My MISSION SUPPORT Patient Support Program™

PATIENT SUPPORT PROGRAM
ENROLLMENT FORM

Phone: **855-421-6172** / Fax: **866-870-6241** / **www.MyMISSIONSupport.com**

Complete sections 1, 2, 5, 6, 7, 8, and 10. Depending on requested services, complete appropriate additional sections as listed below.

Requested Service(s) (check all that apply):

- ☐ Benefit Investigation and Prior Authorization Support
- ☐ Claims Support
- ☐ Copay Support for Commercially Insured Patients
- ☐ Patient Assistance (please apply if uninsured or underinsured) - Sections 3, 9
- ☐ Patient Education and Support - Section 4

Prescribers and Patients Must:

Complete and **Sign** Form and **Attach** Copy of Insurance Card(s) (front and back)

Fax all pages to My MISSION Support - 866-870-6241

1. Patient Information

Last Name: _____ First Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ / _____ / _____

Primary Phone: (_____) _____ - _____ ☐ Cell ☐ Home Secondary Phone: (_____) _____ - _____ ☐ Cell ☐ Home

Legal Guardian/Power of Attorney Name: _____

Primary Phone: (_____) _____ - _____ ☐ Cell ☐ Home Secondary Phone: (_____) _____ - _____ ☐ Cell ☐ Home

Best Time to Contact: ☐ Morning (8am – 12pm EST) ☐ Afternoon (12pm – 4pm EST) ☐ Evening (4pm – 8pm EST)

2. Patient Insurance Information

☐ **Patient Does Not Have Medical Insurance**

Primary Medical Insurance Provider: _____ Insurance Type: ☐ Commercial ☐ Government ☐ Other

Beneficiary/Cardholder Name: _____

Policy/ID #: _____ Group #: _____ Phone: (_____) _____ - _____

Secondary Medical Insurance Provider: _____ Insurance Type: ☐ Commercial ☐ Government ☐ Other

Beneficiary/Cardholder Name: _____

Policy/ID #: _____ Group #: _____ Phone: (_____) _____ - _____

3. Patient Assistance Program

By signing below, I hereby request enrollment in the Patient Assistance Program ("PAP").

Please apply if uninsured or underinsured.

Current Annual Household Income $: _____ Number of People in Household: _____

I understand that I am providing "written instructions" authorizing the PAP and its vendor, under the Fair Credit Reporting Act ("FCRA"), to obtain information from my credit profile or other information from Experian Health, for the purpose of determining financial qualifications for the PAP. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process for the PAP. I promise that any information, including financial and insurance information that I provide, are complete and true. If my income or health coverage changes, I will call My MISSION Support at 855-421-6172. This information will only be used to determine eligibility for the PAP. I understand that I may be required to submit verification for all sources of household income. I understand that neither I, nor any of my physicians or treatment facilities, or anyone else acting on my behalf may seek reimbursement for any free drug provided under the PAP.

By signing here, I agree to enrollment in the PAP upon a determination that I am eligible.

Patient Name (please print): _____

SIGN & DATE **Patient or Legal Guardian Signature:** _____ **Date:** _____ / _____ / _____

4. Patient Education and Support Services

By signing below, I hereby request enrollment in My MISSION Support's Patient Education and Support Services.

I am requesting enrollment in My MISSION Support's Patient Education and Support Services, and authorize MorphoSys US Inc., Incyte Corporation or their affiliates, agents and designees, to provide me with certain product and disease education through periodic outbound calls.

I consent to receive support calls, direct mail, and texts from and on behalf of My MISSION Support, including calls and texts made with an auto-dialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required or a condition of purchasing any products or services. Number of messages will vary based on my program selections, with an average of 1 to 5 messages per year. Message and data rates may apply. I understand that I can read the full MorphoSys US Inc. Privacy Policy at www.morphosys.com/us/privacy-policy and the Incyte Corporation Privacy Policy at www.incyte.com/privacy-policy. Text STOP to opt out and HELP for help.

If you would also like to receive communication by EMAIL please supply your email address: _____

Patient Name (please print): _____

SIGN & DATE **Patient or Legal Guardian Signature:** _____ **Date:** _____ / _____ / _____

5. Patient Consent - Provided by patient or authorized caregiver on behalf of patient

By signing below, I (or my authorized caregiver) understand that my signature gives MorphoSys US Inc., Incyte Corporation or their respective third-party contractors, agents or designees consent for my enrollment into My MISSION Support. In addition, I grant MorphoSys US Inc., Incyte Corporation or their respective third-party contractors, agents or designees permission to contact my healthcare provider, specialty distributor, specialty pharmacy, or insurance plan, on my behalf, in connection with my access to MONJUVI® (tafasitamab-cxix). **Finally, I understand I/my caregiver may stop my participation in My MISSION Support at any time by calling 855-421-6172 or faxing 866-870-6241.** I understand that my refusal to sign this authorization will not affect my ability to receive MONJUVI, my treatment, payment for treatment, eligibility or enrollment in health benefits; however, such refusal will limit my ability to receive support services through My MISSION Support.

Patient Name (please print): _____

SIGN & DATE **Patient or Legal Guardian Signature:** _____ **Date:** _____ / _____ / _____

6. Patient Authorization to Use and Disclose Health Information

I (or my authorized caregiver) authorize my healthcare providers, including my pharmacies (together, "Healthcare Providers"), my health insurer, health plan or programs that provide me healthcare benefits (together, "Health Insurers"), and any distributor that dispenses the product to disclose to MorphoSys US Inc., Incyte Corporation or their respective third-party contractors, agents or designees health information about me including information related to my medical condition and treatment, health insurance coverage and claims, and referral to and enrollment in My MISSION Support (referred to as "Program") described as "My Information", for the purposes of enrolling me in and providing certain services, including:

- To determine if I am eligible to participate in the Program
- Coverage determination or Program eligibility
- To investigate my health insurance coverage for MONJUVI
- To obtain prior authorization for coverage
- To assist with appeals of denied claims for coverage
- For the operation and administration of the Program
- To refer me to other programs, independent foundations, or alternative sources of funding or coverage that may be available to provide assistance to me with the cost of my MONJUVI
- To receive certain education and support in connection with my treatment

I understand that signing this authorization is voluntary and that my Healthcare Providers will not condition my treatment on my agreement to sign this authorization, and my Health Insurers will not condition payment for my treatment, insurance enrollment or eligibility for insurance benefits on my agreement to sign this authorization. I understand that I am entitled to receive a copy of this authorization after I sign it. Once My Information has been disclosed, I understand that federal privacy laws may no longer protect it from further disclosure. However, the Program agrees to protect My Information by using and disclosing it only for the purposes allowed by me in this authorization, or as otherwise allowed by law. I understand that I do not have to sign this authorization. A decision by me not to sign this authorization will not affect my ability to obtain medical treatment, insurance coverage, access to health benefits, or medications manufactured or marketed by MorphoSys or Incyte Corporation. However, if I do not sign this authorization, I understand that I will not be able to participate in the Program. I agree to immediately notify My MISSION Support if my health insurance status changes in the future, if I obtain any new health insurance plan or if I become entitled to, or enroll in a government health insurance program/payer (i.e., Medicare or Medicaid). I understand that My MISSION Support reserves the right to modify, change or terminate My MISSION Support at any time with or without notice.

I understand that this authorization shall remain in effect for one (1) year or until my participation in the Program ends unless I withdraw (take back) this authorization before then. Further, I understand that I may withdraw this authorization at any time by calling My MISSION Support at 855-421-6172; or faxing a written request to 866-870-6241. Withdrawal of this authorization will end my participation in the Program and will not affect any disclosure of My Information based on this authorization made before my request is received and processed by my Healthcare Providers and my Health Insurers.

Patient Name (please print): _____

SIGN & DATE **Patient or Legal Guardian Signature:** _____ **Date:** _____ / _____ / _____

7. Prescriber Information - Prescriber to complete

Last Name: _____ First Name: _____

NPI #: _____ SLN #: _____ Tax ID #: _____

Facility Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

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

Site of Infusion (if different from above): _____ Contact Number: (_____) _____ - _____

8. Patient Medical Information

Patient Primary Diffuse large B-cell lymphoma (DLBCL) Diagnosis:

- ☐ C83.30 Unspecified site
- ☐ C83.31 Lymph nodes of head, face, and neck
- ☐ C83.32 Intrathoracic lymph nodes
- ☐ C83.33 Intra-abdominal lymph nodes
- ☐ C83.34 Lymph nodes of axilla and upper limb
- ☐ C83.35 Lymph nodes of inguinal region and lower limb
- ☐ C83.36 Intrapelvic lymph nodes
- ☐ C83.37 Spleen
- ☐ C83.38 Lymph nodes of multiple sites
- ☐ C83.39 Extranodal and solid organ sites
- ☐ Other: _____

Please attach any pertinent medical history and prior treatments.

9. Prescription Order Information - Only for Patient Assistance Program ("PAP")

Prescription is valid only if received in accordance with applicable state requirements.

The prescription information below must be complete and accurate for MONJUVI® (tafasitamab-cxix) to be dispensed.

Patient Name: _____ Date of Birth: _____ / _____ / _____ Patient Weight (kg): _____

Dosing: _____ mg per dose (recommended dose: 12mg/kg)

☐ **Prescription #1 (Cycle 1)**

MONJUVI

Directions: ☐ Administer as an intravenous solution on Day 1, Day 4, Day 8, Day 15 and Day 22 of each cycle

☐ Other

Quantity: 5 Doses (28 Day Supply)

0 Refills

☐ **Prescription #2 (Cycles 2 and 3)**

MONJUVI

Directions: ☐ Administer as an intravenous solution on Day 1, Day 8, Day 15 and Day 22 of each cycle

☐ Other

Quantity: 4 Doses (28 Day Supply)

1 Refill

☐ **Prescription #3 (Cycles 4+)**

MONJUVI

Directions: ☐ Administer as an intravenous solution on Day 1 and Day 15 of each cycle

☐ Other

Quantity: 2 Doses (28 Day Supply)

_____ Refills

10. Prescriber Declaration

(Patient's enrollment request cannot be processed without signed Prescriber Declaration.)

I certify that the Patient and Prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed MONJUVI based on my judgment of medical necessity and I will be supervising the patient's treatment.

I have received the necessary patient authorization prior to the transmittal of health information to MorphoSys US Inc., Incyte Corporation or their respective third-party contractors, agents or designees, to initiate patient enrollment into My MISSION Support.

If requested, I authorize the forwarding of the prescription to a dispensing specialty pharmacy on behalf of myself and the Patient. I agree that I will not seek reimbursement for any free product received under the PAP for this Patient or for any other patient. I further agree that the Patient should also not seek reimbursement for any free product received under the PAP. In addition to not seeking reimbursement, I agree to notify My MISSION Support immediately if the Patient is no longer receiving product through the PAP and agree to return unused donated PAP product.

I certify that I will comply with all applicable state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. I understand that non-compliance with state specific requirements could result in outreach.

Prescriber Name (please print): _____

SIGN & DATE **Prescriber Signature:** _____ **Date:** _____ / _____ / _____