ServierONE Enrollment Form

COMPLETE THIS FORM TO ENROLL PATIENTS IN THE SERVIER PATIENT SUPPORT SERVICES FOR TIBSOVO® (IVOSIDENIB TABLETS)

This form is not required for patients to apply for the Commercial $25 Co-Pay Program for TIBSOVO.
The Co-pay program is for eligible patients with commercial insurance. To apply, please visit ServierONE-copay.com

SERVICE SELECTION DIRECTIONS

With this single form you can connect your patients taking TIBSOVO to a variety of services.

1 ServierONE Patient Support Services

(check all that apply)

- ◯ I would like benefits investigation assistance for my patient.
- ◯ I would like support evaluating my patient for ServierONE Patient Services financial Support Programs.
- ◯ I would like my patient to be connected to a ServierONE Care Manger for one-on-one support.

Fax this Completed Form to ServierONE at 1-844-409-1143

Questions? Call ServierONE at 1-844-409-1141 Monday to Friday, 8 am to 6 pm ET

BEFORE FAXING:

- ◯ Be sure provider and patient have both signed where indicated
- ◯ Be sure to include completed form and a copy of both sides of the patient's insurance card(s)

1 PATIENT INFORMATION

Patient name (first and last)

/ / Date of birth (MM/DD/YYYY)

◯ Male ◯ Female

Social Security number
(to be used for verifying identity and eligibility for some programs)

Contact Information: (to be used for medication delivery):

Street address | City | State | ZIP

Primary phone (best contact number)

Alternate contact name and phone

2 INSURANCE INFORMATION

Please copy both sides of patient's insurance card(s)

Patient insurance (check all that apply): ❑ No insurance ❑ Medicare ❑ Medicaid ❑ Commercial/private ❑ Other

Primary health insurance	Prescription drug insurance	Secondary insurance
Plan name	Plan name	Plan name
Phone #	Phone #	Phone #
Policy ID #	Policy ID #	Policy ID #
Group #	Group #	Group #
Policy holder (if other than patient)	Rx BIN #	
Name	PCN #	
Date of birth ____/____/____ (mm/dd/yyyy)		

3 PATIENT DIAGNOSIS

- ◯ ICD-10-CM C22 Malignant neoplasm of liver and intrahepatic bile ducts
- ◯ ICD-10-CM C22.1 Intrahepatic bile duct carcinoma
- ◯ ICD-10-CM C24.0 Malignant neoplasm of extrahepatic bile duct
- ◯ ICD-10-CM C24.1 Malignant neoplasm of ampulla of Vater *
- ◯ ICD-10-CM C24.8 Malignant neoplasm of overlapping sites of biliary tract
- ◯ ICD-10-CM C24.9 Malignant neoplasm of biliary tract, unspecified
- ◯ ICD-10-CM C78.7 Secondary malignant neoplasm of liver and intrahepatic bile duct
- ◯ ICD-10-CM C92.00 Acute myeloblastic leukemia, not having achieved remission
- ◯ ICD-10-CM C92.01 Acute myeloblastic leukemia, in remission
- ◯ ICD-10-CM C92.02 Acute myeloblastic leukemia, in relapse
- ◯ IDC-10-CM C94.6 Myelodysplastic disease, not classified
- ◯ ICD-10-CM D46.9 Myelodysplastic syndrome, unspecified
- ◯ ICD-10-CM D46.2 Refractory anemia with excess of blasts [RAEB]
- ◯ ICD-10-CM D46.Z Other myelodysplastic syndromes
- ◯ Other ICD-10 (fill in below)

Current medications:

Allergies:

PATIENT NAME _____ DOB ____/____/_____

3 PATIENT DIAGNOSIS CONT.

(Answer Yes/No to all the below questions)

YES	NO	
◯	◯	1. Is this a newly diagnosed/frontline AML patient?
◯	◯	1a. Has the patient comorbidities that preclude the use of intensive induction chemotherapy?
◯	◯	2. Is this a refractory/relapse AML patient ?
◯	◯	3. Has the patient been diagnosed with locally advanced or metastatic cholangiocarcinoma?
◯	◯	3a. If yes, has the patient been previously treated?
◯	◯	4. Has the patient tested or is planning to test for IDH1 mutation?
◯	◯	5. Are IDH1 test results available?
◯	◯	5a.If yes, did the patient test positive for IDH1?
◯	◯	6. Will the patient receive a hypomethylating agent in addition to TIBSOVO for their treatment regimen?

4 PRESCRIBER INFORMATION

Prescriber name _____ Prescriber specialty _____

Practice name _____ Practice contact _____

Phone _____ Fax _____ Street address _____

Email _____ City _____ State _____ ZIP _____

NPI # _____ Tax ID # _____ State license # _____

DEA # _____ Medicare/Medicaid provider # _____

Provider Transaction Access Number (PTAN) _____

I certify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed TIBSOVO based on my judgment of medical necessity and I will be supervising the patient's treatment. I authorize, if appropriate, the forwarding of this prescription to an authorized specialty pharmacy on behalf of myself and the patient. I understand that neither I nor the patient may seek reimbursement from any government program or third-party insurer for any free product received under the program.
I certify that I have obtained the patient's authorization to release the above information and such other information as may be required by Servier or its agents to assist the patient in obtaining coverage for TIBSOVO, to assist the patient in initiating or continuing TIBSOVO therapy and to provide financial assistance to the patient.

Physician Signature _____ Date _____/_____/_____

Can ServierONE Patient Support Services follow up with you regarding your experience by phone or email? ◯ **No** ◯ **Yes**

PATIENT NAME _____ DOB ____/____/_____

5 PRESCRIPTION INFORMATION

Please be sure to fill out the below information in its entirety, including number of refills for Tibsovo (ivosidenib tablets 250mg).

Rx start date _____/_____/_____

TIBSOVO Dosage: _____ Quantity (days): _____ Refills: _____

Directions for use: _____

The recommended dose for TIBSOVO is 500 mg (two 250-mg tablets) orally once daily until disease progression or unacceptable toxicity.

Physician Signature _____ Date _____

(Dispense as written). Signature stamps not acceptable.

Physician Signature _____ Date _____

(Substitution permitted). Signature stamps not acceptable.

INSURANCE AUTHORIZATION INFORMATION

If a prior authorization and/or an appeal have been submitted to the insurance company please indicate the dates below.

Prior authorization submitted date: _____

Appeal submitted date: _____

Additional appeals submitted: _____

Please continue to next section

6 PATIENT AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I understand that ServierONE Patient Support Services is a service offered by Servier Pharmaceuticals, Inc. to help eligible patients who have been prescribed TIBSOVO obtain insurance coverage and financial assistance for TIBSOVO.

I give permission for my physician and their staff to disclose my health and other personal information, including, but not limited to the information on this form, to Servier Pharmaceuticals, Inc. and its agents and representatives (collectively "Servier") so that Servier may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers and patient assistance groups (collectively, "Third Parties") in order to: (1) enroll me in the Programs; (2) facilitate the filling of my prescription for and the delivery and administration of TIBSOVO; (3) assist me in obtaining insurance coverage for TIBSOVO; (4) contact me about TIBSOVO and the Programs (this may include supplemental educational materials, information, offers and services related to my therapy or my medical condition, or opportunities to participate in focus groups, surveys, or interviews); and (5) manage the Programs.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to Servier in order to assist Servier in accomplishing the purposes described above.

I understand that once my information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws (the Health Insurance Portability and Accountability Act) or state privacy laws and may be further disclosed to others. However, I understand that Servier will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent.

I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive TIBSOVO that is paid for by my insurer, my treatment, payment for treatment, eligibility for or enrollment in health benefits, but it will limit my ability to receive support services for TIBSOVO, including participation in free medication programs.

I understand that this authorization will remain in effect for 3 years, or a shorter period as may be required by state law, from the date of my signature, unless I revoke it earlier by contacting Servier in writing at AllCare c/o Servier Patient Support Services, 200 Pier Four Blvd. Boston, MA 02210. If I revoke this authorization, Servier and any Third Parties who are notified of my revocation will stop using and disclosing my information as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization.

I understand that the services described in this authorization may be reduced at any time, without prior notification. However, if any services are added, Servier will obtain my authorization to receive any such additional services.

I understand that certain Third Parties may receive compensation in exchange for their disclosure of my information to Servier. I also understand that I have the right to receive a copy of this authorization.

I verify the information provided is true and correct. If I am the caregiver/representative for the patient, I confirm I am authorized to sign on behalf of the patient.

*Patient name (print)*_____ *Representative name (print, if applicable)*_____

*Patient/Representative Signature*_____ *Date* _____/_____/_____

PATIENT NAME _____ **DOB** _____/_____/_____

7 INTEREST IN SERVIERONE PATIENT SERVICES FINANCIAL SUPPORT PROGRAMS INCLUDING THE FREE PRODUCT (PAP) FOR UNINSURED/UNDERINSURED PATIENTS AND THE QUICK START PROGRAM

To be completed by the patient or patient representative.

◯ **Yes, please assess my eligibility for ServierONE financial support services and have a one-on-one Care Manager contact me.**

◯ **Yes, I am a US resident**

Number of family members in household _____
(people who contribute to or are dependent on the household income)

Annual gross pretax household income _____
Note: *Dollar amount should be consistent with your 1040 tax form or W2.*

◯ Yes, I understand that in order to qualify for certain financial support programs I must meet program requirements. I certify that the information I have provided about my household income and size is accurate. I know that ServierONE Patient Support Services will ask me for a copy of my recent tax returns or other proof of income for the purpose of an audit and I agree to provide such documentation in a timely manner, if requested. I certify that the information provided above is truthful and accurate to the best of my knowledge and that any other information I provide at Servier's request will be truthful and accurate.

I understand that my eligibility for the program is based on requirements determined by Servier in its discretion (that ServierONE Patient Support Services may change at any time) and that, if approved, I must reapply and continue to meet eligibility requirements on an ongoing basis. I certify that I will notify the ServierONE Patient Assistance Program at 1-844-409-1141 if my income or health insurance status changes. I agree not to seek reimbursement from any government program or third-party insurer for any free product received under the program.

I verify the information provided is true and correct. If I am the caregiver/representative for the patient, I confirm I am authorized to sign on behalf of the patient.

*Patient name (print)*_____ *Representative name (print, if applicable)*_____

*Patient/Representative Signature*_____ *Date* _____/_____/_____