PumaPatientLynx™ ENROLLMENT FORM

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

Request Type: ☐ Benefit Verification ☐ Prior Authorization/Appeal Support ☐ Supportive Care Products

1 DISPENSE/NERLYNX® (NERATINIB) SPECIALTY PHARMACY PREFERENCE

☐ Oncology Office Pharmacy

☐ AcariaHealth™ ☐ Biologics, Inc. ☐ Diplomat Specialty Pharmacy® ☐ 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

2 PATIENT INFORMATION

Name (First & Last) _____ Email Address _____
Address _____ DOB (MM/DD/YYYY) _____
City _____ Home Phone Number _____
State _____ Zip Code _____ Alternate Phone Number _____
Gender ☐ Male ☐ Female ☐ Work ☐ Cell

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

4 CLINICAL INFORMATION

Medication Start Date: (MM/DD/YYYY) _____
To the highest level of specificity, provide:
Primary Diagnosis

☐ C50 Malignant neoplasm of breast and HER2 positive
Has patient previously been treated with trastuzumab? ☐ Yes ☐ No
☐ Early-Stage Breast Cancer (Extended Adjuvant)
☐ Metastatic Breast Cancer (Advanced)
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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5 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 Email Address _____

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 NERLYNX® (neratinib) 40 mg tablets
Directions _____
Quantity 180
Number of Refills _____ Starting Dose: ☐ 240 mg ☐ Other: _____
Other/Different Instructions: _____

☐ **Quick Start Rx** Complete Below** OR ☐ Check if E-Prescribing
Product Name NERLYNX® (neratinib) 40 mg tablets
Directions _____
Quantity 126 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.

7 OTHER PRODUCTS*

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

☐ **Capecitabine:** Dose _____ Qty _____ Refills _____ Strength _____
Directions _____
☐ **Loperamide:** Dose _____ Qty _____ Refills _____ Strength _____
Directions _____
☐ **Budesonide:** Dose _____ Qty _____ Refills _____ Strength _____
Directions _____
☐ **Colestipol:** Dose _____ Qty _____ Refills _____ Strength _____
Directions _____
☐ **Other:** Dose _____ Qty _____ Refills _____ Strength _____
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 have obtained written consent from this patient to release insurance information to Puma for the purpose of verifying insurance benefits for NERLYNX® (neratinib). 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 PharmaCord) 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
(dispense as written)
Date

_____ _____ / _____ / _____
Supervising physician signature
(where required)
Date

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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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
- I authorize calls/texts may mention the name of Puma products or services, details about my insurance coverage and my doctor's name. I understand that I am not required to consent to being contacted by phone or text message as a condition of any purchase of Puma products or enrollment. Message and data rates may apply. I understand that I may opt out of receiving these communications at any time by calling Puma Patient Lynx.
- 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 Puma Biotechnology may offer an ongoing customized patient support program. The support program could include a nurse contacting me by telephone, email, or text to provide ongoing personalized support over a period of time.

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: Puma Patient Lynx, PO Box 5490, Louisville KY 40255.

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 understand that my pharmacy, health insurers, and third party vendors may receive remuneration (payment) from Puma Biotechnology in exchange for disclosing my personal information to Puma Biotechnology and/or for providing me with support services for the purposes described 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 will not seek reimbursement for any medication dispensed from the program. 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.

nerlynx® (neratinib) tablets