PATIENT CONNECT™

EUSA PATIENT CONNECT PROGRAM

PATIENT ENROLLMENT FORM (HCP)

Call Toll Free: 1-855-299-8844
Fax #: 888-223-1746
Monday - Friday: 8:00am to 5:00pm, ET

1. REQUESTED PATIENT SUPPORT

☐ Benefit Investigation | ☐ Copay Support | ☐ Patient Assistance Program (PAP)

2. PATIENT INFORMATION

First Name: | Last Name: | M.I.:

Address: *(Note: A physical address will be required to ship the medication)* | Apt./Suite #: | City:

State: | Zip Code: | Date of Birth: / / | Gender: M F

Primary Contact: | Relationship:

Home Phone #: | Work Phone #: | Cell Phone #: | Email:

Preferred Phone #: ☐ Home ☐ Work ☐ Cell | Preferred Language: ☐ English ☐ Other:

Alternate Contact/Caregiver/Parent: | Contact Phone #:

Appointment Reminder: ☐ Yes ☐ No

3. INSURANCE INFORMATION (IF YOU ARE ATTACHING COPIES, YOU DO NOT NEED TO COMPLETE THE INSURANCE INFORMATION BELOW)

☐ Check here if you are attaching a copy (front and back) of the patient's insurance card(s).

☐ Yes ☐ No Is the patient prescription paid for in whole or part by a government-funded program such as Medicare, Medicaid, or a Medicare Part D plan, TRICARE, VA or DoD?

☐ Yes ☐ No Do you have a Prescription Drug Card? | Prescription Drug Insurer Name: | Phone #:

Card Holder Name:

ID #: | Group #: | BIN #: | PCN #:

Primary Insurance #: | Phone #:

Card Holder Name: | ID #: | Group #:

Secondary Insurance: | Phone #:

Card Holder Name: | ID #: | Group #:

4. PRESCRIBER INFORMATION

Prescriber First Name: | Prescriber Last Name:

Facility Name: | **Office Contact Name:**

Address: | City: | State: | Zip Code:

Office Phone #: **Ext:** | **Office Fax #:** | Email:

Tax ID #: | NPI #: | Medicaid ID #: | State License #:

5. DIAGNOSIS AND CLINICAL INFORMATION (THIS IS FOR INSURANCE PURPOSES ONLY, NOT TO SUGGEST APPROVED USES OR INDICATIONS)

☐ Benign Neoplasm of Lymph Nodes (D36.0) | ☐ Castleman Disease (D47.Z2) | ☐ Localized Enlarged Lymph Nodes (R59.0)

☐ Generalized Enlarged Lymph Nodes (R59.1) | ☐ **Enlarged Lymph Nodes, unspecified (R59.9)** | ☐ Other

6. PRESCRIPTION INFORMATION AND STATEMENT OF MEDICAL NECESSITY

☐ **SYLVANT (siltuximab) 100mg vial** **Qty #:____** **Refills:____** | ☐ **SYLVANT (siltuximab) 400mg vial** **Qty #:____** **Refills:____**

SIG:

Special Instructions:
(Special Note: New York prescribers, please submit prescription of an original NY State prescription blank. For all other States, if not faxed, prescription **must be on State specific blank if applicable for your State.)**

Drug Allergies:
☐ No Known Drug Allergies:

By signing below, I certify that (1) I am prescribing EUSA medication for the patient identified in Section 3. I certify that this prescription is medically necessary for the patient and that it will be used as directed. I certify that I will be supervising the patient's treatment and verify that the information provided is complete and accurate to the best of my knowledge; (2) I have received the appropriate permission from the patient and met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and applicable state law needed to release the above information to EUSA and contractors designated by EUSA for the purposes of verifying the patient's insurance coverage for SYLVANT, seeking prior authorization for SYLVANT, if needed, on my patient's behalf, providing information on appeals of denials of claims, coordinating delivery of SYLVANT, to my patient's preferred site, and providing me and my patient with other educational and support associated with SYLVANT; (3) I agree that I shall not seek reimbursement for any EUSA medication dispensed to the patient through the Patient Assistance Program (PAP) from any government program or third-party insurer; (4) I authorize the above **prescription to be forwarded to the pharmacy chosen by the named patient. I understand that I must comply with my state specific prescription requirements such as e-prescribing, state specific prescription** form, fax language, etc. (5) contacting the patient with educational materials about the patient's prescription medication or to evaluate the effectiveness of the PAP; and (6) for EUSA's internal business purposes.

X PRESCRIBER SIGNATURE (REQUIRED): (NO STAMPS ALLOWED — DISPENSE AS WRITTEN) | DATE (REQUIRED):

1. REQUESTED PATIENT SUPPORT (check all boxes that apply)

1.1 Benefit Investigation: Check this box to find out about your patient's eligibility for EUSA medication.

1.2 Co-pay Support: Check this box if you want to find out about your patient's eligibility for co-pay support.

1.3 Patient Assistance Program (PAP): Check this box to find out what affordability assistance might be available for your patient.

2. PATIENT INFORMATION

2. Patient Information: Kindly provide all the details requested in this section.

3. INSURANCE INFORMATION

3. Check here if you are attaching a copy: Remember to check the first box in section 3, if you are attaching a copy of the front and back of your patient's insurance card.

3.1 Insurance Information: If you are attaching the copies of your patient's insurance card, you don't have to fill out this section. Otherwise, provide all the requested information.

4. PRESCRIBER INFORMATION

4. Prescriber Information: Please provide your prescriber information.

5-6. DIAGNOSIS, CLINICAL, AND PRESCRIPTION INFORMATION

5-6. Diagnosis, Clinical, and Prescription Information: Make sure all the information in sections 5 and 6 match your patient's diagnosis, clinical, and prescription information accurately. Any incorrect information will delay the approval of their medication.

X. PRESCRIBER SIGNATURE

X. Prescriber Signature: The prescriber should sign here in ink. No stamps allowed.

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This will help avoid delays at the pharmacy PATIENT NAME:_____ DATE OF BIRTH:_____

7. PATIENT AUTHORIZATION AND CONSENT (READ AND SIGN) — REQUIRED

As further described below, I hereby authorize my providers and health plans to share my personal and medical information as described below with EUSA, the manufacturer of SYLVANT® (siltuximab), and its contractors for limited purposes, all in accordance with this authorization.

Persons Authorized to Disclose My Information: My healthcare providers, including any pharmacy that fills my prescription for SYLVANT® (siltuximab) and other drugs or devices, and any EUSA health plans or programs that **provide me healthcare benefits.**

Information to Be Disclosed: Personal information about me (for example, my name, mailing address, and insurance information) and my medical information (including information about my status) (together all such information is called my "health information" in this authorization). I understand that my pharmacy providers may receive remuneration for disclosing my personal and medical information pursuant to this authorization.

Persons to Which My Health Information May Be Disclosed: EUSA, including the third party administrator responsible for the administration of the EUSA Patient Connect Program and the PAP (collectively referred to in this authorization as "EUSA").

Use of Information and Purposes for Which the Disclosures Are To Be Made: 1) establish my eligibility for benefits from my health plan or other programs; 2) provide financial assistance, access reimbursement, and referral support, and communicating with my healthcare providers, including, but not limited to, facilitating the provision of SYLVANT® (siltuximab) to me in certain limited situations; 3) to contact me to evaluate therapy, the effectiveness of the program and to conduct market research; 4) for EUSA's internal business purposes, including quality control, and support enhancing surveys; 5) to ensure the accuracy and completeness of my application for assistance; and 6) to send me marketing information, offers, and educational materials related to Castleman's disease and/or SYLVANT® (siltuximab), including the customer relationship marketing program (upon my consent, below).

I understand that once my health information has been disclosed to EUSA, privacy laws may no longer restrict its use or disclosure; however, EUSA intends to protect my health information by using and disclosing it for the purposes described above and as required by law. I further understand that I may refuse to sign this authorization and that if I **refuse, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not** have access to the support available through this program. I may cancel this authorization at any time by notifying EUSA in writing and submitting it by fax or at the EUSA Patient Connect Program address below. If I cancel, EUSA will stop using this authorization to access my health information after that cancellation date, but the cancellation will not affect any health information that has already been disclosed in reliance on this authorization before that cancellation date. I authorize the EUSA Patient Connect Program to leave a message, including the prescription name if I am unavailable. I am entitled to a copy of this signed authorization, which expires at the earlier of 10 (ten) years or other time period required under the state in which I reside, from the date it is signed by me.

PATIENT NAME (REQUIRED):	**DATE OF BIRTH** :
Patient Email:	Cell Phone #:
Prescriber Name:	Prescriber Phone #:
X **SIGNATURE** (REQUIRED): *(Signature of Patient or Authorized Patient Representative)*	**DATE** (REQUIRED):
Authorized Patient Representative Name *(if signing for the patient)*:	
Authorized Patient Representative Relationship to Patient:	

FAX COMPLETED FORM TO EUSA PATIENT CONNECT PROGRAM

EUSA Patient Connect Program, 6931 Arlington Road, Suite 308, Bethesda, Maryland 20814 (Monday-Friday 8AM - 5PM EST)

X. PATIENT SIGNATURE

X. Signature Required: The patient or the authorized patient representative must sign here. The required patient information should also be filled out.

FAX NUMBER:

1-888-223-1746

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