Anktiva® (nogapendekin alfa inbakicept)

Patient Enrollment Form

Accredo By EVERNORTH

To enroll your patient, please complete and submit this enrollment form by faxing to 888.302.1028

Accredo business hours:
Monday through Friday 7 AM to 10 PM
Oncology Provider line is open 8 AM - 9 PM EST.
Verbal and Clarification Callback Phone #: 866-828-1129.
Prescription referral fax #: 888-302-1028

Top Requested Patient Support (Select all that apply)

- ☐ Benefits Verification
- ☐ Copay Assistance Program
- ☐ Prior Authorization Support
- ☐ Patient Assistance Program

1. PATIENT INFORMATION REQUIRED

☐ Check here if a copy of patient's face Sheet is included.

Patient First Name _____ Patient Last Name _____

DOB _____

Email _____

Gender: ☐ Male ☐ Female ☐ Other

Street Address _____

Patient preferred language (other than English) _____

City _____ State _____ Zip Code _____

Phone # _____ ☐ Home ☐ Mobile

Alternate Contact Phone # _____

☐ Check here if it is OK to leave a detailed message

Alternate Contact Relationship to Patient _____

2. PATIENT INSURANCE INFORMATION REQUIRED

(Include Medicare, Medicaid, VA benefits or private insurers) Include front and back copies of insurance cards for each type of insurance.

☑ Check here if patient DOES NOT have insurance coverage.

Primary Insurance		Secondary Insurance	
Insurance Company		Insurance Company	
Plan Name		Plan Name	
Policy #		Policy #	
Group #		Group #	
Phone #		Phone #	
Policyholder Name		Policyholder Name	
Relationship to Patient		Relationship to Patient	

3. PATIENT FINANCIAL INFORMATION REQUIRED ONLY IF APPLYING FOR PATIENT ASSISTANCE PROGAM

Current annual household income: $ _____ Household size (including you): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other _____

I have received and reviewed the attached Terms and Conditions and authorize ImmunityBio under the Fair Credit Reporting Act to use my demographic information to access reports on my individual credit history from consumer reporting agencies. I understand that, upon request, ImmunityBio will tell me whether an individual consumer report was requested and the name and address of the agency that furnished it. I further understand and authorize ImmunityBio to use any consumer reports about me and information collected from me, along with other information they obtain from public and other sources, to estimate my income in conjunction with the Patient Assistance Program eligibility determination process, if applicable. I further understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale. Continuation in the ImmunityBio Patient Assistance Program is conditioned upon timely verification of income. In addition, I agree to notify ImmunityBio if my insurance situation changes.

Patient Name Print _____ Patient Signature ✕ _____ Date _____

4. PATIENT AUTHORIZATION – *I have read and agree to the authorization in section 10* REQUIRED

Patient Name Print _____ Patient Signature ✕ _____ Date _____

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PATIENT NAME: _____ DATE OF BIRTH: ____/____/____

5. DIAGNOSIS REQUIRED

Primary Diagnosis ICD-10: _____ Secondary Diagnosis ICD-10: _____

☐ Patient has BCG-unresponsive nonmuscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors

6. PRESCRIBER INFORMATION REQUIRED

Prescriber First Name	Prescriber Last Name	NPI	State License #	Office Contact Name

Site/Facility Name	Tax ID #	PTAN	Office Contact Email Address ☐ Preferred

Site/Facility Address (Include City, State and Zip Code)	Office Phone# ☐ Preferred	Office Fax#

7. SITE OF CARE (if different than Prescriber Information) REQUIRED

Name of Site where patient will be instilled Anktiva	Site of Care Scheduler Name	Site of Care Email

Address (Include City, State and Zip Code)	Site of Care Scheduler Phone #	Site of Care Scheduler Fax #

NPI Number	Tax ID Number	State License Number	Administering Physician if different from Prescriber

8. PRESCRIPTION INFORMATION REQUIRED

Dosing Phase	Directions	Quantity	Refills	Day Supply
☐ **First Induction**	400 mcg / 0.4 mL administered once a week for 6 weeks	6	0	90 days
☐ **Second Induction** A second induction course may be administered if complete response is not achieved at month 3.	400 mcg / 0.4 mL administered once a week for 6 weeks	6	0	90 days
☐ **Maintenance (months 4-24)**	400 mcg / 0.4 mL administered once a week for 3 weeks at months 4, 7, 10, 13 and 19	3	4	90 days
☐ **Maintenance (months 25-37)** For patients with an ongoing complete response at month 25 and later, additional maintenance instillations may be administered	400 mcg / 0.4 mL administered once a week for 3 weeks at months 25, 31, and 37	3	2	180 days

TICE BCG Co-Administration – Anktiva is administered with TICE BCG. Please indicate source for the TICE BCG below:

☐ TICE BCG to be processed by Accredo, prescription sent to Accredo separately
☐ TICE BCG to be processed by an alternate Specialty Pharmacy.
☐ TICE BCG supplied through Provider's office

Drug allergies ☐ No known drug allergies

Concurrent medications ☐ No known concurrent medications

9. PROVIDER AUTHORIZATION

I or others in my healthcare provider practice group have received and reviewed the attached Terms and Conditions and have obtained authorization from the patient that complies with the requirements of the HIPAA Privacy Rule and authorizes me and the Practice, as well as the patient's health insurance plan(s), to disclose the patient's personal health information (PHI) for the purposes of benefits investigation and reimbursement support. I further certify that the product support provided through ImmunityBio CARE on behalf of any patient is not made in exchange for any express or implied agreement that I would recommend, prescribe, or use the above therapy. I will not seek reimbursement for any medication or service provided by ImmunityBio CARE. I authorize ImmunityBio CARE Hub to act on my behalf for the limited purposes of transmitting this prescription by any means allowed under applicable law to the appropriate pharmacy designated by the patient utilizing their benefit plan.

PRESCRIBER'S SIGNATURE ✕ _____ **Date** _____
(dispense as written) Signature stamps not acceptable

PRESCRIBER'S SIGNATURE ✕ _____ **Date** _____
(substitution permitted) Signature stamps not acceptable

▶ THE FOLLOWING SECTION TO BE COMPLETED BY **PRESCRIBER** ◀

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ImmunityBio®

10. PATIENT AUTHORIZATION

I hereby certify and agree to the following:

I am (i) the Patient and legally permitted to make decisions about how my health information is used and disclosed or (ii) the legal guardian or authorized representative of the Patient and legally permitted to make decisions about how the Patient's health information is used and disclosed.

I authorize my healthcare providers and staff to disclose my Protected Health Information (PHI) to ImmunityBio (including Accredo, ImmunityBio CARE and its affiliates, vendors, and business partners who are performing services related to this program) as related to the use and/or need for Anktiva. ImmunityBio may further disclose my information to other healthcare providers, pharmacies, insurance companies, prescription drug plans, and other third-party payers in order to (1) Determine the Patient's insurance eligibility, coverage, and payment obligations for Anktiva; (2) Provide Anktiva and related services to the Patient and to coordinate care for the Patient related to the Patient's Anktiva prescription; (3) Provide the Patient with ongoing support services such as patient education, educational resources, reminder calls, emails, letters, or text messages; (4) Address adverse events and product quality complaints.

I authorize ImmunityBio to use my PHI to send me information or materials related to Anktiva or any related products or services in which I might be interested and to contact me occasionally to get my feedback about Anktiva or programs as required or permitted by law. I understand that my PHI disclosed under this authorization may be redisclosed by ImmunityBio and is no longer protected by federal privacy laws.

I understand that I may refuse to sign this authorization and that this will not affect my ability to receive Anktiva, payment for treatment, enrollment in a health plan, or eligibility for benefits. However, if I do not sign this authorization, I will not be able to receive support services from Accredo.

I understand and agree that my health plan, provider and/or pharmacy may receive payment or other remuneration for disclosing my personal information and distributing marketing material pursuant to this authorization.

This authorization expires five years after the date the form is signed. I may cancel this authorization at any time by calling 833-422-2731.

I have received a copy of this authorization.

11. COPAY PROGRAM TERMS AND CONDITIONS

Eligibility and Restrictions

In order to qualify for copay assistance through the ImmunityBio Care copay assistance program (the "copay program"), patients must meet the following eligibility criteria:

- Must be 18 years of age or older.
- Must live in and receive treatment in the United States or its territories.
- Be in receipt of a valid prescription for ANKTIVA® for an FDA-approved indication.
- Have private or commercial health insurance with coverage for ANKTIVA. The patient must be enrolled in and seek reimbursement from a commercial health plan—such as a plan through an employer or a commercial plan that is purchased in the healthcare exchange marketplace.
- This copay assistance program is not valid for patients covered, in whole or in part, under a federal or state healthcare program such as Medicaid (including Medicaid patients enrolled in a qualified health plan purchased through a health insurance exchange/marketplace established by a state government or the federal government), Medicare, a Medicare Part D or Medicare Advantage plan (regardless of whether a specific prescription is covered), TRICARE, CHAMPUS, VA, Puerto Rico Government Health Insurance Plan ("Healthcare Reform"), or any other state or federal medical or pharmaceutical benefit program or pharmaceutical assistance program (collectively, "Government Programs").
- The copay program is not valid for uninsured patients.

Offer Details

- Eligible patients may pay as little as $100 of copay per dose of ANKTIVA. The benefit available under the copay program is limited to the amount that the patient's private health insurance company indicates on the Explanation of Benefits (EOB). The maximum copay program benefit per patient, per calendar year (January 1 through December 31), is $25,000. Patients are responsible for all copays and any other balances not covered by the copay program.
- An EOB from your/the patient's private health insurance must be submitted within 120 days of the date of administration for the patient to receive any applicable copay assistance benefit; provided, however, that no EOB may be submitted more than 365 days after the expiration date of the copay program. The EOB must reflect the patient's out-of-pocket cost for ANKTIVA and submission of the claim by the patient's provider for the cost of ANKTIVA.

- The benefit available under the copay is valid for the patient's out-of-pocket cost for ANKTIVA only. It is not valid for any other out-of-pocket costs (for example, office visit charges or medication administration charges) even if such costs are associated with the administration of ANKTIVA. A claim for ANKTIVA must be submitted by the provider to the patient's private health insurance separately from claims for any other services and products.
- Patient and provider agree not to seek reimbursement for all, or any part of, the benefit received by the patient through the copay program. Patient and provider are responsible for reporting receipt of copay program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the copay program, as may be required.
- By participating in this copay program, the patient authorizes his or her provider to submit the EOB received from his or her private insurance company to the copay program, and to receive on patient's behalf, if applicable, any benefit for which the patient is eligible under the copay program.
- The provider agrees to apply any amounts received from the copay program toward the satisfaction of patient's obligation for the cost of ANKTIVA only.
- Patient will be responsible for any amount owed to his or her provider per dose of ANKTIVA that is not covered by the copay program. If patient has already paid provider for his or her share of the cost of ANKTIVA for which he or she later receives a benefit through the copay program, patient will seek the amount, less the amount patient owes per dose, back from his or her provider.
- The copay program is not insurance. If your insurance status changes, you must notify us immediately.
- The copay program is void where prohibited by law, taxed, or restricted. The copay program offer is not transferable and is limited to one offer per person. No substitutions are permitted. Not valid if reproduced. This offer cannot be redeemed for cash.
- The copay program benefit cannot be combined with any other copay program, free trial, discount, prescription savings card, or other offer.
- If acquiring ANKTIVA from a Specialty Pharmacy (to be later administered in a physician office or outpatient institution), additional documentation may be required.
- This program is managed by Cencora on behalf of ImmunityBio, Inc. ImmunityBio reserves the right to rescind, revoke, modify, or amend the copay program or these Terms and Conditions at any time without notice.
- No other purchase is necessary.
- The copay program is not contingent on any past or commercial sale of any ANKTIVA.
- Data related to your redemption of benefits under the copay program may be collected, analyzed, and shared with ImmunityBio for market research and other purposes related to assessing ImmunityBio's programs. Such data will be aggregated and de-identified. The information disclosed may include patient co-pay ID, pharmacy demographics, prescriber information, and details relating to the copay claim, such as co-pay amount, insurance details, and therapy received. For more information, please see the ImmunityBio Privacy Policy at www.immunitybio.com/privacy
- To talk one-on-one live with a dedicated Patient Access Specialist call (833) 422-2731 (toll free) Monday – Friday, 8AM – 8PM (ET) Multilingual options available.

By using this offer, you are certifying that you meet the eligibility criteria and will comply with the Terms and Conditions described herein and will not seek reimbursement for any benefit received through this program. Reconfirmation of information may be requested periodically to ensure accuracy of data and compliance with terms.

Provider/Pharmacist

When you apply this offer, you are certifying that you have not submitted a claim for reimbursement under any Government Program for this prescription, or where prohibited by law. Participation in this program must comply with all applicable laws and regulations as a pharmacy provider. By participating in this program, you are certifying that you will comply with the eligibility criteria, and Terms and Conditions described herein. You also certify that you will not seek reimbursement for any benefit received through this offer.