



IncyteCARES Program Enrollment Form

(Page 1 of 5)

Please legibly complete all fields not marked optional, for timely processing. **Fax completed form to 1-855-525-7207.**

We will contact you within 2 business days. For questions, call **1-855-452-5234**.

For details about all program services your patient can receive upon enrollment, see **HCP.IncyteCARES.com/ZYNZY**.

☐ Check here to request only a Benefits Investigation for your patient.

PATIENT INFORMATION

Full Name _____ Date of Birth ____ / ____ / ____

Home Address _____

City _____ State _____ ZIP _____

Medicare ID (Required for patients with Medicare) _____

Email (Optional) _____

Phone Number _____ Alternate Phone Number (Optional) _____

Best Time to Call (Optional) ☐ Morning ☐ Afternoon ☐ Evening

Primary Language (Optional) ☐ English ☐ Spanish ☐ Other _____

Is patient a resident of the United States or Puerto Rico? ☐ Yes ☐ No

ALTERNATE CONTACT (Optional)

Full Name _____ Relationship _____ Phone _____

FINANCIAL INFORMATION (Optional)—Required only to apply for the Patient Assistance Program.

See **HCP.IncyteCARES.com/ZYNZY** for details.

Current Annual Household Income _____ Number of People in Household _____

INSURANCE INFORMATION

☐ Patient does not have medical insurance.

Primary Insurer _____ **Type of insurance:** ☐ Commercial ☐ Government ☐ Other

Policy ID Number _____ Group Number _____

Phone _____ If patient is the policy subscriber, check here and skip fields below. ☐

Subscriber Name _____ Subscriber Date of Birth ____ / ____ / ____

Secondary Insurer (If applicable) _____ Phone _____

Policy ID Number _____ Group Number _____

If patient is **not** the policy subscriber, check here and complete fields below. ☐

Subscriber Name _____ Subscriber Date of Birth ____ / ____ / ____

Fax completed form to 1-855-525-7207. Need help? Call us at **1-855-452-5234**.

For complete program details, visit **HCP.IncyteCARES.com/ZYNZY**.

Please see Full Prescribing Information for **ZYNZY® (retifanlimab-dlwr)** at **ZYNZY.com**.



ZYNZY and the ZYNZY logo are registered trademarks of Incyte.
Incyte and the Incyte logo are registered trademarks of Incyte.
© 2026, Incyte. INC-0005 05/26

PRESCRIPTION FOR ZYNYZ® (retifanlimab-dlwr)

Use this section to write your patient's prescription.

A separate prescription form is not needed, unless required by state law.

Date ____ / ____ / ____

Patient Name _____ Date of Birth ____ / ____ / ____

Medication Name: ZYNYZ® (retifanlimab-dlwr)

☐ **Merkel Cell Carcinoma (MCC)** Adult patients with metastatic or recurrent locally advanced MCC

☐ Prescription: 500 mg administered as an intravenous infusion over 30 minutes every 4 weeks

☐ **Squamous Cell Carcinoma of the Anal Canal (SCAC)** Adult patient with locally recurrent or metastatic SCAC

☐ Prescription: 375 mg administered as an intravenous infusion over 30 minutes every 3 weeks

☐ Prescription: 500 mg administered as an intravenous infusion over 30 minutes every 4 weeks

☐ **Other Indication**

☐ Prescription: _____

Number of Treatments: _____ DEA Number _____

Concurrent Medications ☐ None _____

Allergies ☐ None _____

Prescriber Signature _____ Date ____ / ____ / ____

PRESCRIBER INFORMATION

Prescriber Full Name _____ State License Number _____

Payer-Specific ID Number _____ Tax ID Number _____

NPI Number _____ Site/Facility Name _____

Street Address _____ City _____ State ____ ZIP _____

Office Contact Name _____ Email (Optional) _____

Phone Number _____ Fax Number _____

Site of Infusion (If different from above) _____

CLINICAL INFORMATION

Patient Diagnosis (Primary ICD-10-CM Code) _____

Description _____

Previous Therapy Given

Dates _____ Dose _____

Therapy Given _____ Frequency _____

Fax completed form to 1-855-525-7207. Need help? Call us at 1-855-452-5234.

For complete program details, visit [HCP.IncyteCARES.com/ZYNYZ](https://www.hcp.incytecares.com/ZYNYZ).

Please see Full Prescribing Information for ZYNYZ® (retifanlimab-dlwr) at ZYNYZ.com.



ZYNYZ and the ZYNYZ logo are registered trademarks of Incyte.
Incyte and the Incyte logo are registered trademarks of Incyte.
© 2026, Incyte. INC-0005 05/26

HIPAA AUTHORIZATION

I authorize my healthcare providers (eg, physicians, pharmacies) and my insurance company to disclose personal health information about me, including information related to my medical condition and treatment, my health insurance coverage, and my address, email address, and telephone number (collectively, my “PHI”) to Incyte, its agents, and the IncyteCARES program (collectively, “Incyte”) so that Incyte may use the information for purposes of: (i) assisting in my enrollment in IncyteCARES; (ii) assessing my eligibility for out-of-pocket cost assistance or free drug or referring me to other programs or sources of funding and financial support; (iii) coordinating delivery of ZYNYZ® (retifanlimab-dlwr) to me or my healthcare provider; (iv) providing education, information on Incyte products and services, and ongoing support services to me related to ZYNYZ; (v) gathering feedback on my therapy and/or disease state; (vi) contacting me by mail, email, phone, or fax for any of the above purposes; and (vii) creating information that does not identify me personally for use for other purposes related to ZYNYZ. I understand that my pharmacy providers may receive remuneration for making such disclosures. I also authorize my healthcare providers and my insurance company to use my PHI to communicate with me about Incyte products and services and I understand that they may receive remuneration for making such communications. I understand that, once disclosed pursuant to this authorization, my PHI may no longer be protected under federal or state law and could be disclosed by Incyte to others, but I understand that Incyte will make reasonable efforts to keep it private and to disclose it only for the purposes set forth in this authorization.

I understand that I do not have to sign this authorization to obtain healthcare treatment or benefits; however, in order to receive the services and communications described above, I must sign the authorization. I understand that I may cancel my authorization at any time by contacting IncyteCARES at 1-855-452-5234 or by mail at PO Box 221798, Charlotte, NC 28222-1798. My cancellation of this authorization will be effective when my healthcare providers and insurance companies are notified of its receipt by Incyte, but will not apply to PHI already used or disclosed in reliance upon this authorization.

Continued on next page

Fax completed form to 1-855-525-7207. Need help? Call us at 1-855-452-5234.

For complete program details, visit **HCP.IncyteCARES.com/ZYNYZ**.

Please see Full Prescribing Information for ZYNYZ® (retifanlimab-dlwr) at ZYNYZ.com.



ZYNYZ and the ZYNYZ logo are registered trademarks of Incyte.
Incyte and the Incyte logo are registered trademarks of Incyte.
© 2026, Incyte. INC-0005 05/26

All fields are required unless noted.

I understand that I have a right to receive a copy of this authorization. This authorization expires one year after the date below unless I cancel it before then. To review Incyte's Privacy Policy, please visit <https://incyte.com/privacy-policy>.

☐ **I consent** ☐ **I do not consent**

Printed Name of Patient

Printed Name of Legal Guardian (if applicable)

Signature of Patient (or legal guardian)

Dated (MM/DD/YY)

By signing above, I am indicating that I am legally authorized to consent and that I am providing my consent as the patient or the patient's legal guardian for Incyte to collect, process and disclose my health data I provide for the purposes described within the consent above.

PATIENT OPT-IN FOR ONGOING EDUCATION AND SUPPORT

All fields are required unless noted.

I consent to Incyte collecting, using and disclosing my health data for the following purposes:

- To enroll me and manage my participation in Incyte's IncyteCARES program, which includes activities related to my condition or treatment (for example, co-pay card programs, payer medication coverage verification, nurse educator support, disease management support), and to manage Incyte's products, services, and programs related to my condition or treatment.

Incyte uses the following when it administers the Incyte IncyteCARES program:

- Health data—my name (and the name of my caregiver if applicable), gender, date of birth, contact information and information relating to my health condition or treatment.

I understand that my consent to this use of my health data is required for me to participate in the Incyte IncyteCARES program. I also understand that Incyte will not sell my health data to third parties, but Incyte may disclose my health data to

Continued on next page

Fax completed form to 1-855-525-7207. Need help? Call us at 1-855-452-5234.

For complete program details, visit HCP.IncyteCARES.com/ZYNYZ.

Please see Full Prescribing Information for ZYNYZ® (retifanlimab-dlwr) at ZYNYZ.com.



ZYNYZ and the ZYNYZ logo are registered trademarks of Incyte.
Incyte and the Incyte logo are registered trademarks of Incyte.
© 2026, Incyte. INC-0005 05/26

Incyte's vendors only for Incyte's business purposes related to the Incyte IncyteCARES program. I understand that Incyte may use my health data to contact me by mail, email, or telephone, for the above purposes. I also understand that if I do not consent to the use of my health data for the above purposes, I will not be able to participate in the program. Finally, I understand that I may withdraw my consent to processing my health data for the above purposes at any time by calling 1-855-446-2983 or visiting www.incyte.com/privacy-policy and that if I withdraw my consent, I will no longer be able to participate in the program. I understand that this consent will remain in effect for one year.

By signing the consent to use, I agree that these entities may use my health information to administer the program or as permitted or required by applicable privacy laws. I permit such use for one year after the dates I sign the consent, unless and until I revoke it in writing prior to that time.

☐ **I consent** ☐ **I do not consent**

Printed Name of Patient

Printed Name of Legal Guardian (if applicable)

Signature of Patient (or legal guardian)

Dated (MM/DD/YY)

By signing above, I am indicating that I am legally authorized to consent and that I am providing my consent as the patient or the patient's legal guardian for Incyte to collect, process and disclose my health data I provide for the purposes described within the consent above.

Fax completed form to 1-855-525-7207. Need help? Call us at 1-855-452-5234.

For complete program details, visit **HCP.IncyteCARES.com/ZYNYZ**.

Please see Full Prescribing Information for ZYNYZ® (retifanlimab-dlwr) at ZYNYZ.com.



ZYNYZ and the ZYNYZ logo are registered trademarks of Incyte.
Incyte and the Incyte logo are registered trademarks of Incyte.
© 2026, Incyte. INC-0005 05/26