IncyteCARES for PEMAZYRE Form

Use this form to:
- Enroll your patient in the IncyteCARES for PEMAZYRE Patient Assistance Program or Temporary Access Program
- Write a prescription for PEMAZYRE® (pemigatinib)

Please legibly complete all required fields. **Fax completed form to 1-888-714-0016**.

We will contact you within 2 business days for program applications. For questions, call **1-855-452-5234**.

For more information, see ***HCP.IncyteCARES.com/PEMAZYRE****.*

PATIENT INFORMATION

Full Name ____________________ Date of Birth ____/____/____

Home Address ____________________

City ____________________ State __________ ZIP ____________

Social Security Number *(Optional)* ____________ 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 a US territory? ☐ Yes ☐ No

ALTERNATE CONTACT *(Optional)*

Full Name ____________________ Relationship __________ Phone Number ____________

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

Current Annual Household Income ____________________ Number of People in Household ______

INSURANCE INFORMATION

Primary Prescription Insurer ____________________ Phone *(Optional)* ____________

Policy ID Number ____________________ Group Number *(Optional)* ____________

If patient is the policy subscriber, check here and skip fields below. ☐

Subscriber Name ____________________ Subscriber Date of Birth ____/____/____

Secondary Prescription Insurer *(Optional)* ____________________ 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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CLINICAL INFORMATION

Indication for which you are prescribing PEMAZYRE® (pemigatinib) tablets for this patient:

☐ Previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test.

☐ Relapsed or refractory myeloid/lymphoid neoplasms (MLNs) with FGFR1 rearrangement.

☐ Other (include description and diagnosis code) ______________________________

Treatment status: ☐ New to PEMAZYRE ☐ Currently on PEMAZYRE ☐ Restarting PEMAZYRE

PRESCRIPTION FOR PEMAZYRE

Use this section to write your patient's prescription. (No Patient Authorization signature is required.)

A separate prescription form is not needed, unless required by state law. Date ____ /____ /____

Patient Name ______________________________

Allergies ______________________________

Concurrent Medications *(Optional)* ______________________________

____

Medication Name: PEMAZYRE® (pemigatinib) tablets Dosage: ☐ 4.5 mg ☐ 9 mg ☐ 13.5 mg

Directions ______________________________

Quantity ______ Days Supply ______ Refill(s) ______

Prescriber Signature ______________________________ Date ____/____/____

Ship medication to: ☐ Patient's Home ☐ Doctor's Office ☐ Other ______________________________

PRESCRIBER INFORMATION

Prescriber Full Name ______________________________

Please provide at least one of the following:

State License Number ______________________________ Payer-Specific ID Number ______________________________

Tax ID Number ______________________________ NPI Number ______________________________

Site/Facility Name *(Optional)* ______________________________

Street Address ______________________________ City ______________ State ____ ZIP ____________

Office Contact Name ______________________________ Email *(Optional)* ______________________________

Phone Number ______________________________ Fax Number ______________________________

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PRESCRIBER DECLARATION

I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed PEMAZYRE based on my professional judgment of medical necessity.

I represent and warrant that I have my patient's authorization on file to (i) disclose his/her health information and to transfer such information to Incyte and its agents to use and disclose as necessary to provide reimbursement services and (ii) to forward this prescription to a dispensing pharmacy on behalf of my patient.

I appoint IncyteCARES solely to convey on my behalf, to the pharmacy chosen by or for the patient, the prescription described herein.

I authorize IncyteCARES to perform a preliminary assessment of insurance verification for the patient, and I further authorize and request that the program provide to me any and all information necessary for completing a Letter of Medical Necessity as may be required as a result of such insurance verification assessment.

☐ **I have read and agree to the declaration above.**

Prescriber Name ____________________ Date ____/____/____

PATIENT AUTHORIZATION

All fields are required unless noted.

I authorize my Healthcare Professionals (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 Program (collectively, "Incyte") so that Incyte may use the information for purposes of: (i) assessing my eligibility for copay assistance or free drug or referring me to other programs or sources of funding and financial support; (ii) coordinating delivery of PEMAZYRE® (pemigatinib) to me or my Healthcare Professional; (iii) providing education, information on Incyte products and services, and ongoing support services to me related to PEMAZYRE; (iv) gathering feedback on my therapy and/or disease state; (v) contacting me by mail, email, phone, or fax for any of the above purposes; and (vi) creating information that does not identify me personally for use for other legitimate purposes. I understand that my pharmacy providers may receive remuneration for making such disclosures. I also authorize my Healthcare Professionals and my insurance company to use my

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PHI to communicate with me about Incyte products and services and I understand that they may receive remuneration for making such communications. 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 at 1-855-452-5234 or by mail at 11800 Weston Parkway, Cary, NC 27513. My cancellation of this authorization will be effective when my Healthcare Professionals 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 and that it expires one year after the date below unless I cancel it before then.

Patient's Full Name ______________________________

Signature ______________________________ Date ___/___/___

Patient's Legal Representative *(Optional)* ______________________________

Signature ______________________________ Date ___/___/___

Relationship with patient ______________________________

This Patient Authorization expires one year after signature date. Please keep a copy for your records.

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