

TIBSOVO® (ivosidenib) tablets

Patient Support Program Enrollment Form

Complete this form to enroll patients in the ServierONE Patient Support Services for TIBSOVO.

PATIENT INFORMATION (see pages 2, 4, and 5)

Section 1: Complete the Patient Information section.

Section 2 (optional—for applicable patients only):
Enter your Caregiver Information.

Section 3: Complete the Patient Insurance Information section and be sure to provide legible copies (front and back) of the patient's medical and prescription insurance cards.

Section 4: Complete the Patient Financial Eligibility Information section to have a Care Manager contact you for information about financial support services available to you.

Sections 8 and 9: Read the Patient Authorization to Share Personal Health Information section (page 4) and Consent to Participate in ServierONE Patient Support Program section (page 5) and if you agree, provide your signature at the bottom of page 5.

(Optional) Check the boxes at the bottom of page 5 if you agree to receive text messages by or on behalf of ServierONE Patient Support services, including marketing information, educational and treatment support materials, and/or surveys related to your medical condition.

PATIENT SUPPORT SERVICES (check all that apply)

- ☐ I would like benefits investigation assistance for my patient.
- ☐ I would like support evaluating my patient for ServierONE financial support services.
- ☐ I would like my patient to be connected to a ServierONE Care Manager for one-on-one support.

PRESCRIBER INFORMATION (see page 3)

Section 5: Complete the Prescriber Information section. Make sure to provide the correct Prescriber/Practice information.

Section 6: Clinical information is important and often requested when verifying benefits. The correct diagnosis and ICD-10 code(s) are required. If you are working with a Specialty Pharmacy, make sure to provide that information as well.

Section 7: Read the Physician Declaration and Authorization, and if you agree, provide your signature and date in the designated form fields at the bottom of page 3.

Fax the completed enrollment form to 844-409-1143

Before faxing: Be sure provider and patient have both signed where indicated. Be sure to include completed form and a copy of both sides of the patient's insurance card(s)



For assistance, please contact ServierONE at **844-409-1141** Monday – Friday (8 AM to 6 PM ET) or visit **ServierONE.com**

ServierONE™ offers a comprehensive suite of services, assistance, and resources to help patients access TIBSOVO

Eligible patients can choose from a wide range of support programs helping with access, financial assistance, treatment adherence, and patient education.



Patient Support Program

- A dedicated Care Manager will identify the applicable financial support programs for patients



Copay Assistance

- Patient may pay as little as \$0 per prescription fill
- No income restrictions
- Commercial insurance approval is required (and not available to patients with Medicaid, Medicare, or other government programs)



QuickStart Program

- For qualified patients facing insurance coverage delays lasting longer than 5 business days
- A 30-day supply will be provided, with a potential additional 30-day supply in the case of further delays



Bridge Program

- For qualified patients experiencing a lapse in insurance coverage
- A 30-day supply will be provided, with a potential additional 30-day supply in the case of further delays



Patient Assistance Programs (PAP)

- For qualified patients residing in the United States or Puerto Rico
- Patient is uninsured, underinsured, or facing affordability issues
- ≤600% of federal poverty level (FPL)
- if over 600% of FPL please contact ServierONE to be assessed for additional support



Phone: 844-409-1141
Hours of Operation: 8 AM to 6 PM ET
Fax: 844-409-1143

Patient Support Program Enrollment Form

*Required Field

Section 1. Patient Information

*Patient First Name _____ Middle Name _____

*Last Name _____ *Date of Birth ____/____/____ (MM/DD/YYYY)

*Street Address _____ *City _____ *State _____ *ZIP _____

*Gender ☐ Male ☐ Female ☐ Other: _____

*Preferred Language ☐ English ☐ Spanish ☐ Other: _____

*Preferred Phone Number _____ Alternate Phone Number _____

*Email _____

Preferred time of day to contact ☐ Morning ☐ Afternoon ☐ Evening

Okay to leave message/voicemail ☐ Yes ☐ No

Section 2. Caregiver Information (if applicable)

Caregiver First Name _____ Caregiver Last Name _____

Relationship to Patient _____

Caregiver Phone Number _____ Caregiver Email _____

Caregiver is the main point of contact? ☐ Yes ☐ No

Section 3. Patient Insurance Information

Please copy both sides of patient's insurance card(s)

Patient insurance (check all that apply): ☐ No insurance ☐ Medicare ☐ Medicaid ☐ Commercial/private ☐ Other

Primary health insurance

Plan Name _____

Phone # _____

Policy ID # _____

Group # _____

Policy holder (if other than patient)

Name _____

Date of Birth ____/____/____
(mm/dd/yyyy)

Prescription drug insurance

Plan Name _____

Phone # _____

Policy ID # _____

Group # _____

Rx BIN # _____

PCN # _____

Secondary insurance

Plan Name _____

Phone # _____

Policy ID # _____

Group # _____

If a prior authorization and/or an appeal have been submitted to the insurance company please indicate the dates below.

Prior authorization submitted date: _____

Appeal submitted date: _____

Additional appeals submitted: _____

Section 4. Patient Financial Eligibility Information

☐ Yes, please assess my eligibility for ServierONE financial support services and have a Care Manager contact me for one-on-one support.

☐ Yes, I am a US resident

Number of family members in household
(people who contribute to or are dependent
on the household income) _____

Annual gross pretax household income
Note: Dollar amount should be consistent with
your most recent 1040 tax form or W-2. _____

*Patient First Name _____ *Last Name _____ *Patient DOB: ____ / ____ / ____
(MM/DD/YYYY)

Section 5. Prescriber Information

*Prescriber Name _____ Prescriber Specialty _____

*Practice Name _____

*Practice Street Address _____ *City _____ *State _____ *ZIP _____

*NPI # _____ *Tax ID # _____

Office Contact Name _____ Office Contact Title _____

Office Contact Phone Number _____ Office Contact Fax Number _____

Office Contact Email _____

Section 6. Patient Diagnosis and Prescription Information

- | | |
|--|---|
| ☐ ICD-10-CM C22 Malignant neoplasm of liver and intrahepatic bile ducts | ☐ ICD-10-CM C92.00 Acute myeloblastic leukemia, not having achieved remission |
| ☐ ICD-10-CM C22.1 Intrahepatic bile duct carcinoma | ☐ ICD-10-CM C92.01 Acute myeloblastic leukemia, in remission |
| ☐ ICD-10-CM C24.0 Malignant neoplasm of extrahepatic bile duct | ☐ ICD-10-CM C92.02 Acute myeloblastic leukemia, in relapse |
| ☐ ICD-10-CM C24.1 Malignant neoplasm of ampulla of Vater * | ☐ IDC-10-CM C94.6 Myelodysplastic disease, not classified |
| ☐ ICD-10-CM C24.8 Malignant neoplasm of overlapping sites of biliary tract | ☐ ICD-10-CM D46.9 Myelodysplastic syndrome, unspecified |
| ☐ ICD-10-CM C24.9 Malignant neoplasm of biliary tract, unspecified | ☐ ICD-10-CM D46.2 Refractory anemia with excess of blasts [RAEB] |
| ☐ ICD-10-CM C78.7 Secondary malignant neoplasm of liver and intrahepatic bile duct | ☐ ICD-10-CM D46.Z Other myelodysplastic syndromes |
| | ☐ Other ICD-10 _____ |

Current Medications: _____

Allergies: _____

Please be sure to fill out the information below in its entirety, including number of refills for TIBSOVO.

RX START DATE: ____ / ____ / ____ **TIBSOVO DOSAGE:** _____ **QUANTITY (DAYS):** ____ **REFILLS:** ____
(MM/DD/YYYY)

DIRECTIONS FOR USE:

The recommended dose for TIBSOVO is 500 mg (two 250-mg tablets) orally once daily until disease progression or unacceptable toxicity.

*MAINTENANCE PRESCRIPTION

*Maintenance Prescriber Signature – Dispense as written (MM/DD/YYYY)

*Maintenance Prescriber Signature – Substitution Allowed (MM/DD/YYYY)

QUICKSTART/BRIDGE PRESCRIPTION

QuickStart/Bridge Prescription Request

Prescriber Signature – Dispense as written (MM/DD/YYYY)

Prescriber Signature – Substitution Allowed (MM/DD/YYYY)

***Preferred Specialty Pharmacy:** Preferred pharmacy will be honored when allowed by patient's insurance.

☐ Biologics by McKesson ☐ Onco360 Oncology Pharmacy

Pharmacy Name: _____ Phone Number: _____ Fax: _____

Section 7. Physician Declaration and Authorization

I certify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed TIBSOVO based on my judgment of medical necessity, and I will be supervising the patient's treatment. I authorize, if appropriate, the forwarding of this prescription to an authorized specialty pharmacy on behalf of myself and the patient. I understand that neither I nor the patient may seek reimbursement from any government program or third-party insurer for any free product received under the program.

I certify that I have obtained the patient's authorization to release the above information and such other information as may be required by Servier or its agents to assist the patient in obtaining coverage for TIBSOVO, to assist the patient in initiating or continuing TIBSOVO therapy, and to provide financial assistance to the patient.

*Physician Signature

____ / ____ / ____ (MM/DD/YYYY)
*Date



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*Patient First Name _____ *Last Name _____ *Patient DOB: ____ / ____ / ____
(MM/DD/YYYY)

Section 8. Patient Authorization to Share Personal Health Information

Please read the following authorizations carefully, and if you agree, provide your signature on page 5.

I understand that ServierONE Patient Support Services is a service offered by Servier Pharmaceuticals, Inc. to help eligible patients who have been prescribed TIBSOVO obtain insurance coverage and financial assistance for TIBSOVO.

I give permission for my physician and their staff to disclose my health and other personal information, including, but not limited to the information on this form, to Servier Pharmaceuticals, Inc. and its agents, representatives, and third parties that support Servier's programs so that Servier may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers and patient assistance groups (collectively, "Third Parties") in order to: (1) enroll me in the Programs; (2) facilitate the filling of my prescription for and the delivery and administration of TIBSOVO; (3) assist me in obtaining insurance coverage for TIBSOVO; (4) contact me about TIBSOVO and the Programs (this may include supplemental educational materials, information, offers and services related to my therapy or my medical condition, or opportunities to participate in focus groups, surveys, or interviews); and (5) manage the Programs.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to Servier in order to assist Servier in accomplishing the purposes described above.

I understand that once my information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws (the Health Insurance Portability and Accountability Act) or state privacy laws and may be further disclosed to others. However, I understand that Servier will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent.

I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive TIBSOVO that is paid for by my insurer, my treatment, payment for treatment, eligibility for or enrollment in health benefits; my refusal will limit my ability to receive support services for TIBSOVO, including participation in free medication programs.

I understand that this authorization will remain in effect for 3 years, or a shorter period as may be required by state law, from the date of my signature, unless I revoke it earlier by contacting Servier in writing at IQVIA c/o Servier Patient Support Services, 200 Pier Four Blvd. Boston, MA 02210. If I revoke this authorization, Servier and any Third Parties who are notified of my revocation will stop using and disclosing my information as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization.

I understand that the services described in this authorization may be reduced at any time, without prior notification. I also understand that I have the right to receive a copy of this authorization.



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*Patient First Name _____ *Last Name _____ *Patient DOB: ____/____/____
(MM/DD/YYYY)

Section 9. Consent to Participate in ServierONE Patient Support Program Including the TIBSOVO Copay Program, QuickStart Program, Bridge Program, and Patient Assistance Program

Please read the following authorizations carefully, and if you agree, provide your signature below.

By signing below, I understand that in order to qualify for certain financial support programs I must meet program requirements. I certify that the information I have provided about my household income and size is accurate. I know that ServierONE Patient Support Services will ask me for a copy of my recent tax returns or other proof of income for the purpose of an audit, and I agree to provide such documentation in a timely manner, if requested. I certify that the information provided above is truthful and accurate to the best of my knowledge and that any other information I provide at Servier's request will be truthful and accurate.

For support via the Patient Assistance Program (if applicable), I authorize Servier to use my demographic information to access reports on my individual credit history from consumer reporting agencies. I understand that upon request, Servier will tell me whether an individual consumer report was requested and the name and address of the agency that furnished it. I further understand and authorize Servier to use any consumer reports about me and information collected from, along with other information they obtain from public and other sources to estimate my income in conjunction with the patient assistance program eligibility determination process, if applicable. I verify that unless I have identified otherwise in this application, I have no other coverage for prescription medications, including Medicaid, Medicare or any public or private assistance programs, or any other form of insurance.

For support via the TIBSOVO Copay Program (if applicable), I certify that I am not a beneficiary of a federal or state healthcare program, including but not limited to Medicaid, Medicare, Veterans Affairs (VA), Department of Defense (DoD), TRICARE, or any state-funded programs. Once enrolled, I understand that Servier will pay my eligible copay and/or coinsurance costs up to the program maximum, but that any costs over the program maximum or those that are not eligible for payment under the TIBSOVO Copay Program are my responsibility. I understand that my benefits will reset at the start of each calendar year.

I understand that my eligibility for any of ServierONE Patient Services Financial Support Programs is based on requirements determined by Servier in its discretion (that ServierONE Patient Support Services may change at any time) and that, if approved, I must reapply and continue to meet eligibility requirements on an ongoing basis. I certify that I will notify ServierONE Patient Assistance Program at 844-409-1141 if my income or health insurance status changes. I agree not to seek reimbursement from any government program or third-party insurer for any free product received under the programs. I understand that the programs are not insurance. Servier Pharmaceuticals reserves the right to rescind, revoke, or amend the programs at any time, without notice.

I verify that the information on this enrollment form and other supporting documentation is complete and accurate. If I am the caregiver/representative for the patient, I confirm I am authorized to sign on behalf of the patient.

☐ **(Optional)** I agree to receive text messages by or on behalf of ServierONE Patient Support Services at the telephone number(s) that I provide. I understand that my consent is not required as a condition of purchasing any goods or my enrollment in ServierONE Patient Support Services. Message and data rates may apply. All carriers may not be supported.

☐ **(Optional)** I agree to receive marketing information, educational and treatment support materials, and/or surveys related to my medical condition, TIBSOVO, or ServierONE Patient Support Services from Servier by mail, phone, text, and/or email. I understand that my consent is not required as a condition of purchasing any goods or my enrollment in ServierONE Patient Support Services.



*Patient Name _____ *Date of Birth ____/____/____
(MM/DD/YYYY)

Parent/Authorized Representative Name _____

Relationship to Patient _____

*Signature _____ *Date ____/____/____
(MM/DD/YYYY)