PharmaEssentia SOURCE™
Your resource for patient support & education

PharmaEssentia SOURCE Enrollment Form

PLEASE COMPLETE THE ENTIRE FORM, SIGN, AND FAX IT TO 800-700-5065. For assistance, call 800-700-5053, Monday–Friday, 8 AM to 8 PM ET.

1. PATIENT INFORMATION

First Name: _____ Last Name: _____
Date of Birth (MM/DD/YYYY): _____ Gender: ❍ Male ❍ Female
Street Address: _____ City: _____ State: _____ ZIP: _____
Primary Phone*: _____ Mobile Phone*: _____ Email: _____
Primary Language: ❍ English ❍ Spanish ❍ Other: _____
Preferred Contact Method: ❍ Call* ❍ Email ❍ Text ❍ Consent to Text*
Best Time to Contact: ❍ Morning ❍ Afternoon ❍ Night
Patient Representative Name: _____ Patient Representative Phone: _____

*By providing my phone number, I authorize PharmaEssentia to use autodialers or prerecorded and artificial voice messages to contact me. I understand that these calls/texts may mention the name of PharmaEssentia products or services and include details about my insurance coverage and my doctor's name. I understand that I am not required to consent to being contacted by phone or text message as a condition of any purchase of PharmaEssentia products or enrollment. Message and data rates may apply. I understand that I may opt out of receiving these communications at any time by calling PharmaEssentia at 800-700-5053.

2. INSURANCE INFORMATION *Attach copies of ALL of the patient's insurance card(s)*

Primary Medical Insurance: _____
Coverage: ❍ Medicare ❍ Medicaid ❍ Commercial/Private/Health Exchange ❍ Other ❍ Uninsured
Phone: _____ Policy ID: _____
Group #: _____ BIN #: _____ PCN #: _____
Employer Name: _____ Policyholder Name: _____
Policyholder Date of Birth: _____ Policyholder's Relationship to Patient: _____

Primary Prescription Insurance (or Drug Coverage): _____
Coverage: ❍ Medicare ❍ Medicaid ❍ Commercial/Private/Health Exchange ❍ Other
Phone: _____ Policy ID: _____
Group #: _____ BIN #: _____ PCN #: _____
Employer Name: _____ Policyholder Name: _____
Policyholder Date of Birth: _____ Policyholder's Relationship to Patient: _____

3. FINANCIAL INFORMATION (required to verify eligibility for assistance programs)

Number of All Household Members (including enrollee): _____ Annual Gross Household Income: $ _____

4A. PHARMAESSENTIA SOURCE ENROLLMENT CONSENT

By signing below, I certify that I have read the "Consent for Enrollment in PharmaEssentia SOURCE" on page 4, and I agree to the terms of enrollment.

Printed Name of Patient: _____ Date: _____
SIGN HERE _____ Date: _____

Printed Name if Signed by a Patient Representative: _____

❑ I do not wish to be contacted for market research or to arrange for my receipt of educational, promotional, and/or marketing materials about PharmaEssentia support programs or PharmaEssentia products.

4B. AUTHORIZATION TO USE AND DISCLOSE MY INFORMATION

By signing below, I certify that I have read the "Consent and Privacy Authorization to Use and Disclose My Information" on page 4, and I authorize the disclosure of my information to PharmaEssentia as described.

Printed Name of Patient: _____ Date: _____
SIGN HERE _____ Date: _____

Printed Name if Signed by a Patient Representative: _____

REQUIRED

Patient Name: _____ Date of Birth: _____

5. PRESCRIBER INFORMATION

Prescriber Name (First, Last): _____

NPI #: _____ DEA #: _____

Site/Facility Name: _____ State License #: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Primary Office Contact: _____ Phone: _____ Fax: _____

Email: _____ Preferred Contact Method: ❍ Call ❍ Email ❍ Fax

Alternate Office Contact: _____ Best Time to Contact: ❍ Morning ❍ Afternoon ❍ Evening

Phone: _____ Email: _____

6. PREFERRED SPECIALTY PHARMACY (selection will be honored if permitted by patient's insurance)

Choose one of the following specialty pharmacies:

❍ Biologics ❍ Onco360 ❍ No preference

OR

❍ Eligible in-network hospital pharmacy or oncology GPO member MID/IOD (pharmacy name and NPI):

_____

7. CLINICAL INFORMATION *Attach a copy of the patient's current medication list*

REQUIRED

❍ **Primary *ICD-10* Diagnosis: D45, polycythemia vera (PV)**

❍ **Other Diagnosis Code:** _____

Does patient have history of thrombosis (blood clots)? ❍ Yes ❍ No

Please list any medication allergies:

_____

PV Therapies to Date							
	Previous	**Current**	**Dose/ Frequency**		**Previous**	**Current**	**Dose/ Frequency**
Aspirin	❍	❍		PEGINTRON®	❍		
Hydroxyurea	❍	❍		INTRON® A	❍		
JAKAFI®	❍	❍		Phlebotomy	❍	❍	
PEGASYS®	❍	❍		None ❍			
Other:					❍	❍	

REQUIRED

Patient Name: _____ Date of Birth: _____

8. PRESCRIPTION FOR BESREMi® (ropeginterferon alfa-2b-njft)

A. Rx Quantity: 2 Prefilled Syringes (28-Day Supply) and Refills

In order for the Rx to be valid, you must check the box for the 500 mcg/mL syringe, write in the number of refills, and ALSO check the box for one of the 3 dosage options.

❑ 500 mcg/mL solution for subcutaneous injection in a single-dose prefilled syringe. **Refills (mandatory):** _____

Indicate dosage below (required to select one):

❍ *Inject 100 mcg subcutaneously on first injection. Increase dose by 50 mcg every 2 weeks as directed by physician, up to a maximum dose of 500 mcg.*

❍ *For patients transitioning from hydroxyurea, inject 50 mcg subcutaneously on first injection. Increase dose by 50 mcg every 2 weeks as directed by physician, up to a maximum dose of 500 mcg.*

❍ *If different than above, indicate dosage and titration schedule:* _____

_____

Provider Signature: SIGN HERE _____ Date: _____

Print Provider Name: _____ NPI/DEA: _____

Dispense as written. No stamps please.

B. Rx Quantity: 1 Prefilled Syringe (14-day Temporary Supply) Quick Start or Bridge in Event of Insurer Delay

In order for the Rx to be valid, you must check the box for the 500 mcg/mL syringe and ALSO check a box for one of the 3 dosage options.

❑ 500 mcg/mL solution for subcutaneous injection in a single-dose prefilled syringe (1 per package). Refills: 3

Indicate dosage below (required to select one):

❍ *Inject 100 mcg subcutaneously on first injection. Increase dose by 50 mcg every 2 weeks as directed by physician, up to a maximum dose of 500 mcg.*

❍ *For patients transitioning from hydroxyurea, inject 50 mcg subcutaneously on first injection. Increase dose by 50 mcg every 2 weeks as directed by physician, up to a maximum dose of 500 mcg.*

❍ *If different than above, indicate dosage and titration schedule:* _____

_____

In the event of delays in insurance coverage investigations, patients with insurance may receive 2-week supplies of BESREMi for up to 2 months. Patients must have a prescription and must not seek reimbursement or credit for this prescription from any insurer, health plan, or provider.

By signing below, I certify that I understand the PharmaEssentia SOURCE™ program terms and agree that I shall not seek reimbursement for BESREMi dispensed through the PharmaEssentia SOURCE program.

Provider Signature: SIGN HERE _____ Date: _____

Print Provider Name: _____ NPI/DEA: _____

Dispense as written. No stamps please.

All, please note: My signature certifies that the person named on this form is my patient, the information provided, to the best of my knowledge, is complete and accurate, and that therapy with BESREMi is medically necessary. I certify that I have obtained my patient's written authorization in accordance with all applicable state and federal laws to release the individually identifiable health information included on this form to PharmaEssentia SOURCE and I understand that the information that I provide on this form will be used by the program for the purposes of verifying my patient's insurance coverage and eligibility, coordinating the dispensing of my patient's prescription medicine, and introducing PharmaEssentia SOURCE support services to my patient, including contacting my patient for these purposes. I authorize PharmaEssentia SOURCE to transmit the above prescription for BESREMi to the appropriate specialty pharmacy on behalf of my patient. I understand that I am under no obligation to prescribe any PharmaEssentia products and that I have not received nor will I receive any benefit from PharmaEssentia for doing so. I will not seek reimbursement from any third-party payer or government entity for any product provided free of charge by PharmaEssentia SOURCE.

Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form.

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ENROLLMENT CONSENT AND PRIVACY AUTHORIZATION

CONSENT FOR ENROLLMENT IN PHARMAESSENTIA SOURCE

Please read the following, and if you agree, sign and date where indicated in Section 4A of the Enrollment Form.

By signing, I am enrolling in PharmaEssentia SOURCE product support services ("Services"). Services may include verification of insurance benefits and drug coverage, medication education, copay assistance, and other forms of patient assistance (no-cost medication).

I understand that PharmaEssentia's copay assistance and patient assistance programs are subject to eligibility criteria and that completing this application does not ensure that I will qualify for these programs. I certify that all the information provided in this application, including my health insurance plan and annual gross household income, is complete and accurate. I understand that assistance will terminate if PharmaEssentia becomes aware of any fraud.

I understand that if I receive support from a PharmaEssentia SOURCE Case Manager who is available to help me understand how to take my prescribed medication, offer tips and reminders for taking my medication, and provide other information that may help me manage a healthy lifestyle, PharmaEssentia SOURCE Case Managers do not give medical advice and are trained to direct me to my healthcare professionals for treatment-related advice.

CONSENT AND PRIVACY AUTHORIZATION TO USE AND DISCLOSE MY INFORMATION

Please read this page carefully, and if you agree, sign and date where indicated in Section 4B of the Enrollment Form. You may keep a copy of this form for your records.

As part of my enrollment in PharmaEssentia SOURCE, I authorize any health plan, physician, healthcare professional and their staff, hospital, clinic, pharmacy provider or other healthcare provider (collectively, "Providers") to use and to disclose to PharmaEssentia Corporation, and its affiliates, business partners, vendors, and other agents (collectively, "PharmaEssentia"), health information about me, including information related to my medical condition and treatment, care management, health insurance and coverage claims, and prescription (including fill/refill information) for BESREMi®, as well as all information provided on this form (my "Information"). I understand PharmaEssentia may provide my Information to a specialty pharmacy to fulfill the prescription. PharmaEssentia may also use my Information for internal uses, including data analysis. Once my Information has been disclosed to PharmaEssentia, I understand that federal privacy laws may no longer protect it from further disclosure. However, I also understand that PharmaEssentia will protect my Information by using and disclosing it only for the purposes allowed by me in this authorization or as otherwise required by law. I understand that my Providers may receive payment from PharmaEssentia in exchange for disclosing my Information and providing program services.

I understand that I do not have to sign this authorization. A decision by me not to sign this authorization will not affect my ability to obtain medical treatment from my healthcare professionals, my eligibility for health insurance benefits, or my access to PharmaEssentia medication. However, if I do not sign this authorization, I understand I will not be able to participate in the PharmaEssentia SOURCE Services. I understand that this authorization expires 5 years from the date signed here, or as otherwise required by state or local law, unless and until I cancel this authorization by then. I may change my mind and cancel this authorization at any time by calling 800-700-5053 or by notifying PharmaEssentia in writing at 35 Corporate Drive, Suite 325, Burlington, MA 01803. If I reside in California, I may find **more information on PharmaEssentia's privacy practices by visiting PharmaEssentiaSOURCE.com**.