PumaPatientLynx™
Enrollment Form

Phone: 855-816-5421
Fax: 844-276-5153
NERLYNX.com

PUMA PATIENT LYNX ENROLLMENT – HEALTH CARE PROVIDER INFORMATION NEEDED

This Enrollment Form can be used to request the following patient support services for NERLYNX® (neratinib) tablets at no cost to the patient:

- Patient Insurance Coverage and Benefit Verification
- Prior Authorization/Appeal Support
- Enrollment and eligibility for QuickStart and related programs in the event of insurance coverage delay
- Enrollment and eligibility for anti-diarrheal supportive care product program
- Other support programs and assistance that may be available from Puma Patient Lynx

Provide all patient demographic and insurance information (please include a copy of the insurance card, front and back, if possible)

Provide as much clinical information as possible so Puma Patient Lynx can assist with any prior authorization if required

Once benefit coverage has been determined, if your patient is uninsured or has financial needs, Puma Patient Lynx can help research potential alternative funding support options and refer the patient to the correct financial assistance program option based on qualifications:

- Puma Commercial Copay/Coinsurance Assistance Program
- Independent Third-Party Copay Foundations
- Government or other Thirty Party Assistance Programs
- Puma Patient Assistance Program

Programs offered by Puma or Third-Party Organizations may have specific eligibility and qualification requirements for participation. Programs may be subject to change or cancellation without notice.

Patient and product support services provided by Puma Patient Lynx shall not be deemed a guarantee of product coverage or reimbursement. The healthcare provider and patient remain fully responsible for all claims made to private insurers or government programs, including the accuracy of all information submitted.

PRESCRIBER INFORMATION

Physician Name ____________________ NPI# ____________ Tax ID# ____________

Address ____________________ City/State/Zip ____________________

Office Contact Name ____________________ Facility Name ____________________

Phone Number & Ext ____________________ Fax Number ____________________

Preferred Method of Contact: ☐ Phone ☐ Email ☐ Fax

DISPENSE/NERLYNX® (NERATINIB) SPECIALTY PHARMACY PREFERENCE

☐ Oncology Office Pharmacy

☐ Biologics, Inc. ☐ Onco360® ☐ Accredo® Health Group, Inc.

☐ CVS Caremark® Specialty Pharmacy ☐ Optum® Specialty Pharmacy

☐ Please mark if prescription has already been sent to the specialty pharmacy checked above

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PATIENT INFORMATION

Name (First & Last) ______________________ Email Address ______________________

Address ______________________ DOB (MM/DD/YYYY) ______________________

City ______________________ Cell Phone Number ______________________

State __________ Zip Code __________ Alternate Phone Number ______________________

Patient signature required for Health Information Authorization Form.
(*See separate Patient Authorization form*)

☐ **Patient has no commercial insurance**

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 ______________________

Is the patient enrolled in a government funded health insurance program (e.g., Medicare or Medicaid)?

☐ **Yes** ☐ **No**

CLINICAL INFORMATION

Medication Start Date: (MM/DD/YYYY) ______________________

To the highest level of specificity, provide:

Primary Diagnosis

☐ C50 Malignant neoplasm of breast

☐ HER2+ Early-Stage Breast Cancer (Extended Adjuvant) previously treated with trastuzumab

☐ HER2+ Metastatic or Advanced Breast Cancer previously treated with 2 or more anti-HER2-based regimens in the metastatic setting

Is the patient also starting Capecitabine? ☐ Yes ☐ No

☐ Other (provide ICD10): ______________________

Secondary Diagnosis - ICD10: ______________________

Other Previous Treatments/Dates: ______________________

Medication Allergies: ______________________ ☐ No Known Allergies ______________________

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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

Product Name____

Directions____

Quantity ☐180

Number of Refills ____________Starting Dose: ☐120mg ☐240 mg

Other/Different Instructions: ______________________________

Quick Start Rx** Complete Below

(in the event of delay in obtaining NERLYNX® product coverage for patient)

Product Name____

Directions____

Quantity ☐133

Number of Refills ____________(Max 1)

Other/Different Instructions: ______________________________

** The NERLYNX Quick Start Rx provides a 21-day supply of treatment of NERLYNX® (neratinib) tablets at no charge for eligible patients experiencing a delay in obtaining coverage for NERLYNX® 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. At no time may NERLYNX® received under this program be sold, traded, transferred, given away, or submitted to any third-party payer for reimbursement. Patients must be 18 years or older and reside in the US or its territories. This program is not available where it is prohibited by law and is subject to change or be canceled at any time with or without notice.

PRESCRIBER DECLARATION

By signing this form, I declare and attest that: (1) I am a licensed healthcare professional duly authorized to prescribe medication and have prescribed NERLYNX® (neratinib) tablets (and any other products listed in this form) based on my independent professional judgment of medical necessity and in the best interests of this patient, (2) the information provided in this form is true and correct to the best of my knowledge, (3) I have obtained written consent from this patient (or their authorized legal representative)to release the above information to Puma (and third party companies working with Puma) for the purpose of verifying insurance benefits and other coverage support needs for NERLYNX® and enrolling them in Puma Patient Lynx including any related support programs, (4) I have obtained written patient authorization(s) in the form and manner required by applicable state and federal law, including HIPAA, to release the patient information on this form and as otherwise required to facilitate their participation in Puma Patient Lynx and related support programs, and (5) any medication supplied or provided for by Puma pursuant to this enrollment form is only for the use of the patient named on this form and shall not be sold, traded, transferred, returned for credit, or submitted to any third-party payer for reimbursement.

I authorize the release of medical and/or other patient information relating to NERLYNX® therapy to Puma, (including third-party representatives and service providers of Puma), and insurers, pharmacy(ies), other medical providers and their respective third-party representatives and service providers (to use and disclose such information as reasonably necessary to fulfill and conduct the product and services for the above-named patient.

(**Signature stamps not acceptable**)

______________________________ ________ / ________ / ________

Prescriber signature Date
dispense as written

______________________________ ________ / ________ / ________

Supervising physician signature Date

(where required)

Fax the completed Enrollment Form and all supporting documents to Puma Patient Lynx at **844-276-5153**.
Incomplete information may delay the process.

nerlynx®
(neratinib) tablets

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OTHER PRODUCTS*

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

Patient Name ______________________________ DOB (MM/DD/YYYY)____________________

Address ____

☐ **Capecitabine**: Dose ____________ Qty ____________ Refills ____________ Strength____________

Directions____

☐ **Loperamide**: Dose ____________ Qty ____________ Refills ____________ Strength____________

Directions____

☐ **Budesonide**: Dose ____________ Qty ____________ Refills ____________ Strength____________

Directions____

☐ **Colestipol**: Dose ____________ Qty ____________ Refills ____________ Strength____________

Directions____

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(**Signature stamps not acceptable**)

______________________________ ________ / ________ / ________

Prescriber signature Date

☐ ***dispense as written***

______________________________ ________ / ________ / ________

Supervising physician signature Date

(where required)

Trademarks referenced in this form are the intellectual property of their respective owners

NERLYNX® is a registered trademark and Puma Patient Lynx™ is a trademark of Puma Biotechnology, Inc.
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