VYLOY® zolbetuximab-clzb for injection 100mg vial

SUPPORT™ SOLUTIONS

VYLOYSupportSolutions.com
Phone: 1-855-272-6609
Fax: 1-855-272-6653

VYLOY Support Solutions Patient Enrollment Form

Instructions for Healthcare Providers:

- Complete this form, including the patient's and healthcare provider's signatures
- Fax the completed form to VYLOY Support Solutions at **1-855-272-6653** or visit the Prescriber Portal at VYLOYSupportSolutions.com to enroll online

If you have questions or need assistance, call VYLOY Support Solutions at **1-855-272-6609**, Monday–Friday, 8:00 AM–8:00 PM ET.

Please note: All fields denoted with an asterisk (*) are required fields. Missing information may delay enrollment.

PATIENT INFORMATION

First Name*: | Last Name*: | Date of Birth (MM/DD/YYYY)*: | Sex: ☐ Male ☐ Female

Home Address*: | Unit #: | City*: | State*: | ZIP*:

Phone #*: | Phone Type: ☐ Home ☐ Work ☐ Cell | Voicemail Allowed: ☐ Yes ☐ No

Email Address: | Preferred Language: ☐ English ☐ Spanish ☐ Other
If Other, please specify:

Authorized Caregiver or Alternate Contact Name: | Relationship to Patient:

Alternate Contact Phone #: | Voicemail Allowed: ☐ Yes ☐ No | Alternate Contact Email Address:

INSURANCE INFORMATION* (Please include front and back copies of all medical and pharmacy insurance cards)

No Insurance: ☐

	Primary Medical/Health Insurance	Secondary Medical/Health Insurance	Prescription Insurance
Insurer/Policy Name			
Insurer/Policy Phone #			
Policy Holder Name			
Policy Holder Date of Birth			
Relationship to Patient			
Policy ID #			
Group #			
Rx BIN #	NA	NA	

PRESCRIBER INFORMATION

Prescriber Name*: | Specialty: | Email Address:

Practice Name*: | Street Address*: | Suite #:

City*: | State*: | ZIP*:

Office Phone #*: | Office Fax #*:

MD NPI #*: | Tax ID #*: | State License #*:

Medicare/Medicaid Provider #*: | Office Contact Name:

Office Contact Phone #: | Office Contact Email Address:

Site of Administration: ☐ Physician Office ☐ Outpatient Hospital Setting ☐ Other | If Other, please specify:

PLEASE CLICK HERE FOR FULL PRESCRIBING INFORMATION.

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PATIENT INFORMATION

First Name*: | Last Name*: | Date of Birth (MM/DD/YYYY)*:

PATIENT MEDICAL INFORMATION/DIAGNOSIS/PRESCRIPTION INFORMATION*

Primary ICD-10-CM Diagnosis Code:

Description:

Secondary ICD-10-CM Diagnosis Code (if applicable):

Description (if applicable):

☐ Claudin-18.2 (CLDN18.2) Test Has Been Performed

CLDN18.2 Testing Date:

Single Loading Dose (in 100-mg increments): ☐ Administer ____ mg (800 mg/m^2) # of Vials: ____ Refills: ____

Maintenance Doses (in 100-mg increments): ☐ Administer ____ mg (600 mg/m^2 every 3 weeks) or ☐ Administer ____ mg (400 mg/m^2 every 2 weeks) # of Vials: ____ Refills: ____

Prescriber Name (please print):

Prescriber Signature: X _____ Date: _____

Stamped signatures not accepted. Dispense as written.

Prescriber Certification and Attestation Statement

By signing below, I hereby attest that I am the prescribing healthcare provider and I agree to submit requests to VYLOY Support Solutions because I have determined that VYLOY® (zolbetuximab-clzb) is medically appropriate and I have explained such to my patient. To the best of my knowledge, the patient and physician information in this form is complete and accurate. I certify that I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act [HIPAA] of 1996) to the Service Providers for the purpose of providing access and reimbursement support, assisting in initiating or continuing therapy, and/or the evaluation of the patient's eligibility for support. I authorize Service Providers, as my designated agent and on behalf of my patients, to forward a prescription for VYLOY by fax or other mode of delivery, to a pharmacy within the VYLOY Support Solutions network.

I also certify that this prescription complies with all applicable state and local laws. I agree to notify the Service Providers if I become aware at any time in the future of changes in my patient's circumstances that would affect his or her eligibility, including but not limited to changes in health insurance status or coverage, financial status, United States residency status, or the indication for which VYLOY has been prescribed for this patient. I understand that Astellas reserves the right to change or terminate the Astellas Patient Assistance Program at any time, or to refuse to provide VYLOY under the Astellas Patient Assistance Program to any patient.

PATIENT INFORMATION

First Name*:	Last Name*:	Date of Birth (MM/DD/YYYY)*:

Prescriber Certification and Attestation Statement (Continued)

I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. If my patient obtains VYLOY® (zolbetuximab-clzb) via the Astellas Patient Assistance Program, I understand that (a) any medication supplied under the Astellas Patient Assistance Program is for the use of the patient named on this form only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (including the patient or any third-party payor) for reimbursement; (b) I will receive and secure my patient's medication at my office separate from commercially purchased medication until it's dispensed to my patient, when applicable; (c) I will comply with and abide by my State Practitioner Dispensing Laws for authorized prescribers, when applicable; and (d) the provision of free drug as part of the Astellas Patient Assistance Program is not contingent on any future purchase or prescribing of VYLOY.

I certify that if my patient is eligible and enrolled in the VYLOY Copay Assistance Program, I will not collect and have not collected any patient copay amount associated with the prescribed VYLOY.

I acknowledge I may be contacted by email, postal mail, or fax using the information I've provided, and I understand my personal information will be used and disclosed by Astellas in accordance with Astellas' privacy policy, available at www.astellas.com/us/privacy-policy.

I certify that a copy of the Patient Authorization Statement has been given to the patient named on page 1 or their representative and that I have provided my patient with a description of VYLOY Support Solutions.

My signature below certifies that I have read, understand, and agree to the Prescriber Certification and Attestation Statement on pages 2-3.

Prescriber Name (please print): _____

Prescriber Signature: X _____ Date: _____

(Enrollment cannot be processed without an original signature)

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PATIENT INFORMATION		
First Name*:	Last Name*:	Date of Birth (MM/DD/YYYY)*:

Patient Authorization Statement

By signing below, I authorize my doctors, pharmacies and other healthcare providers, as well as my health insurance plan, to disclose to Astellas Pharma US, Inc. ("Company") and its third-party suppliers, vendors, and other service providers supporting VYLOY Support Solutions (collectively, the "Service Providers") personally identifiable information about me (my "Personally Identifiable Information") (for example, my name, Social Security number, address, insurance policy number, and income) and my medical condition (for example, my diagnosis or medications). This Personally Identifiable Information can include spoken or written facts about my health and insurance benefits. It can include copies of records from my healthcare providers or health plans about my health or healthcare.

I understand that my healthcare providers and my pharmacy may receive remuneration, or payment, for disclosing my Personally Identifiable Information pursuant to this Authorization.

I understand that VYLOY Support Solutions is a component of Astellas Pharma Support Solutions℠ and that the Service Providers may be compensated by Company.

Company and/or the Service Providers may use and disclose my Personally Identifiable Information to:
(i) assist me with my enrollment in VYLOY Support Solutions and assess my eligibility for participation in the Copay Assistance Program ("CAP") and, if eligible, enroll me in the CAP;
(ii) contact me by phone or mail to request further information;
(iii) provide me with educational and other materials, information, and support related to VYLOY Support Solutions;
(iv) verify, investigate, and assist me with obtaining coverage for VYLOY® (zolbetuximab-clzb) from my health insurance plan;
(v) assess my eligibility for participation in the patient assistance program, if necessary;
(vi) refer me to other independent programs or alternative sources that may be available to provide assistance to me as allowed under the law, if necessary; and
(vii) help analyze the efficiencies and performance of the services provided by Service Providers.

I specifically authorize Company and the Service Providers to use and disclose my Personally Identifiable Information for the purposes described above. If I am deemed eligible and enrolled in the CAP, I certify that I have private commercial insurance and I am not insured by any federal or state health care program, including, but not limited to, Medicare, Medicaid, TRICARE, or Veterans Affairs. I agree to immediately notify VYLOY Support Solutions if there is a change in the status of my insurance coverage.

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PATIENT INFORMATION		
First Name*:	Last Name*:	Date of Birth (MM/DD/YYYY)*:

Patient Authorization Statement (Continued)

If an application is submitted to determine my eligibility under the Astellas Patient Assistance Program (PAP), I also authorize Company and Service Providers to use my Personally Identifiable Information, including, but not limited to, my 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 Astellas PAP. I agree to notify my healthcare providers 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 United States residing status. I understand that completing this enrollment form does not guarantee that I will qualify for the Astellas PAP.

In some instances, the Service Providers may de-identify my Personally Identifiable Information and use or disclose the de-identified information (in individual or aggregated form) for legitimate business purposes. I understand that the Company and the Service Providers will make reasonable efforts to keep my Personally Identifiable Information private; however, I understand that once information has been disclosed to the Service Providers, it may no longer be protected under federal privacy law and could be disclosed to others.

This authorization will last for three (3) years from the date on which I agree to this authorization (or such shorter period as applicable state law may require). My choice as to whether to sign this authorization will not change the way my doctors, healthcare providers, or payers treat me, but if I decline to sign it, I will not be able to have my insurance coverage verified, have alternate sources of assistance researched, or access other support provided by or on behalf of VYLOY Support Solutions.

I understand that I may revoke this authorization at any time by providing written notice to VYLOY Support Solutions at 600 Emerson Road, 3rd Floor, Suite 300, Creve Coeur, MO 63141. Cancellation of this authorization will be valid when received by the administrators of VYLOY Support Solutions. I understand that a cancellation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I understand that I am entitled to receive a copy of this authorization after I have provided my signature.

This Authorization Statement is governed by and interpreted in accordance with the laws of the state of Illinois, excluding Illinois conflict of law rules, and applicable federal law.

PATIENT INFORMATION		
First Name*:	Last Name*:	Date of Birth (MM/DD/YYYY)*:

Patient Authorization Statement (Continued)

INCOME AND ASSESSMENT FOR PATIENT ASSISTANCE PROGRAM (Complete this section to be evaluated for PAP)	
Annual Income:	Household/Family Size:

My signature below certifies that I have read, understand, and agree to the Patient Authorization Statement on pages 4-6.

Patient Name (please print): _____

Patient/Authorized Representative Signature: X_____ Date: _____

☐ I am acting for another person and I hereby affirm that I have the legal right to do so, I am the parent or legal guardian of the patient, or I otherwise have a valid power of attorney to act on behalf of the patient. (Note: Office personnel cannot sign on behalf of the patient.)

Authorized Representative Name (if applicable): _____ Relationship to Patient: _____

If you have questions or need assistance accessing VYLOY® (zolbetuximab-clzb), go to VYLOYSupportSolutions.com or call VYLOY Support Solutions at 1-855-272-6609, Monday–Friday, 8:00 AM–8:00 PM ET.

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