YONSA SUPPORT™ Enrollment Form

PO Box 29051, Phoenix, AZ 85038-9051
1-855-44YONSA (1-855-449-6672) | Fax: 1-877-872-6575

STEP 1 Requested Services (Required)

☐ Benefits Investigation and Prior Authorization Assistance ☒ Financial Assistance (PAP, EAP, Co-Pay) ☒ All Services

STEP 2 Patient Information (Required)

Name (First, MI, Last) Gender ☐ Female ☐ Male

Address Date of Birth *(MM/DD/YYYY)*

City State Zip

Email

Home Phone Cell Phone ☒ Ok to leave detailed message on voicemail?

I understand that I will be contacted by Sun Pharma in connection with the Patient Access Program as described in the Patient Authorization.

SIGNATURE

SIGNATURE REQUIRED

Patient Signature **Print Patient Name** **Date (MM/DD/YYYY)**

SIGNATURE REQUIRED

Signature of Personal Representative **Print Personal Rep Name (if applicable)** **Date (MM/DD/YYYY)**

By signing above, I acknowledge that I have read and agree to the Patient HIPAA Authorization on the back of this form.

STEP 3 Patient Insurance Information (Required)

(Please attach a copy of both sides of the patient's insurance card(s). If not available, please complete the information below.)

Insurance Type ☐ HMO ☐ PPO ☐ Medicaid ☐ Medicare ☐ Other Veteran Status? ☐ Yes ☐ No

Primary Insurance Name

Beneficiary/Cardholder Name Relationship to Patient

Policy ID # Group # Primary Insurance Phone

Secondary Insurance Name *(if applicable)*

Beneficiary/Cardholder Name Relationship to Patient

Policy ID # Group # Secondary Insurance Phone

If patient has a separate prescription coverage plan, please list below. *(Medicare patients: Please use Medicare Part D information.)*

Pharmacy Benefit Plan Name *(if applicable)*

Policyholder Name Relationship to Patient

Policy ID # Rx Group #

Rx BIN Rx PCN PBM Phone

STEP 4 Patient Financial Information (Required for Patient Assistance Program)

US Resident? ☐ Yes ☐ No Disabled (longer than 2 years)? ☐ Yes ☐ No

☐ **Provider attestation:** Please contact the above-identified patient to explore alternate funding options, including YONSA SUPPORT™. I understand that the patient will be asked for the following information:

_____ Total number of people living in the household, including patient
_____ Total monthly income, including all people contributing to the income

STEP 5 Healthcare Provider Information (Required)

Healthcare Provider Name *(First, MI, Last)*

Practice Name Specialty

Address City State Zip

NPI # DEA #

State License # Tax ID #

Phone # Fax #

Practice Contact *(First, Last)*

Contact Phone # Contact Email Address

☐ Self Dispensing Pharmacy Specialty Pharmacy Name *(NPI# if different than above)*

☐ Non-self Dispensing Pharmacy Specialty Pharmacy Name/NPI#

Phone # Fax #

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STEP 6 Prescription and Provider Authorization

Prescriber: Please attach a separate prescription if this section does not comply with your state's prescription law.

Patient Name | Patient DOB

ICD-10 Diagnosis Code ☐ C61 - malignant neoplasm of the prostate ☐ Other

Secondary Diagnosis/ICD-10

☑ YONSA® (abiraterone acetate) 125 mg

Dosing Instruction **Separate prescription needed for methylprednisolone*

Quantity # Day Supply

Refill Void After

Has the patient previously been treated with: ☐ Zytiga® and/or the generic Abiraterone Acetate ☐ Xtandi®

The brands listed are registered trademarks of their respective owners and are not trademarks of Sun Pharmaceutical Industries, Inc.

Is patient non-compliant with food restrictions? ☐ YES ☐ NO

Sun Pharma Inc and its contractors and agents (together "Sun Pharma"), will use the information you provide to administer and improve YONSA SUPPORT™ (the "Program") as well as authorize Sun Pharma to communicate via telephone, fax, or email to carry out the services described in the enrollment form.

By signing below, I (the prescriber) understand and agree that:

- I have prescribed YONSA® (abiraterone acetate) based on my professional judgement of medical necessity
- Any medication supplied by Sun Pharma as a result of this form is for use of the named patient only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third-party payer (private or government) for reimbursement
- Sun Pharma may modify or terminate the program at any time without notice
- My patient has provided a signed HIPAA Authorization that allows me to share protected health information with Sun Pharma for purposes of this program

Prescriber Signature (NO STAMPS) **Date**

SIGNATURE REQUIRED

☑ Dispense as written

Patient Assistance Program (PAP) Consent for Physician (Mandatory for Patients Enrolling in the Patient Assistance Program)

STEP 7 Patient Authorization and Consent

By signing Section 2 on the front of this form, I give permission for my healthcare providers (HCP), my pharmacies, my health insurer(s), and third-party contractors or service providers to disclose my personal information, including information about my insurance, prescriptions, medical condition, and health ("Personal Information") to Sun Pharma Inc., its affiliates, business partners, service providers, third-party contractors, and agents (together, "Sun Pharma") so that Sun Pharma can (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with the Sun Pharma Oncology medication prescribed by HCP on the Service Request Form, (ii) coordinate my receipt of, and payment for the Sun Pharma Oncology medication prescribed by HCP on this Service Request Form, (iii) facilitate my access to the Sun Pharma Oncology medication prescribed by HCP on this Service Request Form, (iv) provide me with information about the Sun Pharma Oncology medication prescribed by HCP on this Service Request Form, disease awareness and management programs and educational materials, (v) manage the patient access program, (vi) provide me with adherence reminders and support, and (vii) conduct quality assurance, surveys, and other internal business activities in connection with the patient support program.

I give permission to Sun Pharma to disclose my Personal Information to any pharmacies, my health insurer(s), healthcare providers, my caregivers, and other third parties for the purposes described above. I give permission to Sun Pharma to contact me directly for the purposes described above.

I understand that my pharmacy, health insurer(s), and healthcare providers may receive remuneration (payment) from Sun Pharma Inc. in exchange for disclosing my Personal Information to Sun Pharma Inc and/or for providing me with therapy support services.

I understand that once my Personal Information is disclosed it may no longer be protected by federal privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization at any time in the future by calling 1-855-44YONSA (1-855-449-6672). My refusal or future revocation will not affect the commencement or continuation of my treatment by my doctor(s); however, if I revoke this authorization, I may no longer be eligible to participate in the patient access program. If I revoke this authorization, Sun Pharma will stop using or sharing my information (except as necessary to end my participation in the program) but my revocation will not affect uses and disclosers of my Personal Information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for five (5) years after the date of my signature, unless I revoke it earlier. I also understand that the patient access program may change or end at any time without prior notification. I understand that I have the right to receive a copy of this form.

I agree to be contacted by Sun Pharma by mail, email, telephone calls, and text messages at the number(s) and address(es) provided on the Service Request Form for all purposes described in this Patient Authorization. I confirm that I am the subscriber for the telephone number(s) provided and the authorized user for the email address(es) provided, and I agree to notify Sun Pharma promptly if any of my number(s) or address(es) change in the future. I understand that my wireless service provider's message and data rates may apply.

I understand that Sun Pharma Inc does not permit my Personal Information to be used by its business partners for their own separate marketing purposes. I understand and agree that Personal Information transmitted by email and cell phone cannot be secured against unauthorized access.

I also consent to receive marketing information, offers, and promotions from Sun Pharma regarding my disease and related conditions and other products and therapies available from Sun Pharma (the "Marketing Program") and to be contacted for my opinions regarding them. I understand that the Personal Information I supply to Sun Pharma Inc. will be shared with and among its business partners to bring me the Marketing Program and/or to conduct market research. I may opt-out of the Marketing Program by separately checking the Opt-Out Box below or by calling 1-855-44YONSA (1-855-449-6672).

☐ Check this box to opt out of the Marketing Program provided by Sun Pharma.

SUN PHARMA