

ENROLLMENT FORM

Complete, sign, and submit this form via:



Fax: 1-888-920-2830

Email: AVEOACE@connectmed360.com

You can also complete this form online by visiting
www.FOTIVDA.com/patient-support/aveo-ace-program
or by scanning the QR code here:



START HERE

AVEO ACE PROGRAM SUPPORT OPTIONS (Check All That Apply)

Insurance Coverage Support:

- ☐ Benefit Investigation, Prior Authorization, Appeals Support
- ☐ Quick Start Program
- ☐ Bridge Program

Financial Assistance:

- ☐ Co-Pay Assistance Program (Commercial Only)
[Click to Enroll Online](#)
- ☐ Patient Assistance Program (PAP)

Ongoing Education and Support:

- ☐ Nursing Support Program

All services and programs are subject to eligibility requirements. Please visit www.FOTIVDA.com for full eligibility requirements and co-pay terms and conditions.

Required fields are marked with a red asterisk (*)

PATIENT AND INSURANCE INFORMATION

1 PATIENT INFORMATION

*First Name: _____ Email: _____

*Last Name: _____ Phone: (_____) _____ - _____ ☐ Home ☐ Mobile

*Address: _____ Preferred Contact Method: ☐ Phone ☐ Email

*City: _____ Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

*State: _____ *Zip: _____ Caregiver/Alternate Contact Name: _____

*Date of Birth: ____/____/____ Gender: _____ Phone: (_____) _____ - _____ ☐ Home ☐ Mobile

Language Preference (if other than English): _____ Relationship to Patient: _____

2 INSURANCE INFORMATION

Patient Has Insurance: ☐ Yes ☐ No *If 'Yes', Please attach a copy of patient's insurance card(s) (front/back).*

Prior Authorization (PA) on File: ☐ Yes ☐ No Authorization #: _____

Insurance Type: ☐ Private / Employer Based ☐ Medicare ☐ Medicaid ☐ Other (e.g., Tricare, VA)

Primary Medical Insurance Provider

Insurance Name: _____ Member/Policy #: _____

State: _____ Insurance Phone: (_____) _____ - _____ Group #: _____

Policy Holder Name: _____

Prescription Drug Insurance Provider

*Insurance Name: _____ *Member/Policy #: _____

*State: _____ Insurance Phone: (_____) _____ - _____ *Group #: _____

*Policy Holder Name: _____ *RX BIN #: _____ *RX PCN #: _____

If patient has secondary insurance please include copies of that information.

3 AVEO ACE PATIENT AUTHORIZATION

Scan for Electronic Version:



☐ **Patient Authorization to Enroll in Additional AVEO ACE Support (Optional)**

I understand that by checking this box, I authorize AVEO Oncology and its agents to provide me with information and product materials, regarding offers, services, and programs, educational training and ongoing support on the use of AVEO Oncology products that may be of interest to me, and to contact me by mail, email, or telephone to discuss AVEO products and obtain feedback for market research purposes. This marketing consent is not required to participate in the AVEO ACE program. I understand that I may opt out of these individual communications entirely at any time by calling 1-833-368-4832.

☐ **AVEO ACE Co-Pay Assistance Program for Commercially Insured Patients (Check ONLY IF you want to apply for the ACE Co-Pay Program)**

I understand that by checking this box, I authorize AVEO ACE to enroll me in the Co-Pay Assistance Program and to use my personally identifiable information related to my therapy for program administration. By signing below, I acknowledge and attest that I do not participate in any Medicaid, Medicare, or similar federal, state, or other government-funded program. I understand that personal information provided and information pertaining to the use of the AVEO ACE Co-Pay Program at the pharmacy, such as date the transaction was processed and the amount of co-pay that will be paid for by AVEO ACE, will be shared with AVEO Oncology, the sponsors of the program, and its third party partners. Visit www.FOTIVDA.com for terms and conditions.

AVEO ACE Patient Consent Form Authorization

 **By signing below, I certify that I have read, understand, and agree to the Patient Consent to Release Healthcare Information on page 5.**

*Patient Name: _____

*Patient/Legal Representative Signature: _____

Name of Legal Representative: _____

*Date: ____/____/____

Relationship to Patient: _____

4 PATIENT ASSISTANCE PROGRAM

Patients who are uninsured or underinsured and meet certain eligibility requirements may access FOTIVDA free of charge through the AVEO ACE Patient Assistance Program.

To See If You Are Eligible, Please Provide the Information Indicated Below:

US Resident: ☐ Yes ☐ No **Total Number of People in Household (including self):** ____ **Total Gross Monthly Household Income: \$** _____

Patient Assistance Program Patient Authorization (Required for Processing)

I understand that completing this form does not ensure that I will qualify for patient assistance. I certify that the information provided in this enrollment form is complete and accurate. I agree to notify AVEO ACE if I obtain coverage through another source or if I no longer meet the income criteria for the Patient Assistance Program (PAP).

It is important to note that income limits apply. This information will only be used to determine eligibility for the AVEO ACE PAP. Applicants may be required to submit verification for all sources of income. I agree that I will not seek reimbursement from any insurer, health plan, or government program for any free drug provided to the patient under the AVEO ACE PAP. If I am a member of a Medicare Part D plan, I will not seek to have this prescription cost counted as part of my out-of-pocket (TrOOP). I understand that participation in the AVEO ACE PAP is not contingent on any purchase.

To the best of my knowledge, my insurance company did not require me to apply for assistance or to hide my insurance plan to make me appear uninsured or underinsured. I have not authorized a third-party entity to apply for patient assistance on my behalf, otherwise known as Alternate Funding Programs (AFPs). Patients whose insurance companies partner with or use AFPs are not eligible for the AVEO ACE Patient Assistance Program. The Alternate Contact listed on my application (if any) is not associated with or a representative of my insurance company, employer, or third-party entity (AFP). If I subsequently learn that my insurance company or employer uses an AFP, I agree to notify AVEO ACE immediately and understand that I will no longer be eligible for support.

I understand that assistance may be temporary and I may need to reapply each year. I understand that participation in the AVEO ACE PAP may be discontinued or the rules for participation may change at any time, without notice.

I understand that this form authorizes AVEO ACE, 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 qualification for the AVEO ACE PAP. I understand that I must affirmatively agree to these terms in order to proceed with the financial screening process. I certify that any information that I provide is complete and accurate. If my income or health coverage changes, I will notify AVEO ACE by calling 1-833-368-4832.

 **I have read this authorization and agree to its terms and conditions:**

*Patient Name: _____

Patient Date of Birth: ____/____/____

*Patient/Legal Representative Signature: _____

*Date: ____/____/____

Name of Legal Representative: _____

Relationship to Patient: _____

To be completed by the Healthcare Provider.

 HCP AND PRESCRIPTION INFORMATION

5 HEALTHCARE PROFESSIONAL INFORMATION

*Prescriber Name: _____ *Office Contact Name: _____
*Prescriber Title: _____ *Phone: (_____) _____ - _____
*NPI #: _____ *DEA #: _____ *Fax: (_____) _____ - _____
*Facility Name: _____ Email: _____
*Address: _____ *Preferred Contact Method: ☐ Phone ☐ Email
*City: _____ *State: _____ *Zip: _____

6 PREFERRED SPECIALTY PHARMACY (Select One)

☐ Biologics, Inc. ☐ Onco360 ☐ In-office Dispense ☐ No preference

7 CLINICAL INFORMATION

*Patient Diagnosis: _____ *ICD-10 Code: _____ *Diagnosis Date: ____/____/____
Previous Treatment: _____ Treatment Dates: _____ Reason Discontinued: _____
Previous Treatment: _____ Treatment Dates: _____ Reason Discontinued: _____
Previous Treatment: _____ Treatment Dates: _____ Reason Discontinued: _____
*Known Allergies: _____
*Current Medications: _____

8 PRESCRIPTION INFORMATION

*Patient Name: _____ *Date of Birth: ____/____/____ *Height: _____ *Weight: _____

Rx for FOTIVDA *Strength: ☐ 1.34mg or ☐ 0.89mg *Quantity: _____ *Refills: _____ *Start Date: ____/____/____

Directions for Use: Once daily with or without food for 21 days on treatment followed by 7 days off treatment (28-day cycle)

Additional Directions: _____

*Prescriber Name: _____

 *Prescriber Signature: _____ *Date: ____/____/____

9 QUICK START PROGRAM - PRESCRIPTION INFORMATION

Complete this section and Quick Start Program Prescription if you believe your patient may face delays accessing FOTIVDA. The AVEO ACE Quick Start Program provides free FOTIVDA to eligible patients who experience a payer decision delay of 5 business days or more. Once enrolled in the AVEO ACE Program, a Program Specialist can see if the patient is eligible for the Quick Start Program.

Patient Name: _____ Date of Birth: ____/____/____ Height: _____ Weight: _____

Rx for FOTIVDA Strength: ☐ 1.34mg or ☐ 0.89mg Quantity: **7** Refills: _____ Start Date: ____/____/____

Directions for Use: Once daily with or without food for 21 days on treatment followed by 7 days off treatment (28-day cycle)

Additional Directions: _____

Prescriber Name: _____

 Prescriber Signature: _____ Date: ____/____/____

Prescriber should comply with any state-specific prescription requirements such as state-specific prescription form, original prescription, and/or e-prescribing.

10 HEALTHCARE PROFESSIONAL CERTIFICATION

By signing below, I hereby represent, covenant, and certify as follows: (1) To the best of my knowledge, the patient and physician information in this form is complete and accurate; (2) I have obtained from my patient his or her consent and any required written authorization as required by HIPAA and other federal or state laws to release to AVEO and AVEO ACE and its representatives/agents all patient information provided on and accompanying this application, including, without limitation, my patient's financial and medical information; (3) I have prescribed the medication to this patient based on my professional judgment of medical necessity; (4) I understand that this information will be used by AVEO ACE for the purpose of assessing the patient's insurance coverage and eligibility for participation in AVEO ACE patient support programs, coordinating the dispensing of my patient's prescription, and contacting my patient by telephone or mail to share information about AVEO ACE; (5) I authorize AVEO ACE to transmit the above prescription to the appropriate specialty pharmacy for my patient; (6) To the best of my knowledge, the patient has no prescription drug coverage (including Medicare, Medicaid, or other public or private programs), or is unable to afford the cost-sharing requirements for this medication associated with his/her insurance coverage, and the patient's insurance, if any, does not require his/her application to AVEO ACE PAP and does not change or hide the patient's insurance coverage to make them appear to be underinsured and eligible for AVEO ACE PAP; (7) 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 AVEO ACE if I become aware of any such changes; (8) I will not submit an insurance claim or other claim for payment to anyone else, including third-party payer (private or government) or the patient, for free medication provided to the patient by the AVEO ACE PAP; (9) I have not received, nor will I seek or accept payment from my patient for any co-insurance amount paid for by the AVEO ACE Co-pay Program or for any AVEO Oncology product; (10) I understand that I am under no obligation to prescribe any AVEO Oncology drug and I have not received and will not receive any benefit from AVEO Oncology for prescribing their drug; (11) the information contained in this form is complete and accurate to the best of my knowledge; and (12) I will notify AVEO ACE of any errors regarding the foregoing, and will make every effort to correct those errors.

Signature stamps are not acceptable. The prescriber is to comply with their state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

 Disclosures

I understand that receipt of marketing communications are optional services at no cost to me. The consent(s) above in no way affects my right to obtain any medications and I do not have to provide consent to be able to receive any medications. To obtain a copy of the consent(s) above or to withdraw my consent to collection, processing, and/or disclosure of my health data for any of the above purposes to which I have consented, I can contact AVEO Oncology at 1-857-400-0101. For more information about AVEO Oncology's privacy practices, AVEO's Privacy Policy can be found at www.aveooncology.com/privacy-policy.

*Healthcare Professional Signature: _____

*Dispense as Written: _____ *Date: ____/____/____

PATIENT CONSENT TO RELEASE HEALTHCARE INFORMATION

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 to AVEO Oncology, an LG Chem company, and its affiliates and service providers that work on behalf of AVEO Oncology in order to: (a) contact me, or the person legally authorized to sign on my behalf, by phone, mail or text message, regarding my participation in AVEO ACE, (b) contact my insurance company on my behalf to obtain information on my insurance coverage for FOTIVDA[®] (tivozanib), (c) determine my eligibility for enrollment in the AVEO ACE Patient Support Programs, (d) manage my participation in any AVEO ACE programs, (e) share information regarding alternate sources of funding or coverage that may be available to provide assistance with out-of-pocket expenses, (f) coordinate my treatment fulfillment, including through communication with my healthcare professionals and specialty pharmacy, (g) provide me with adherence reminders and support, and (h) send me educational materials or other program information that may be of interest to me or for other marketing purposes.

I understand that once my health information has been disclosed, federal privacy laws may no longer protect the information. However, I understand that AVEO Oncology and other companies authorized to receive my health information pursuant to this Authorization will use and disclose it only for purposes authorized in this Authorization or as required by law or regulations. I understand that I may refuse to sign this Authorization. I also may revoke (withdraw) this Authorization at any time in the future by calling 1-833-FOTIVDA (1-833-368-4832). If I do not sign this Authorization, I understand my eligibility for health plan benefits and treatment by my doctor will not change, but I will no longer be eligible to participate in AVEO ACE, or additional patient support programs provided by AVEO Oncology. If I revoke this Authorization, AVEO Oncology will stop using or sharing my Protected Health Information, but my revocation will not affect uses and disclosures of my Protected Health Information previously disclosed in reliance on this Authorization. If I do not withdraw this Authorization, it will remain valid for 5 years (or at such lesser time as state law may require). I understand I am entitled to receive a copy of this Authorization.

Disclosures

I understand that receipt of marketing communications are optional services at no cost to me. The consent(s) above in no way affects my right to obtain any medications and I do not have to provide consent to be able to receive any medications. To obtain a copy of the consent(s) above or to withdraw my consent to collection, processing, and/or disclosure of my health data for any of the above purposes to which I have consented, I can contact AVEO Oncology at 1-857-400-0101. For more information about AVEO Oncology's privacy practices, AVEO's Privacy Policy can be found at www.aveooncology.com/privacy-policy.