TerSera SupportSource | VARUBI® (rolapitant) tablets

TerSera SupportSource Varubi Enrollment Form

Fax completed enrollment form to 1-855-836-3066

Check for services requested:

☐ **Coverage Support (Benefits Investigation, Prior Authorization/Precertification Information, and/or Appeals Support)** (complete side 1)

☐ **Patient Assistance Program** (complete both sides of form)

1 Prescriber/Facility Information

Prescriber's Name: _____

NPI #: _____ DEA #: _____

PTAN #: _____ Tax ID #: _____

Site/Facility Name: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Office Contact's Name: _____

Select Preferred Method of Contact:

◯ Office Contact's Phone #: _____ ◯ Fax #: _____

◯ Office Contact's Email: _____

2 Patient information

Patient's Name: _____

Sex: ◯ Male ◯ Female Date of Birth: _____

Patient's Address: _____

City: _____ State: _____ ZIP: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Best Time to Contact Patient: _____

Alt. Contact Name: _____

Alt. Contact Relationship: _____

Alt. Contact Phone #: _____

3 Clinical Information

Primary Diagnosis: _____ Primary Diagnosis ICD-10 Code: _____

Supportive Care Diagnosis: _____ Supportive Care ICD-10 Code: _____

Expected Chemotherapy Regimen: _____

Expected Chemotherapy Duration: _____ Expected Chemotherapy Cycle Frequency: _____

Prior Supportive Care Therapies: _____ Drug Allergies: _____

Target Start Date: ____ / ____ / _____ Notes: _____

4 Insurance Information (Check the relevant box)

◯ **Medicare** ◯ **Medicaid** ◯ **Commercial/Private** ◯ **Other/Uninsured**

☐ **Copy of both sides of the patient's insurance card attached**

Medical Insurance Plan

Insurance Name: _____

Phone #: _____

Policy ID #: _____ Group #: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy Holder's Relationship to Patient: _____

Prescription Drug or Secondary Insurance Plan

Insurance Name: _____

Phone #: _____

Policy ID #: _____ Group #: _____

BIN: _____ PCN: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy Holder's Relationship to Patient: _____

5 REQUIRED: Healthcare Professional Policy and Consent

TerSera Therapeutics and its contractors and agents (together "TERSERA"), will use the information you provide to administer and improve TerSera SupportSource (the "Program").

By signing below, you represent, covenant, and certify as follows:

(i) My patient has provided all required written authorization(s) as required by HIPAA 164.508 and other federal or state laws to release to TERSERA and the Program all patient information needed for this application, including without limitation financial and personally identifiable information in order to (1) conduct coverage support services, and (2) determine eligibility and enroll patient for financial assistance; (ii) All of the information provided in this application is complete and accurate; (iii) VARUBI® (rolapitant) was prescribed based on my medical judgment or the medical judgment of another healthcare professional in my office; (iv) I understand and have explained to my patient that TERSERA may modify or terminate the Program at any time without notice and that completion of this application does not guarantee enrollment in any particular part of the Program; (v) I understand and agree that any medications supplied by TERSERA under the Program are for use of the named patient only and shall not be sold, traded, bartered, transferred, returned for credit, submitted to any third party payor (private or government) for reimbursement, or counted toward the patient's Medicare Part D out-of-pocket costs; (vi) I have not received nor will I seek or accept payment from my patient for any co-insurance amount paid for by the Program; (vii) I understand that I am under no obligation to prescribe any TERSERA drug and I have not received and will not receive any benefit from TERSERA for prescribing a TERSERA drug; and (viii) if I become aware of any errors in the information provided, I will promptly notify TERSERA of those errors.

Healthcare Professional Name (Please print): _____

Healthcare Professional Signature (No Stamps Please): _____ Date: _____

Please share a copy of this application with your patient for his or her records.

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Financial Assistance

This section should **only** be completed for financial assistance or enrollment into the Patient Assistance Program **(PAP)**

1 Patient Financial Information (Required for financial assistance)

Annual Gross Household Income: $_____ # of Household Members (Including patient_____

Please attach or complete the embedded prescription if you are seeking PAP for your patient. Please note, eligibility for the PAP is based on the Federal Poverty Level and may change year to year. Income will be verified using tax returns or other alternate financial documentation. In cases where income cannot be verified, or there are discrepancies, additional proof of income may be required.

2 Prescription Information (Check below to apply for PAP)

☐ **Rx for VARUBI® (rolapitant) tablets Patient Assistance Program**

☐ **I authorize the dispensing pharmacy to dispense all doses (including refills) as one prescription***

Quantity: 2 tablets (1 wallet card) **Refills:** _____ **Target Start Date:** _____ / _____ / _____

Directions for Use: Take two tablets by mouth within 2 hours prior to initiation of chemotherapy, as directed by your physician.

Other Directions:

With signature, I authorize TerSera Therapeutics and the specialty pharmacy to dispense VARUBI directly to the patient (if indicated in Section 5) as part of the Patient Assistance Program.

Prescriber's Name (Please print): _____

Prescriber's Signature (No Stamps Please): _____ Date: _____

Please attach a separate prescription if this section does not comply with your state's prescription law.

*Maximum 6 doses of VARUBI per shipment will be sent to patient's address unless otherwise specified. Additional PAP shipments allowed, pending continued patient eligibility.

3 Preferred Shipping Location

○ Prescriber's Office

○ Patient's Address

☐ **Rx for VARUBI is included or embedded with this fax**

○ Other Address (eg, infusion center):

Facility Name: _____

Recipient Name: _____

Street: _____

City: _____ State: _____ ZIP: _____

4 REQUIRED: Patient Signature for Income Verification

I understand that I am providing *written instructions* authorizing TerSera Therapeutics to receive and store my personal information including applicable financial records for the purpose of determining financial qualifications for programs administered by TerSera. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I promise that any information, including financial and insurance information that I provide, is complete and true. If my income or health coverage changes, I will call TerSera SupportSourse at 855-686-8725. If eligible, I would like to be considered for programs administered by TerSera.

Patient/Guardian Name (Please print): _____

Patient's Signature: _____ Date: ____/____/_____

Upon receipt of a completed application, the healthcare professional and patient will be notified of program eligibility. If patient is eligible for this program, the prescribed quantity of VARUBI will be shipped to the address indicated in Section 5 on the previous page.

Call us at 1-855-686-8725 Monday-Friday (8 AM to 8 PM ET) | **Fax us the completed enrollment form at 1-855-836-3066**

TerSera therapeutics