M ☐ F ☐ Other

Address _____ City _____ State _____ Zip code _____

Cell phone # (_____) _____ Home phone # (_____) _____ Email address _____

Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening Communication preference: ☐ Phone ☐ Email ☐ Mail ☐ OK to leave a detailed message

By signing below, you agree to receive communications from the ILUMYA SUPPORT™ Program and verify that you have read and agree to the Patient HIPAA Authorization on the back of this form.

- By providing my cell phone number, I agree to receive automated (and/or prerecorded) calls, texts, and emails about the ILUMYA SUPPORT™ Program. I confirm that I am the subscriber for the telephone number(s) provided and the authorized user for the email address(es) provided, and I agree to notify Sun Pharmaceutical Industries, Inc, promptly if any of my numbers or addresses change in the future. I understand that my wireless service provider's message and data rates may apply. I understand that no purchase is necessary to receive these calls, texts, or emails. I understand that I can opt out from receiving future text messages by texting STOP to 20808 from my mobile phone, and that I can request help by texting HELP to 20808. By signing below, I agree and certify that I am 18 years of age.

X	X	X			X
Patient Signature	**Print Patient Name**	**Date (MM/DD/YYYY)**	**Signature of Personal Representative** (Legally authorized to act on behalf of the patient)	**Print Personal Rep Name** (if applicable)	**Date (MM/DD/YYYY)**

I acknowledge that I have read and agree to the Patient HIPAA Authorization on the back of this form.

X	X	X			X
Patient Signature	**Print Patient Name**	**Date (MM/DD/YYYY)**	**Signature of Personal Representative** (Legally authorized to act on behalf of the patient)	**Print Personal Rep Name** (if applicable)	**Date (MM/DD/YYYY)**

3. Patient Insurance Information

☐ No insurance coverage **OR** ☐ Copy of the policyholder's insurance card(s) (front and back) is attached (include all insurance cards: commercial, Medicare, and/or secondary insurance and prescription card) **OR** ☐ Complete the insurance information below (if you cannot copy the policyholder's insurance card[s]).

Primary insurance _____ Policyholder _____ Insurance phone # (_____) _____

Policy ID # _____ Group # _____ Rx BIN _____ PCN _____

4. Healthcare Provider Information

First name _____ Last name _____

Facility/practice name _____ Specialty _____

Practice address _____ City _____ State _____ Zip code _____

Practice phone # (_____) _____ Practice fax # (_____) _____ NPI # _____ State license # _____ Tax ID # _____

Practice contact first and last name _____ Phone # (_____) _____ Email address _____

Preferred shipment location Choose one: ☐ Practice ☐ Alternative site of care

Location name _____ NPI # _____

Address _____ City _____ State _____ Zip code _____

By signing below, I acknowledge that I have read and agree to the Provider Agreement on the back of this form.

X	X
Provider Signature	**Date (MM/DD/YYYY)**

5. Prescription Information (To Be Completed by the Provider Only)

ILUMYA™ Prescription (Please attach your prescription if this form does not comply with your state laws)

Primary diagnosis ☐ Psoriasis vulgaris (ICD-10-CM code: L40.0) ☐ Other _____

Prescribed dose ILUMYA™ (tildrakizumab-asmn) 100 mg/1 mL prefilled syringe; SIG: administer 100 mg (1 mL) subcutaneously at week 0, week 4, and every 12 weeks thereafter Quantity _____ # of refills _____

Scheduled injection date (if known) _____

Has your patient started therapy with ILUMYA™? ☐ Yes ☐ No

If Yes: How many treatments has the patient received? _____

What was the date of the first treatment? _____

What is the date of the next treatment? _____

Preferred Specialty Pharmacy

Preferred specialty pharmacy (used if specialty pharmacy not payer mandated) _____

Preferred specialty pharmacy phone # (_____) _____ Preferred specialty pharmacy fax # (_____) _____

Note: Payer-mandated pharmacies will take first precedence, followed by preferred specialty pharmacy. ILUMYA SUPPORT™ will perform additional research to determine all options.

X	X		
Provider Signature *(Dispense as Written)*	**Date (MM/DD/YYYY)**	**Provider Signature *(Product Substitution Permitted)***	**Date (MM/DD/YYYY)**

OPTIONAL: 6. Patient Financial Information (ONLY complete this section if requesting the Patient Assistance Program)

US resident? ☐ Yes ☐ No Disabled (longer than 2 years)? ☐ Yes ☐ No

☐ **Provider attestation:** Please contact the above-identified patient to explore alternate funding options, including the ILUMYA SUPPORT™ Patient Assistance Program. I understand that the patient will be asked for the following information: • Total number of people living in the household including patient • Total monthly income including all people contributing to the income

Provider Agreement

Sun Pharmaceutical Industries, Inc., its affiliates, business partners, service providers, third-party contractors, and agents (together, "Sun Pharmaceutical Industries, Inc.") will use the information you provide to administer and improve ILUMYA SUPPORT™ Patient Services (the "Program").

By signing Section 5 on the front of this form, I (the prescriber) understand and agree that:

- I certify that the patient and physician information obtained in this enrollment form is complete and accurate to the best of my knowledge.
- I have prescribed ILUMYA™ based on my professional judgment of medical necessity.
- Any medications supplied by Sun Pharmaceutical Industries, Inc., as a result of this form are for use by the named patient only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third-party payer (private or government) for reimbursement.
- Sun Pharmaceutical Industries, Inc., may modify or terminate the program at any time without notice.
- I have received the necessary legal authorization from the patient to transmit the patient's personal health information, for the purposes provided on this form, to Sun Pharmaceutical Industries, Inc.
- I authorize ILUMYA SUPPORT™ Patient Services to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan to dispense the drug above to this patient.
- ILUMYA SUPPORT™ may contact me for additional information relating to the Program, including but not limited to via email, fax, telephone, and text.

I understand that the Early Access Program is designed to support patients who are experiencing a delay in obtaining insurance coverage for ILUMYA™ for up to 2 years or until such coverage is secured. I confirm that I will support the above-identified patient in seeking to secure such coverage as I deem appropriate. I understand that neither I nor the patient may seek reimbursement for free product received under the program.

Patient HIPAA Authorization

By signing Section 2 on the front of this form, I give permission for my health care providers (HCPs), my pharmacies, and my health insurer(s) to disclose my personal information, including information about my health insurance and payment/benefits, prescriptions, medical condition and treatment, and my demographic and contact information ("Personal Information") to Sun Pharmaceutical Industries, Inc., its affiliates, business partners, service providers, third-party contractors, and agents (together, "Sun Pharmaceutical Industries, Inc.") for the purposes described below.

I understand the purpose of this Authorization is to (i) enroll me in the ILUMYA SUPPORT™ Program (the "Program"), including to help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with ILUMYA™, coordinate my receipt of and payment for ILUMYA™, facilitate my access to ILUMYA™, and assist in an appeal, grievance, and/or independent review request of a denial of insurance benefits and/or coverage; (ii) manage the Program, which may include conducting quality assurance and other internal business activities in connection with the Program; (iii) provide me with adherence reminders and treatment support; (iv) for marketing purposes which includes, but is not limited to, providing me with educational and promotional materials, information, special offers, and services related to my therapy or my medical condition, which may be funded or sent by a Program affiliate; and (v) for market research purposes, which includes contacting me to participate in focus groups, surveys, or interviews.

I understand that my Personal Information may be summarized for statistical or other purposes and provided to Sun Pharmaceutical Industries, Inc.

I understand that my pharmacy, health insurer(s), and health care providers may receive remuneration (payment) from Sun Pharmaceutical Industries, Inc., in exchange for disclosing my Personal Information to Sun Pharmaceutical Industries, Inc., and/or for providing me with therapy support services.

While the Program will safeguard my Personal Information and only use it for intended purposes, I understand that once my Personal Information is disclosed it may no longer be protected by federal privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization at any time in the future by sending a written notice to PO Box 29051, Phoenix, AZ 85038-9051, or by calling 855-445-8692, but I understand that this revocation will only apply to my HCP(s), pharmacies, and health insurer(s) once they receive notification of my revocation and only to the extent they have not already taken action based on it. My refusal or future revocation will not affect the commencement or continuation of my treatment, payment for treatment, insurance enrollment, or eligibility for benefits; however, if I refuse to sign this Authorization or if I revoke this Authorization, I may no longer be eligible to participate in the Program. I understand that this Authorization will remain valid for five (5) years after the date of my signature, unless a shorter period is mandated by state law or I revoke it earlier or cancel my authorization before then. I understand that I have the right to receive a copy of this Authorization.

Patient Services

To cancel participation in the ILUMYA SUPPORT™ program, please contact us at 855-4ILUMYA (855-445-8692).

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