PumaPatientlynx™

ENROLLMENT FORM

Phone: 855-816-5421
Fax: 844-276-5153
NERLYNX.com

Please select: ☐ Benefit Verification ☐ Prior Authorization

1 DISPENSE/NERLYNX™ (NERATINIB) SPECIALTY PHARMACY PREFERENCE

☐ AcariaHealth™
☐ Accredo® Health Group, Inc.
☐ Biologics, Inc.
☐ CVS Caremark Specialty Pharmacy
☐ Diplomat Specialty Pharmacy
☐ Onco360®

2 PATIENT INFORMATION

Name (First & Last) _____ DOB (MM/DD/YYYY) _____
Address _____ Home Phone Number _____
City _____ Alternate Phone Number ☐ Work ☐ Cell
State _____ Zip Code _____ _____

Is the patient enrolled in the following?

☐ Early Access Program (ID# _____) ☐ Clinical Trial (ID# _____)

Patient signature required for HIPAA Authorization on page 3 of this form.

3 PATIENT INSURANCE INFORMATION

Attach copies of both sides of the patient's insurance card(s). Include both medical and pharmacy information, if available.

Primary Insurance/PBM Name _____
Insurance/PBM Phone _____
Cardholder Name _____
Policy # _____ Group # _____
Rx BIN _____ PCN _____

Secondary Insurance/PBM Name _____
Insurance/PBM Phone _____
Cardholder Name _____
Policy # _____ Group # _____
Rx BIN _____ PCN _____

☐ Patient has no insurance

Incomplete information may delay the process.

4 CLINICAL INFORMATION

Primary Diagnosis

☐ HER2 positive
☐ C50 Malignant neoplasm of breast
☐ Other (provide ICD10): _____

Has patient previously been treated with trastuzumab? ☐ Yes ☐ No

Other Previous Treatments/Dates: _____ _____

Medication Allergies: _____

☐ No Known Allergies

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5 PRESCRIBER INFORMATION

Physician Name _____ NPI # _____ Tax ID # _____
Address _____ City/State/Zip _____
Office Contact Name _____ Facility Name _____
Phone Number & Ext _____ Fax Number _____

6 NERLYNX (NERATINIB) PRESCRIPTION (*FOR ORAL USE ONLY*)*

*If required by applicable state law, please attach copies of all prescriptions on official state prescription forms.

Patient Name _____ DOB (MM/DD/YYYY) _____
Address _____

☐ **Standard Rx Complete Below** OR ☐ Check if E-Prescribing

Product Name NERLYNX (neratinib) 40 mg tablets
Directions Take 6 tablets (240 mg of neratinib) orally once daily (Recommended Daily Dose) x 30 days
Quantity 180 Number of Refills _____
Other/Different Instructions: _____

☐ **Quick Start Rx** Complete Below** OR ☐ Check if E-Prescribing

Product Name NERLYNX (neratinib) 40 mg tablets
Directions Take 6 tablets (240 mg of neratinib) orally once daily (Recommended Daily Dose) x 21 days
Quantity 126 Number of Refills _____ (MAX 1)
Other/Different Instructions: _____

**Complete the NERLYNX (neratinib) Quick Start Rx for a free 21-day supply in the event of a delay obtaining coverage through the patient's insurer. See page 3 for more information.

(Fulfilled by Covance Specialty Pharmacy, LLC)

7 OTHER MEDICATION

☐ **Loperamide 2 mg** Quantity: [100] _____ Directions _____
☐ **Other Agents (eg, colestipol, budesonide)**
Drug _____ Quantity _____ Directions _____

PRESCRIBER AUTHORIZATION

By signing this form, I certify that I have prescribed NERLYNX (neratinib) based on my professional judgment of medical necessity and that I will supervise the patient's medical treatment. I authorize the release of medical and/or other patient information relating to NERLYNX (neratinib) therapy to agents and service providers of Puma (including but not limited to Covance Specialty Pharmacy) and pharmacies dispensing NERLYNX (neratinib) to use and disclose as necessary for fulfillment of the prescription and furnish any information on this form to the insurer of the above-named patient.

(Signature stamps not acceptable)

_____ _____ / _____ / _____
Prescriber signature *(dispense as written)* Date

_____ _____ / _____ / _____
Supervising physician signature *(where required)* Date

Fax the completed Enrollment Form and all supporting documents to Puma Patient Lynx at 844-276-5153.

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PUMA PATIENT LYNX INFORMATION NEEDED

- This Intake Form can be used to request the following services to assist with determining coverage for NERLYNX (neratinib):
  - Patient Insurance Benefit Verification
  - Prior Authorization/Appeal Support
- Provide all patient demographic and insurance information (please include a copy of the insurance card if possible)
- Provide as much clinical information as possible–by doing so, Puma Patient Lynx can assist with the prior authorization if required
- Once coverage has been determined, if your patient is uninsured or has financial needs, Puma Patient Lynx can research alternative insurance funding options and refer the patient to the correct financial assistance option based on qualifications:
  - Commercial Copay/Coinsurance Assistance Program
  - Independent Copay Foundations
  - Patient Assistance Program

PATIENT HIPAA AUTHORIZATION FOR PUMA PATIENT LYNX SERVICES

I hereby authorize my healthcare providers, my health insurance company, and my pharmacy to disclose my protected health information (PHI) including, but not limited to, my name, address, telephone number, medical records, health insurance coverage, and financial information to Puma Biotechnology and companies working with Puma Biotechnology (collectively "Puma Biotechnology") and its agents for the following purposes:

- Contact me, or the person legally authorized to sign on my behalf, by phone or mail
- Contact my insurance company on my behalf to verify my coverage for NERLYNX (neratinib)
- Determine my eligibility, and enroll in the Commercial Copay/Coinsurance Assistance Program
- Determine my eligibility, and enroll in the Patient Assistance Program (PAP), including verification of my financial information
- Refer me to a third-party foundation for assistance or alternate sources of funding or coverage that may be available to provide assistance with out-of-pocket expenses
- Coordinate my treatment with my healthcare provider and specialty pharmacy
- Send me educational materials or other program information that may be of interest to me

I understand that the information provided by me, my healthcare provider or insurance company may be used for marketing purposes.

Once my health information has been disclosed to Puma Biotechnology, I understand that federal privacy laws may no longer protect the information. However, I understand that Puma Biotechnology and other companies authorized to receive my health information pursuant to this Authorization agree to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. I understand that this authorization does not affect treatment from my healthcare provider or coverage for NERLYNX (neratinib) through my insurance.

I understand that this authorization is voluntary. However, if I refuse to sign, or cancel my authorization, Puma Biotechnology may not be able to determine my eligibility for the Commercial Copay/Coinsurance Assistance Program or the Patient Assistance Program (PAP).

I may cancel this authorization at any time by mailing a letter to Puma Patient Lynx at: PO Box 13185, La Jolla, CA 92039.

This authorization expires ten [10] years from the day that I sign it as indicated by the date next to my signature, unless otherwise canceled as set forth above or unless a shorter period is mandated by the law of my state of residence. I understand that canceling this authorization is not effective to the extent that any person or entity has already acted in reliance on my authorization. I understand and have read this authorization. I understand that I am entitled to receive a signed copy of this form and can do so by calling Puma Patient Lynx at 855-816-5421 or by mailing a request to the address above.

I have read and agree to the Patient HIPAA Authorization.

If I apply for assistance from the PAP, I certify that I do not have insurance, or do not have coverage for NERLYNX (neratinib) and am not eligible for other public health insurance programs. I agree to allow Puma Biotechnology to use my demographic information, including but not limited to Social Security number, date of birth, name, and/or address as needed to access my credit information and information derived from public and other sources, including information from a consumer reporting agency (credit bureau), to estimate my income in conjunction with the eligibility determination process performed to determine my eligibility under the PAP. Puma Biotechnology reserves the right to ask for additional documents and information at any time. I agree to notify my physician if I become aware in the future of changes that would affect my eligibility, including but not limited to changes in health insurance status or coverage, financial status, and my status as a resident of the United States.

Print Patient or Patient Representative Name	Signature of Patient or Patient Representative	Date (MM/DD/YYYY)
Relationship to Patient	Patient Social Security Number	

The NERLYNX Quick Start Rx provides a 21-day supply of treatment of NERLYNX (neratinib) at no charge for eligible patients experiencing a delay in obtaining coverage for NERLYNX (neratinib) through their health insurance. If a gap in coverage extends beyond the first 21 days and the patient/provider is actively pursuing coverage through prior authorization/appeal, the patient may be eligible for one 21-day refill. The program may not be combined with another offer and is not eligible to patients without insurance or whose insurer has made a final coverage determination. Patients must reside in the US or its territories.

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