To be completed and signed by Providers

IncyteCARES Program Enrollment Form – Provider Page

P.O. Box 221798 • Charlotte, NC 28222-1798 • Phone: **1-855-4-Jakafi (855-452-5234)** • Fax: **1-855-525-7207**

Enrollment form and instructions for access and reimbursement and education, support and communications related to Jakafi® (ruxolitinib). See program web site, materials and authorization for more details.

Instructions accompany each section. Please write clearly and fill in all form fields.

1 Physician Information: Include practice and office staff contact information, and any payer-specific provider ID number relevant for the patient's insurance to facilitate timely contact with the payer and your office.

Physician Name: _____ Site/Facility Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Office Contact: _____ Telephone: _____ Fax: _____ Best Time to Call: _____

Office Contact E-mail: _____ **State License #:** _____ **Payer-Specific ID #:** _____

Tax ID #: _____ **NPI #:** _____

2 Patient Clinical Information: **This section is required and could delay the verification process if not fully completed.**

This information will help with enrollment into co-pay assistance and/or prior authorization assistance.

A) Patient Diagnosis / ICD-9 Code*:

☐ 238.76 Myelofibrosis with myeloid metaplasia ☐ 289.83 Myelofibrosis ☐ Other diagnosis: _____

* These codes could be applied for the following diagnoses: primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis.

B) If the patient is less than 65, please indicate if the patient has intermediate- or high-risk myelofibrosis according to the International Working Group for Myelofibrosis Research and Treatment (IWG-MRT). ☐ Yes ☐ No

C) Please provide the following information if available:

Patient's Current Platelet Level (/mcL): ☐ <100K ☐ 100 to <150K ☐ 150 to 200K ☐ >200K ☐ Unknown

Hb level (g/dL): _____

Is the patient currently receiving RBC transfusions? ☐ Yes ☐ No

3 Prescription: FILL IN ALL INFORMATION to complete the prescription. A separate prescription is not needed.† Please check the box to indicate if Jakafi should be shipped to the patient's home or the doctor's office. If there is a preferred in-network specialty pharmacy, please list this here.

Upon confirmation of insurance coverage (or the patient's approval for assistance through the Program), medication should be shipped via a specialty pharmacy provider to the patient's home address (listed above, right) unless otherwise indicated by practitioner:

Patient Name: _____ Date: _____ Product Name: _____

Dosage: ☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 25 mg Directions: _____

Concurrent Medications: _____ Allergies: _____ Days Supply: _____ Refill(s): _____

DEA #: _____ Ship to: ☐ Patient's home ☐ Doctor's office Is there a preferred specialty pharmacy? _____

†PRESCRIPTION NOTES: New York State prescribers must submit a prescription on an original New York State prescription blank; for all other states, if not faxed, must be on state-specific blank if applicable for your state. This prescription is only valid if received by fax.

Physician Signature: _____ _____ | Physician Signature: _____ _____

(no stamps) (Substitution Permitted) Date | (no stamps) (Dispense as Written) Date

4 Physician Declaration: A physician signature is required in order for IncyteCARES to perform a benefit verification.

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Jakafi based on my professional judgment of medical necessity.

I represent and warrant that I have my patient's authorization on file to (i) disclose his/her health information and to transfer such information to Incyte and its agents to use and disclose as necessary to provide reimbursement services and (ii) to forward this prescription to a dispensing pharmacy on behalf of my patient.

I appoint IncyteCARES solely to convey on my behalf to the pharmacy chosen by or for the above-named patient, the prescription described herein.

I authorize IncyteCARES to perform a preliminary assessment of insurance verification for the above-named patient, and I further authorize and request that the Program provide to me any and all information necessary for completing a Letter of Medical Necessity as may be required as a result of such insurance verification assessment.

Physician Signature: _____ Date: _____ / _____ /_____

Please fax completed form to 1-855-525-7207

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Patient Name: _____

IncyteCARES
Connecting to Access, Reimbursement, Education and Support

To be completed and signed by Patients

IncyteCARES Program Enrollment Form - Patient Page 1 of 2

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Instructions accompany each section. Please write clearly and fill in all form fields.

1 Patient Information:

Include patient and alternate contact name and relationship, with alternate phone numbers and best time to call, so the Program can call to discuss benefits and disease treatment and the specialty pharmacy can call to schedule delivery.

Patient Name: _____ **Shipping Address:** _____

City: _____ **State:** _____ **Zip:** _____ **Date of Birth:** _____ **SSN:** _____

Phone Number: _____ Best Time to Call: _____ Alternate Phone Number: _____

Primary Language: _____ E-mail Address: _____

Alternate Contact Name: _____ **Alternate Contact's Phone Number:** _____

Patient is a resident of the United States or Puerto Rico: ☐ **No** ☐ **Yes**

2 Patient Prescription Insurance Information:

Include patient's prescription insurance information: prescription plan name, ID, group # and phone # to facilitate contact with the patient's prescription insurance company to verify benefits. Please include a photocopy of the prescription insurance card(s), if possible.

Primary Prescription Insurer: _____ Telephone: _____

Policy ID Number: _____ Group Number: _____

Subscriber Name: _____ Date of Birth: _____/_____/_____

Secondary Prescription Insurer: _____ Telephone: _____

Policy ID Number: _____ Group Number: _____

Subscriber Name: _____ Date of Birth: _____/_____/_____

Please include a photocopy of the patient's insurance card(s), if possible.

3 Patient Financial Information:

FILL IN ALL INFORMATION to be considered for free drug or co-pay assistance. Patients will be temporarily approved if they meet the eligibility requirements but must provide income documentation (latest tax return, W2, or 1 month of pay stubs) within 90 days to remain eligible for assistance.

Current annual household income: $ _____

Number of household members dependent on income stated above: _____ (include applicant)

If you would like to be considered for co-pay or product support, please provide income information for potential eligibility determination. If approved for support, documentation (latest tax return, W2, or 1 month of pay stubs) will be required within 90 days.

4 Patient Consent to be Contacted:

I agree to be contacted by Incyte, its agents, and the IncyteCARES Program (collectively, "Incyte") regarding information on Incyte products and services at the following e-mail address and phone/facsimile numbers:

E-Mail Address: _____

Phone Numbers: Work: _____ Home: _____ Cell: _____ Fax: _____

See Page 2

Any co-pay assistance or free drug provided to me through IncyteCARES is contingent upon meeting certain eligibility criteria, and Incyte may, at any time, and without notice, modify or discontinue IncyteCARES or any assistance provided directly to me.

Please fax completed form to 1-855-525-7207

Patient Name: _____

IncyteCARES
Connecting to Access, Reimbursement, Education and Support

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IncyteCARES Program

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Patient Authorization for the IncyteCARES Program

I authorize my healthcare providers (e.g., physicians, pharmacies) and my insurance company to disclose personal health information about me, including information related to my medical condition and treatment, my health insurance coverage, and my address, e-mail address and telephone number (collectively, my "PHI") to Incyte, its agents, and the IncyteCARES Program (collectively, "Incyte") so that Incyte may use the information for purposes of: (i) assisting in my enrollment in IncyteCARES; (ii) assessing my eligibility for co-pay assistance or free drug or referring me to other programs or sources of funding and financial support; (iii) coordinating delivery of Jakafi® (ruxolitinib) to me or my healthcare provider; (iv) providing education, information on Incyte products and services, and ongoing support services to me related to Jakafi; (v) gathering feedback on my therapy and/or disease state, (vi) contacting me by mail, email, phone or fax for any of the above purposes and (vii) creating information that does not identify me personally for use for other legitimate purposes. I understand that my pharmacy providers may be reimbursed for making such disclosures. I also authorize my healthcare providers and my insurance company to use my PHI to communicate with me about Incyte products and services and I understand that they may be reimbursed for making such communications. I understand that, once disclosed pursuant to this authorization, my PHI may no longer be protected under federal or state law and could be disclosed by Incyte to others, but I understand that Incyte will make reasonable efforts to keep it private and to disclose it only for the purposes set forth in this authorization.

I understand that I do not have to sign this authorization to obtain healthcare treatment or benefits; however, in order to receive the services and communications described above, I must sign the authorization. I understand that I may cancel my authorization at any time by contacting IncyteCARES by fax at 1-855-525-7207, or by mail at P.O. Box 221798, Charlotte, NC 28222-1798. My cancellation of this authorization will be effective when my healthcare providers and insurance companies are notified of its receipt by Incyte, but will not apply to PHI already used or disclosed in reliance upon this authorization.

I understand that I have a right to receive a copy of this authorization.

This authorization expires one year after the date I sign it as shown below unless I cancel it before then.

Name of Patient: _____

Signature: _____ **Date:** _____ /_____ /_____

Name of Legal Representative: _____

Signature: _____ **Date:** _____ /_____ /_____

If signed by Representative, describe the nature of relationship with patient:

_____

Please fax completed form to 1-855-525-7207

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Patient Name: _____

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