ENROLLMENT FORM

PROVENGE® (sipuleucel-T)

Please complete and submit this enrollment form by faxing to 877-556-3737.
***Dendreon On Call* can be reached at 877-336-3736 Monday – Friday from 8:00 AM – 8:00 PM ET.**

1. Patient Information

First Name: _____ Last Name: _____
Complete with name as it appears on patient's photo ID

Date of Birth: _____ Primary Phone: _____ Secondary Phone: _____

Physical Address: _____
Street, City, Zip

Medical Record Number: _____

Primary Diagnosis (ICD-10): _____ Secondary Diagnosis (ICD-10): _____
Diagnosis codes are required for insurance

2. Healthcare Insurance Information

☐ I do **NOT** have healthcare insurance or indicate an alternate form of payment. If selected, **proceed to Section 3**

Primary Insurance		Secondary Insurance	
Insurance Company		Insurance Company	
Plan Name		Plan Name	
Policy #		Policy #	
Group #		Group #	
Phone #		Phone #	

3. Patient Assistance Programs (PAPs): select the program(s) you would like reviewed for eligibility

See section 8 for program details

☐ **PROVENGE® Uninsured Patient Program**

☐ **PROvide™ Commercial Co-pay Program**

☐ **Co-pay Assistance**

Answer is required for ALL below:

Annual household adjusted gross income is $225K or less ☐ YES ☐ NO

US citizen or permanent resident ☐ YES ☐ NO

How many people living in your household? _____

4. Patient Authorization (required) - I have read and agree to the Authorization in section 7

PATIENT'S SIGNATURE: SIGN _____ DATE: _____

☐ Obtain Patient's Electronic Signature Email Address: _____
(required for electronic signature)

5. Physician and Infusion Site Information

PHYSICIAN NAME: _____ NPI: _____ TAX ID: _____

Infusion Site Name: _____

Infusion Site Address: _____
Street, City, Zip

Contact name: _____ Phone #: _____ Fax #: _____

Is 340 B price requested? ☐ No ☐ Yes If yes, provide 340B number for correct billing: _____

Please provide your infusion site PO number(s) as required for your internal billing for PROVENGE®:

_____ PO #1 _____ PO #2 _____ PO #3

6. Physician Certification and Attestation (required) - I have read and agree to the Certification and Attestation in section 9

PHYSICIAN'S SIGNATURE: SIGN _____ DATE: _____

☐ Obtain Physician's Electronic Signature Physician's Email Address: _____
(required for electronic signature)

7. Patient Authorization (required)

I authorize my prescribing physician and any health insurers, plans, or programs that provide me health care benefits (collectively, "Health Plans") to disclose my past and present medical or other personal information, including information in this enrollment form, information about my treatment with PROVENGE (taken together, "information") and related medical conditions to Dendreon and its agents (collectively "Dendreon") for purposes related to my treatment, as further described in this Authorization. I authorize Dendreon to use and disclose the information for the following specific purposes: ordering, manufacturing, scheduling, delivering, and infusing PROVENGE; obtaining payment from my Health Plan(s); conducting reimbursement verification; applying for or making referrals for Patient Assistance Programs upon my request; providing me with educational and treatment support services ("support services") by mail, e-mail, and/or telephone, or as permitted by law. I understand that support services may include product information materials, treatment reminders, or surveys about my treatment experience with PROVENGE. I understand that, once my information has been disclosed to Dendreon, federal and state privacy laws may no longer protect it against further use or disclosure. However, Dendreon agrees to protect my information by using it only for the purposes authorized in this Authorization or as permitted by law. I understand that signing this Authorization is voluntary and, if I do not sign this Authorization, it will not affect my ability to obtain alternative treatments from my prescribing physician or obtain insurance or insurance benefits. I understand, however, that if I do not sign this Authorization I will not be eligible to receive PROVENGE and the support services and other services described above. I may withdraw this Authorization at any time by mailing a written request to 1208 Eastlake Ave E, Seattle, WA 98109 ATTN: Dendreon On Call or by calling 877-336-3736. Withdrawal of this Authorization will end further uses and disclosures of my information by the parties identified in this Authorization, except to the extent those uses and disclosures have been made in reliance upon this Authorization and as permitted by applicable law. This Authorization expires 10 years from the patient signature date indicated below unless I withdraw it earlier. I am entitled to receive a copy of this Authorization.

8. Patient Assistance Program Information*

PROVENGE Uninsured Patient Program - A program that can provide PROVENGE at no cost if you have no health insurance, including if you do not have drug coverage due to drug benefit carve-out, or are rendered uninsured due to payer claim denial. Dendreon cannot guarantee that you will receive assistance under this program.

PROvide Commercial Copay Program - A program that supports eligible patients with private commercial (non-government payers) insurance by covering any combination of the following cost co-pays, co-insurance, or deductible costs—to a maximum of $10,000 over 3 PROVENGE treatments. Dendreon cannot guarantee that you will receive assistance under this program.

Co-Pay Assistance - Co-pay foundations provide assistance regardless of the choice of medicine, and decisions are based on financial need and according to criteria established by individual foundations. Dendreon can assist patients by referring them to these independent organizations. Dendreon cannot guarantee that patients will be eligible for or receive assistance after referral. Dendreon does not have controlling or managerial influence on these independent organizations.

*By requesting program assistance, you agree to provide proof of income and/or residency information in a timely manner, upon request.

9. Physician Certification and Attestation

I verify the information I have provided in this enrollment form is complete and accurate to the best of my knowledge. I have obtained my patient's authorization, as indicated, to disclose his health information related to treatment with PROVENGE® to Dendreon and its designated agents for Dendreon to use and disclose as necessary in the provision of health services or to offer patient care and support services and/or reimbursement support services.

If patient is enrolled in PROvide™, I agree that I will not submit any third-party claims for patient cost-sharing expenses (including co-pays, deductibles and/or co-insurance) that are covered by the PROvide™ Commercial Co-pay Program. I agree that I will disclose my participation in the Commercial Co-pay Program to third-party payers as required. In addition, I certify that my participation in this program is consistent with my obligations as a participating provider with any third-party payers.

Dendreon

SCAN TO VISIT WEBSITE

PROVENGE.COM/s