Kyowa Kirin Cares Prescription & Enrollment Form

Phone: 833-KK-CARES (833-552-2737) | **Fax:** 844-267-5848 | **Email:** patientsupport@kyowakirincares.com | **Hours:** M–F, 8AM to 8PM ET

= Patient = HCP

Patient First and Last Name: _____ DOB: ___/___/_____

= Patient = HCP

Once pages 1, 2, and 3 of the enrollment form are fully completed and signed, please fax to Kyowa Kirin Cares at 844-267-5848.

Requested for this Patient

☐ Reimbursement Assistant - Prescriber will Buy & Bill ☐ Reimbursement Assistant - Fill Through Specialty Pharmacy ☐ Copay Assistance ☐ Patient Engagement Services Only

Patient Information

First Name: _____ Last Name: _____ DOB: ___/___/_____

Address: _____ City: _____ State: _____ ZIP: _____

US Resident: ☐ Yes ☐ No Gender: ☐ Male ☐ Female

Cell Phone: (_____)_____ Home Phone: (_____)_____ Email: _____

OK to Text?: ☐ *By checking this box, I confirm this is my phone number and agree to subscribe to the Kyowa Kirin Cares Text Message program. I understand the number of texts I receive may vary based on the progress of my enrollment. Full Text Message Program terms and conditions: https://www.kyowakirincares.com/SMS_Terms.pdf*

Preferred Contact Method: ☐ Text ☐ Cell Phone ☐ Home Phone ☐ Email Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

Patient Insurance Information

Please attach copies of cards for both primary and secondary insurance plans

Medical Insurance Name: _____ Phone: (_____)_____

Pharmacy Insurance Name: _____ Phone: (_____)_____

Medical Plan ID #: _____ Policy Holder Name: _____ DOB: ___/___/_____

Group #: _____ Rx BIN: _____ Rx PCN: _____ Secondary Plan? ☐ Yes ☐ No

Plan Type: ☐ Private / Commercial ☐ Medicare Part D ☐ Medicare Advantage ☐ Medicaid ☐ VA or Military ☐ None – Uninsured

Prescriber Information

Prescriber Name: _____ Prescriber NPI#: _____

Prescriber DEA: _____ Prescriber SLN: _____

Facility Name: _____ Facility HIN: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: (_____)_____ Fax: (_____)_____ Office Contact Name: _____

Contact Email Address: _____

Clinical Information

Primary Diagnosis Code (ICD-10): _____ Primary Diagnosis Description: _____

Allergies: _____

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Prescription for POTELIGEO® (mogamulizumab-kpkc)

Rx: POTELIGEO (mogamulizumab-kpkc) – 20mg per 5mL Patient Weight:_____ kg Refills: _____

☐ Initiating Therapy – 1mg/kg IV QW for the first 5 infusions ☐ Maintenance – 1m/kg IV QOW ☐ Other (write in below)

Rx Notes: _____

I certify that the information in this Enrollment Form is complete and accurate to the best of my knowledge. By signing this Enrollment Form*, I certify that I have prescribed POTELIGEO (mogamulizumab-kpkc) according to the approved indication, Mycosis Fungoides or Sézary Syndrome, subtypes of cutaneous T-cell lymphoma (CTCL), who have relapsed or are refractory after at least one prior systemic therapy, and that I will supervise the patient's medical treatment. I authorize the release of medical and/or other patient information relating to POTELIGEO therapy to agents, and service providers of Kyowa Kirin (including but not limited to AllCare Plus Pharmacy, LLC and POTELIGEO-dispensing pharmacies) to use and disclose as necessary for fulfillment of the prescription and to furnish any information on this form to the insurer of the above-named patient for the purpose of verifying benefit eligibility and obtaining coverage authorization.

HCP Sign **Prescriber Signature:** _____ **Date:** ___/___/_____

Original signature is required. *If required by applicable law, please attach copies of all prescriptions on official state prescription forms.

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= Patient = HCP

Patient First and Last Name: _____ DOB: ___/___/_____

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Once pages 1, 2, and 3 of the enrollment form are fully completed and signed, please fax to Kyowa Kirin Cares at 844-267-5848.

Patient Authorization

By signing this Authorization, I authorize each of my prescribers, pharmacists, including any specialty pharmacy that receives my prescription for POTELIGEO (mogamulizumab-kpkc) and other healthcare providers (together "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my Protected Health Information, including but not limited to medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and or group numbers (together, "Protected Health Information") to Kyowa Kirin, its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Kyowa Kirin") including providers of alternate sources of funding for prescription drug costs, and other service providers supporting Kyowa Kirin Cares Support Services (the "Program") for Healthcare Providers and patients for the purposes described below.

Specifically, I authorize disclosure of my Protected Health Information in order to:

I. Enroll me in, and contact me about the Program, including online support, financial assistance services, co-pay assistance, specialist services, and compliance and persistency services,

II. Communicate with my Healthcare Providers and Insurers about benefits, coverage and medical care, including compliance with Product treatments,

III. Locate a specialty pharmacy that can fill my prescription and facilitate dispensing of my prescription by such pharmacy,

IV. Provide me with educational materials, information and services related to my treatment experience with POTELIGEO and my condition,

V. Contact me and leave messages about my use of POTELIGEO and my medical care,

VI. Verify, investigate, assist with, and coordinate my coverage for POTELIGEO with my Insurers,

VII. Coordinate prescription fulfillment

VIII. Contact me as otherwise required or permitted by law.

I understand that pharmacies that ship my medication may be paid to share this information with the Program to help provide the offerings requested for me. Once my Protected Health Information has been disclosed to Kyowa Kirin, I understand that federal privacy laws no longer protect the information. However, Kyowa Kirin agrees to protect my Protected Health Information by using and disclosing it only for the purposes described in this authorization or as permitted by law.

I understand that I may refuse to sign this Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me, but I will not have access to the Program and the services provided by Kyowa Kirin under the Program. If I refuse to sign the Authorization, or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from the Program.

This Authorization will last for a period of five (5) years (unless earlier termination is required by applicable state law). I understand that I may cancel this Authorization at any time in the future, except to the extent that actions have been taken in reliance on the authorization, by mailing a request to 510 Carnegie Center, Suite 600 Princeton, NJ 08540, via fax at 844-267-5848, or by calling 833-552-2737. I understand that revoking this Authorization will end further uses and disclosure of my Protected Health Information by the parties identified above except to the extent those uses and disclosures have been made in reliance upon this Authorization as permitted by applicable law. I am entitled to receive a copy of this Authorization.

The personal and health insurance I have provided on this form is complete and accurate to the best of my knowledge. I will update my information promptly if any of the information reflected on this Form changes by contacting the Program at 833-552-2737.

☐ *If I check this box, I also authorize the use of my information for Kyowa Kirin marketing activities, Patient Ambassador activities, and consent to receive marketing and promotional communications from Kyowa Kirin, including information about opportunities to participate in market research.* ***Checking this box is not a requirement of receiving Kyowa Kirin medicine or Kyowa Kirin Cares services.***

Patient Name (Print): _____

Patient Sign Patient Signature: _____ Date: ___/___/_____

Patient Authorized Representative

I permit Kyowa Kirin Cares Support Services representatives to speak with the following person about this enrollment form. This includes discussing the status of my application, insurance and financial questions, any missing documentation and other issues related to my enrollment, insurance appeals, or any other treatment related issues. I may cancel this authorization at any time by calling: 833-552-2737.

Name of Authorized Representative: _____ Relationship to Patient: _____

Telephone Number: (_____)_____ Email: _____

By signing below, I, the patient named above, allow this representative to speak on my behalf on any matter regarding my enrollment with the Program.

Patient Sign Signature: _____ Date: ___/___/_____

What is POTELIGEO® (mogamulizumab-kpkc)?

POTELIGEO is a prescription medicine used to treat mycosis fungoides (MF) or Sézary syndrome (SS) in adults who have tried at least one prior medicine (taken by mouth or injection) that did not work or in whom the disease has come back.

Important Safety Information

What is the most important information I should know about POTELIGEO?

POTELIGEO may cause serious side effects that can be severe or life-threatening including skin problems, infusion reactions, infections, autoimmune problems, and complications from stem cell transplant.

Call or see your healthcare provider right away if you develop any symptoms of the following problems or if these symptoms get worse:

- Skin problems: Signs and symptoms of skin reactions may include skin pain, itching, skin blistering or peeling, rash, painful sores or ulcers in your mouth, nose, throat or genital area.
- Infusion reactions: Signs and symptoms of infusion reactions may include chills or shaking, redness on your face (flushing), itching or rash, shortness of breath, coughing or wheezing, dizziness, feeling like passing out, tiredness, fever.
- Infections: Signs and symptoms of infection may include fever, sweats or chills, nausea, flu-like symptoms, sore throat or difficulty swallowing, shortness of breath, diarrhea or stomach pain, cough.
- Autoimmune problems: Some people receiving POTELIGEO may develop autoimmune problems, and some people who already have an autoimmune disease may get worse during treatment with POTELIGEO.
- Complications of stem cell transplant: Patients who receive a stem cell transplant using donor stem cells (allogeneic) after treatment with POTELIGEO may experience complications that can be severe and lead to death. Your healthcare provider will monitor you for signs of complications if you have an allogeneic stem cell transplant.

What are the most common side effects of POTELIGEO?

The most common side effects of POTELIGEO include rash, tiredness, diarrhea, muscle and bone pain, and upper respiratory tract infection.

Before starting POTELIGEO treatment, tell your doctor about all your medical conditions, including whether you:

- have had a severe skin reaction after receiving POTELIGEO
- have had an infusion reaction during or after receiving POTELIGEO
- have or have had liver problems including hepatitis B (HBV) infection
- have a history of autoimmune problems
- have undergone or plan to have a stem cell transplant, using cells from a donor
- have lung or breathing problems
- are pregnant or plan to become pregnant
  - It is not known if POTELIGEO will harm your unborn baby
- are breastfeeding or plan to breastfeed
  - Talk to your healthcare provider about the best way to feed your baby during treatment with POTELIGEO

Tell your doctor about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements.

You are encouraged to report suspected adverse reactions to Kyowa Kirin, Inc. at 1-844-768-3544 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Please see full Prescribing Information as well as Patient Information.