CYCLE VITA™
Support for life

Patient Enrollment Form for TASCENSO ODT® (fingolimod) Orally Disintegrating Tablets

Phone: 888-360-8482 FAX: 888-385-8482

TASCENSO ODT®
(fingolimod)
0.25 mg and 0.5 mg ODT

To Enroll, Fax this form:
888-385-8482
Or email: hello@cyclevita.life

All required fields are purple and noted with an asterisk*

PATIENT INFORMATION

Patient Last Name*		Patient First Name*	
Date of Birth*	Gender* ☐ Male ☐ Female ☐ Other		
Parent/Guardian Name *(if patient is a minor) / Caregiver Name*	Relationship to Patient	Power of Attorney/Medical Proxy ☐ Yes ☐ No	
Street Address*		Suite/Floor/Apt #	
City*		State*	Zip code*

Preferred Method of Contact (please specify)*
☐ Cell Phone ☐ Alternate Phone
☐ Email

Language Preferred: ☐ English ☐ Spanish ☐ Other (please specify):

PRESCRIBER INFORMATION

Prescriber Last Name* :		Prescriber First Name* :	
Prescriber Office/Site/Clinic*			
Prescriber Phone Number*		Prescriber Fax Number*	
Prescriber Medicaid Number*		Prescriber Tax ID*	
Street Address*			
City*		State*	Zip Code*
NPI Number*			
Office Contact Name			
Office Contact Phone Number with extension		Office Email Address	

INSURANCE INFORMATION

Please attach a copy of the prescription insurance benefit card, front and back, or complete the following*
☐ Prescription insurance benefit card attached. ☐ Patient does not have insurance. ☐ Patient requires co-pay only.

Primary Insurance Company Name*		Secondary Insurance Company Name	
Primary Insurance Company Phone Number*		Secondary Insurance Company Phone Number	
Name of Primary Cardholder*		Name of Primary Cardholder	
Primary Insurance Member ID*	Group ID*	Secondary Insurance Member ID	Group ID
BIN*	PCN*	BIN	PCN

Prior Authorization Status
☐ Submitted ☐ Not submitted ☐ Approved ☐ Denied

Patient Full Name:	Date of Birth:

CLINICAL INFORMATION

☐ **Diagnosis ICD-10: G35*:** _____

☐ **Other diagnosis (please specify):** _____

Patient Allergies*:

☐ **None Known** ☐ **Known (please list known allergies):**

_____

Most recent Treatment:

☐ **None** ☐ **BRAND Gilenya** ☐ **GENERIC Fingolimod** ☐ **Any other DMT**

Please send patient full medication list in with enrollment form if available.

Initiating Therapy

Patients who are currently treated with another fingolimod product and underwent a First Dose Observation at initiation may be switched to TASCENSO ODT at the same daily dose without a need to repeat a First Dose Observation (unless the previous treatment was discontinued more than 14 days prior).

☐ **The above statement is true for this patient, Baseline Assessments and a First Dose Observation are not required. (Please leave the rest of the Clinical Information section blank and move to the Prescription Information section on the next page.)**

Baseline assessments

☐ **I am requesting that Cycle Vita™ perform the following Baseline Assessments:**

☐ **CBC** ☐ **LFTs and Bilirubin** ☐ **VZV Antibody Serology** ☐ **ECG** ☐ **Macular Edema Screening**

Would you like assistance from Cycle Vita in setting up an FDO (First Dose Observation)?

☐ **Yes** ☐ **No**

First Dose Observations

TASCENSO ODT Starter Pack:

☐ ***Body weight ≤ 40 kg (88.2 lbs):*** **Dispense one (1) carton (30 tablets) of TASCENSO ODT *0.25 mg*, one tablet taken by mouth once a day**

☐ ***Body weight ≥ 40 kg (88.2 lbs):*** **Dispense one (1) carton (30 tablets) of TASCENSO ODT *0.5 mg*, one tablet taken by mouth once a day**

☐ **Alternative Instructions (please specify):** _____

TASCENSO ODT Starter Pack Shipping Address:
The Starter Pack is always sent to the FDO administrator and subsequent fills will be sent to the patient's address.

FDO to be performed:

☐ **In-home by Cycle Vita**

☐ **In-clinic**

Clinic address:

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Phone: _____

Patient Full Name:	Date of Birth:

PRESCRIPTION INFORMATION

Quantity: _____ tablets

Number of days' supply/prescription: ☐ 30 days followed by 11 refills ☐ 90 days followed by 3 refills

☐ 30 days followed by ____ refills ☐ 90 days followed by ____ refills

☐ TASCENSO ODT, 0.25 mg	NDC Number: 70709-062-30
☐ TASCENSO ODT, 0.5 mg	NDC Number: 70709-065-30

Only prescriptions filled with product NDC numbers listed above shall be eligible for Cycle Vita (Eligible Products).

Patient Directions (check all that apply):

☐ Take one 0.25 mg TASCENSO ODT tablet by mouth once a day with or without food, for a total dose of *0.25 mg*/day.

☐ Take one 0.5 mg TASCENSO ODT tablet by mouth once a day with or without food, for a total dose of *0.5 mg*/day.

☐ Other (please specify): _____

Shipping Instructions (check if applicable):

☐ Dispensing pharmacy to notify prescriber when initial shipment is scheduled.

☐ Bridge† - "Bridge" is a FREE supply of TASCENSO ODT that allows patients already on a fingolimod product, with an urgent medical need to begin therapy immediately while Cycle Vita secures appropriate benefit verification and authorization. Bridge may also be requested for existing patients who are temporarily experiencing disruption in therapy due to insurance coverage.

By checking the box above for Bridge, I, as the prescriber, with my signature below on this form, agree and attest that I will not submit a claim to or seek payment from the patient or any third-party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment/reimbursement for any free product(s) provided by Cycle Vita. I agree and understand that any free product provided by Cycle Vita may not be sold, traded, bartered, transferred, or returned for credit and will only be used for the patient named above on this form. Cycle Vita reserves the right to modify or terminate the program without notice at any time.

† Bridge is at no cost, for eligible patients within labeled indication only, and not contingent on purchase of any kind. Bridge is intended to support continuation of prescribed therapy if there is any disruption in therapy due to insurance coverage.

PRESCRIBER DECLARATION

Prescriber Declaration: I understand and agree that, as the prescriber, I will comply with my 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 me, as the prescriber. I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed TASCENSO ODT based on my professional judgment of medical necessity. I authorize Cycle Vita, its affiliates, agents, and contractors (collectively, "Cycle Vita" to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the above-named patient utilizing their benefit plan. I authorize Cycle Vita, its affiliates, agents and contractors to perform any steps necessary to secure reimbursement for TASCENSO ODT, including but not limited to insurance verification and case assessment. I understand that Cycle Vita may need additional information, and I agree to provide it as needed for the purposes of securing reimbursement.

X _____	_____	_____
Prescriber Signature	(Substitution Permitted)	Date of Signature
Dispense as Written		(MM/DD/YYYY)

Patient Full Name*	Date of Birth*

Patient Authorization for Use and Disclosure of Personal Health Information (PHI)

I understand that I must complete this enrollment form before I can receive assistance through Cycle Pharmaceuticals Ltd and the Cycle Vita™ Support Program. I understand that the Cycle Vita Support Program is only applicable for medication marketed by Cycle Pharmaceuticals Ltd and administered through the Cycle Vita Support Program. As part of this process, personnel from Cycle Pharmaceuticals Ltd, or the Cycle Vita Support Program and their agents and contractors (collectively, "Cycle") will need to obtain, review, use and disclose PHI as described below. To ensure I have access to the benefits afforded by the Cycle Vita Support Program for which I may qualify AND to ensure my Personal Health Information (PHI) is appropriately protected in compliance with applicable federal laws and regulations:

- I further authorize my healthcare providers (HCPs) and health plans to disclose my PHI as described below to an authorized Cycle Health Care Professional (HCP) in connection with the Cycle Vita Support Program and I authorize Cycle to use and disclose the information for the purposes stated in this authorization.
    1. Information to Be Disclosed: Personal health information (PHI), including information about me (for example, name, mailing address, financial information, and insurance), my past, current and future medical condition and information provided on this form to include information concerning Adverse Events (AE).
    2. Persons Authorized to Disclose My Information: My HCPs, including any pharmacy that fills my prescription medication, and any health plans or programs that provide me healthcare benefits.
    3. Persons to Whom My Information May Be Disclosed: A qualified HCP, a nurse, Cycle employees, individuals representing Cycle, including any third-party administrators responsible for the administration of the Cycle Vita Support Program, appropriate third parties under contract to Cycle, such as the Cycle Pharmacovigilance Agency and product manufacturer(s), to properly address any reports Adverse Events (AEs) related to Cycle's medication. I understand my PHI will only be shared in accordance with my consent as described within this form.
    4. Purposes for Which the Disclosures Are to Be Made: Disclosures of PHI may be made to Cycle so that Cycle may use and disclose the PHI for purposes of completing the Cycle Vita Support Program enrollment process, verifying my enrollment form and establishing my eligibility for the Cycle Vita Support Program and associated benefits that may include:
        a. Insurance and Reimbursement Assistance: Authorization allows for professional assistance at no charge on Patient's behalf for Claims Settlement, Claims Submission to health insurers, and communication of relevant claim information to/from HCPs and Insurance carriers.
        b. Reimbursement Support: Financial Assistance, including Cycle's sponsored Co-Pay Assistance program, available only for eligible patients.
        c. Patient Benefits Investigation & Payer Prior-Authorization Support: personnel from the Cycle Vita Support Program will contact, investigate, and arrange for Patient's eligible coverage with their respective Health Insurer and/or PBM (Pharmacy Benefit Manager) including assistance with Prior-Authorizations.
        d. Patient Education and Information: Personnel from the Cycle Vita Support Program will provide Patients with full education on medication storage, administration, timely, relevant disease information and product information updates.
        e. Access to Manufacturer / Cycle: This will allow Cycle to alert Patients receiving Cycle's medication about relevant product and market updates, product recalls, Adverse Event notifications, and available resources, including adherence tools and other programs to ensure medication compliance.
        f. Product and Service Development: I understand and agree that any information that I provide or is disclosed to Cycle may be used by Cycle to help develop new products, services and programs. I further understand that Cycle will not sell my personal data to any unrelated third party for marketing purposes without my express permission.

Patient Full Name*	Date of Birth*

5. Limits of Protections after Disclosure. I understand that once my PHI has been disclosed hereunder, State or federal privacy law may no longer restrict its use or disclosure.
6. Option to Refuse. I understand I am not required to sign this Authorization as a condition to receive treatment with Cycle's products, or payment for health care; enrolling in a health plan; or establishing eligibility for benefits. However, by refusing to authorize disclosure of my PHI to a qualified and authorized Cycle HCP, I also understand that I am knowingly foregoing possible access to the benefits offered by the Cycle Vita Support Program.
7. Copy of Authorization and Ability to Cancel Authorization. I understand I will be given a copy of this Authorization after I sign it and my Authorization shall remain in effect until it expires (5 years from the date sign below unless a shorter period is required by the law of my state residence), or unless I revoke Authorization at any time by contacting personnel from the Cycle Vita Support Program at 888-360-8482 (VITA), Monday through Friday, from 8:00am to 8:00pm EST, by FAX, at 888-385-8482 (VITA) or in writing to Cycle Pharmaceuticals Ltd, 200 Portland St., Boston, MA 02114, USA
8. I understand that my pharmacy, health insurers and third-party vendors may receive payment from Cycle as the manufacturer in exchange for securely sharing my PHI to an authorized Cycle's HCP for the sole purpose of providing me access to important patient support as described above.

PATIENT AUTHORIZATION

I have read and understood the Patient Authorization Information and by signing this form authorize the use and disclosure of my personal health information as described above.

***Signature NOT required to begin benefit investigation. Authorization may also be collected verbally upon completion of benefit investigation with Cycle Vita.**

Patient Name (Printed)

Signature of Patient

Date

Signature of Patient Representative*

Date

*If signed by Patient Representative, please explain authority / relation to act on behalf of patient:

Please read the following statement and mark the box:

☐ By checking this box I hereby authorize the Cycle Vita Support Program to use my PHI to contact me by mail, e-mail, text, phone, or any communication method I request for the purposes as described herein.