# NuvationConnect™ Enrollment Form

**Please fax completed form to 1-877-NUV-CON4, or complete enrollment form online at NuvationConnect.com.**

Please complete the required sections on the enrollment form for each type of support requested for the patient. These requirements apply only to support through NuvationConnect™ and are not intended to limit any treatment, payment, or benefit activities with your pharmacy or other healthcare providers.

## 1 NuvationConnect Options (Check any of interest. All programs and support are subject to restrictions and eligibility requirements.)

### INSURANCE VERIFICATION

☐ **Benefits Investigation, Prior Authorization, Appeal Assistance**
*Complete sections* 2 4 5 6 9 10

### FINANCIAL ASSISTANCE

☐ **Patient Assistance Program (PAP)**
*Complete sections* 2 4 5 6 8 9 10 11

☐ **Copay Assistance Program**
*Complete sections* 2 4 5 6 9 10

### TEMPORARY SUPPLY

☐ **Quick Start Program**
*Complete sections* 2 4 5 6 8 9 10

☐ **Bridge Program**
*Complete sections* 2 4 5 6 8 9 10

## 2 Patient Information

Patient Name (first, last):

Home Phone:

Date of Birth: / /

Cell Phone:

Gender: ☐ Male ☐ Female ☐ Other

Email:

Mailing Address:

**PREFERRED CONTACT:** ☐ Home ☐ Cell ☐ Email

City/State: ZIP:

**BEST TIME TO CONTACT:**

US Resident:
☐ Yes ☐ No

Consent to leave voice messages at the primary or alternative contact number: ☐ Yes ☐ No

Consent to receive text messages: ☐ Yes (cell phone is required) ☐ No

## 3 Alternate Contact/Caregiver Information (Optional)

Name (first, last):

**PRIMARY CONTACT:** ☐ Caregiver ☐ Patient

Phone:

**BEST TIME TO CONTACT:**

## 4 Insurance Information (If possible, include copies of both sides of the patient's insurance cards)

**PATIENT IS INSURED BY:** (check all that apply)

☐ Commercial/Private Insurance ☐ Medicare Advantage ☐ State Assistance Program for Medication
☐ Medicare Part D (Prescription) ☐ Medicaid ☐ None
☐ Other:

### PRIMARY INSURANCE

Insurance:

Insurance Phone:

Cardholder Name:

Member ID:

Group #:

### PRESCRIPTION INSURANCE

Insurance:

Insurance Phone:

Cardholder Name:

Member ID: Rx BIN#:

Rx PCN#: Rx GRP#:

Patient Name (first, last): _____ Date of Birth: / /

## 5 Healthcare Professional/Facility Information

Prescriber Name (first, last): _____

Mailing Address: _____

City/State: _____ ZIP: _____

NPI #: _____

DEA #: _____ Tax ID #: _____

Facility Name: _____

Office Contact Name: _____

Office Contact Email: _____

Office Phone: _____

Office Fax: _____

## 6 Clinical Information

Primary ICD-10 Code: _____

Secondary ICD-10 Code: _____

**PRIOR TREATMENT:**

☐ Chemotherapy ☐ Chemotherapy with IO/Immunotherapy

☐ IO/Immunotherapy ☐ ROS-1 TKI: _____

**BIOMARKER STATUS/TEST RESULTS:** (check all that apply)

☐ ROS-1 Positive ☐ G2032R-Positive

Most Recent Biomarker Test Date: / /

**LINE OF THERAPY FOR IBTROZI™ (taletrectinib):**

☐ First Line ☐ Second Line ☐ Third Line

## 7 Specialty Pharmacy (Select one)

☐ Biologics by McKesson ☐ Onco360 ☐ No Preference ☐ In-office Dispensing Site: _____

Unless the patient requests differently or the insurance provider mandates the use of a specific pharmacy, the prescription will be sent to the authorized pharmacy that offers the lowest cost sharing under the patient's insurance plan.

## 8 Prescribing IBTROZI (Restrictions and eligibility criteria apply)

**PATIENT ASSISTANCE PROGRAM:**

☐ IBTROZI 200 mg capsules; 3 capsules once daily (30-day supply).

Quantity: _____

Refills: _____

**QUICK START PROGRAM** (new to therapy)**:**

☐ IBTROZI 200 mg capsules; 3 capsules once daily (10-day supply).

Quantity: _____

Refills: _____

**BRIDGE PROGRAM** (current therapy)**:**

☐ IBTROZI 200 mg capsules; 3 capsules once daily (30-day supply).

Quantity: _____

Additional Instructions: _____

**SHIP PRESCRIPTION TO:** ☐ Patient ☐ HCP Shipping Address: _____

**SIGN HERE** Prescriber Signature: _____ Date: / /

***Dispense as written***

Patient Name (first, last): _____ Date of Birth: / /

## 9 Healthcare Professional Certification

By signing below, I hereby represent, covenant, and certify as follows:

(1) The above therapy (or medicine) is medically necessary for this patient and that I, as the prescriber, have made the decision to prescribe IBTROZI™ (taletrectinib) (the "Product"); (2) I have obtained written consent from the patient (or from the patient's legal representative) as required by the Health Insurance Portability and Accountability Act (HIPAA) and other state and/or federal laws to release all of the patient's personal health information (PHI) needed for this form and such other PHI that Nuvation, NuvationConnect™, the contracted dispensing pharmacy, or other contractors and may be required to (a) perform a preliminary verification of the patient's insurance coverage for the Product and (b) assess the patient's eligibility for participation in the NuvationConnect Program; (3) I understand that any Product provided at no charge to the patient is provided on a complimentary basis. I will not submit or cause to be submitted any claims for payment or reimbursement for such Product to any third-party payor, including, without limitation, a federal healthcare program. If I am or become in possession of such Product, I will not resell or attempt to resell the Product; (4) I have not received, nor will I seek or accept payment from my patient for any co-insurance amount paid for by the Product Copay Program for a Nuvation Bio product; (5) I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible under this program. I will notify NuvationConnect if I become aware of any such changes; (6) I understand that I am under no obligation to prescribe any Nuvation Bio drug, and I have not received and will not receive any benefit from Nuvation Bio for prescribing a Nuvation Bio drug; (7) The information contained in this form is complete and accurate to the best of my knowledge; (8) I agree to comply with the NuvationConnect guidelines and understand that Nuvation Bio, at its sole and absolute discretion, reserves the right to modify or discontinue patient support programs, including such programs provided through NuvationConnect, at any time; and (9) I will notify NuvationConnect of any errors regarding the foregoing, and will make every effort to correct those errors.

Prescriber shall comply with applicable state prescribing requirements, such as e-prescribing, state-specific prescription form(s), fax language, etc. Noncompliance with applicable state prescribing requirements could result in additional communications from NuvationConnect or other contractors to the prescriber.

HCP Name (please print): _____

Designated Agent Name (please print): _____ Title: _____

**SIGN HERE**

HCP Signature (no stamps, please): _____ Date: / /

Designated Agent Signature (no stamps, please): _____ Date: / /

Patient Name (first, last): _____ Date of Birth: / /

## 10 Patient Authorization

I hereby authorize my healthcare professionals, 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 with respect to my treatment, my eligibility for assistance, the coordination of my treatment, and receipt of my medication (collectively, my "Information") to NuvationConnect™ and any third parties engaged to assist Nuvation in administering NuvationConnect for the purposes described below. I understand that once my information has been disclosed to NuvationConnect, it could be subject to redisclosure and that federal privacy laws may no longer protect the information. I authorize the release and use of my Information for the purposes of: (1) verifying, investigating, coordinating, and resolving insurance coverage or reimbursement, or payment inquiries, including by communicating with my healthcare providers and insurance company to verify my coverage and/or my medical care; (2) determining my eligibility for IBTROZI™ (taletrectinib) (the "Product") and support through NuvationConnect; (3) enrolling me in and providing support through NuvationConnect, including facilitating the provision of the Product to me; (4) providing me with information regarding any independent patient assistance programs, patient advocacy organizations, or other alternate sources of funding, coverage, or support that may be available to provide assistance, including with out-of-pocket expenses; (5) coordinating my treatment with my healthcare professionals and specialty pharmacy; (6) providing me with information or materials related to NuvationConnect or the Product, including educational or promotional materials; (7) contacting me by phone, text, email or mail regarding this form or my use or potential use of the Product; (8) administering, evaluating, and improving NuvationConnect, the effectiveness of the Product, services, and programs, and helping to develop new products, services, and programs, and for other Nuvation general business and administrative purposes. I understand that if I refuse to sign this authorization, it will not affect my treatment by my healthcare professionals, or my payment, enrollment, or eligibility for benefits from my health plan. However, if I refuse to sign this authorization, or sign and then withdraw my authorization at a later date, it may affect my ability to participate in NuvationConnect. If I do not withdraw authorization, it will remain valid for 5 years (or at such lesser time as state law may require). I may withdraw this Authorization at any time by sending written notice to NuvationConnect at 13410 Eastpoint Centre Drive, Suite 150, Louisville, KY 40223. Withdrawal will stop further use or disclosure of my information, except as allowed by law or already relied upon. I am entitled to a copy of this signed Authorization, which expires 5 years after signing unless revoked earlier or otherwise specified by law.

By signing as the patient's representative or guardian, I confirm I am legally authorized to do so. Proof of this authority, such as a power of attorney or court order, may be requested.

Patient OR Legal Representative Name (please print): _____

SIGN HERE Patient OR Legal Representative Signature: _____ Date: / /

## 11 Patient Financial Consent (only required if applying for Patient Assistance Program)

Gross Annual Household Income: _____ No. of household members dependent on income (include applicant): _____

I understand that completing this form does not ensure my enrollment in the Patient Assistance Program ("PAP") and that certain eligibility criteria apply. By signing below, I certify that the information provided is complete and accurate. I authorize Nuvation Bio and any third parties engaged to administer the PAP to obtain documentation from me, my employer, or my insurance company to verify my financial or insurance information. I understand that Nuvation Bio may also make an independent determination of my financial need. I understand that if I am eligible to participate in the PAP, there is no purchase requirement associated with such assistance. I will not submit or cause to be submitted any claims for payment or reimbursement for any free supply of Product supplied under the PAP. Nuvation reserves the right at any time, and without notice, to modify or discontinue NuvationConnect and any assistance provided to me. I understand that I must re-apply for the PAP annually and there is no guarantee I will qualify at this time or in future periods. I understand that patients with insurance plans or employers participating in an alternate funding program (also sometimes referred to as patient advocacy programs, among other names) requiring them to apply to a manufacturer's patient assistance program or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of relevant Nuvation Bio products, or that otherwise denies, restricts, eliminates, delays, alters, or withholds any insurance benefits or coverage contingent upon application to, or denial of eligibility for, specialty drug prescription coverage through the alternate funding program are not eligible for the NuvationConnect PAP program. I understand that my health insurer(s) and pharmacy provider(s) may receive remuneration for the use or disclosure of my Information, as authorized above, and that once my Information has been disclosed to Nuvation Bio, my Information may no longer be protected by HIPAA or other federal and state privacy laws. I also understand, however, that Nuvation Bio plans to use and disclose my Information only for the purposes described above or as required by law.

Patient OR Legal Representative Name (please print): _____

SIGN HERE Patient OR Legal Representative Signature: _____ Date: / /