

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

Trademarks referenced herein are held by their respective owners.

**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  Other (provide ICD10): \_\_\_\_\_  
 C50 Malignant neoplasm of breast

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

**Other Previous Treatments/Dates:** \_\_\_\_\_

**Medication Allergies:** \_\_\_\_\_

- No Known Allergies

# PumaPatientlynx™

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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 \_\_\_\_\_  
 Directions \_\_\_\_\_  
 Quantity \_\_\_\_\_ Number of Refills \_\_\_\_\_  
 Other/Different Instructions: \_\_\_\_\_

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

Product Name \_\_\_\_\_  
 Directions \_\_\_\_\_  
 Quantity \_\_\_\_\_ 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 Date  
 (dispense as written)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Supervising physician signature Date  
 (where required)

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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.

