



LEQSELVITM
(deuruxolitinib) tablets 8mg

Begin your patient's LEQSELVITM treatment journey by enrolling them in the

LEQSELVI SUPPORTTM PROGRAM

Enroll your patient in LEQSELVI SUPPORT to obtain complete coverage details and assistance with obtaining authorizations and navigating the limited specialty pharmacy (SP) network.

- **How to enroll in LEQSELVI SUPPORT:**
 - **E-prescribe** to Careform SP from your EMR system
 - **Fax to 1-855-216-6223.** Patient consent can be obtained electronically from a mobile device
 - **Enroll online:** Visit LeqselviEnrollment.com to complete and submit an enrollment form
- **Benefits of participation in LEQSELVI SUPPORT:**
 - Complete benefit verification services
 - Authorization and appeals support
 - Initiate electronic prior authorization (PA) via Surescripts[®]
 - Early Access Program and financial assistance
 - Specialists to triage and monitor your prescription until dispensed
 - Option for personalized 1:1 direct-to-patient support

Limited specialty pharmacies that can dispense LEQSELVI:

- **Accredo**
Phone: 1-866-759-1557
- **BioPlus Specialty Pharmacy**
Phone: 1-888-292-0744
- **CenterWell Specialty Pharmacy**
Phone: 1-800-486-2668
- **CVS Specialty Pharmacy**
Phone: 1-800-237-2767
- **Kroger Specialty Pharmacy**
Phone: 1-888-355-4191
- **Optum Specialty Pharmacy**
Phone: 1-855-427-4682
- **Senderra Specialty Pharmacy**
Phone: 1-855-460-7928
- **Walgreens Specialty Pharmacy**
Phone: 1-888-282-5166

LEQSELVI SUPPORT™ Patient Services Enrollment Form

Fax completed form and copies of both sides of insurance and pharmacy benefit cards to LEQSELVI SUPPORT.
Fax: 1-855-216-6223

Please complete all required fields (marked with an asterisk [*]) to prevent delays. For more information or assistance, please call LEQSELVI SUPPORT at 1-855-327-3007 or visit LeqselviHCP.com/support.

1 Patient Information (*REQUIRED)

*Patient Name: _____ *Date of Birth: _____ / _____ / _____ Male Female Other
*Address: _____ *City/State/ZIP: _____
*Mobile Phone: _____ Alternate Phone: _____ Email: _____

Messaging Consent (OPTIONAL):

- Opt in to receive recurring automated text messages from LEQSELVI SUPPORT, including refill reminders and a digital savings card, at the mobile phone number provided. Consent to receiving text messages is not a condition of purchase of goods or services. Message and data rates may apply. Message frequency varies. Text HELP for help. Text STOP to opt out. Please visit SUN PHARMACEUTICAL INDUSTRIES, INC.'s privacy policy at <https://sunpharma.com/usa/privacy-policy/> and the mobile terms and conditions at <https://LeqselviCopay.com/mobileterms>.
- By checking this box, I am requesting Patient Access Liaison service for my patient. I understand that Patient Access Liaisons do not work under the direction of an HCP, nor do they offer medical advice. By requesting this service, I understand that a Patient Access Liaison may reach out to my patient on a regular basis to offer support throughout the LEQSELVI™ treatment journey.

2 Insurance (*REQUIRED, where applicable)

Patient is: a US resident Uninsured Card(s) attached (if checked, proceed to step 3)

	*Primary Insurer	Pharmacy Insurer
Insurer Name		
Insurer Phone		
Group #		GRP
Policy #		RX BIN
Medicare Beneficiary ID #		RX PCN
If Auth on File, provide reference #		

3 Prescriber (*REQUIRED, where applicable)

*Prescriber Name: _____ *Clinic Name: _____
*NPI #: _____ *State License #: _____ *GRP NPI #: _____
Collaborating MD/DO Name (if Applicable): _____ *Address: _____
NPI #: _____ *City/State/ZIP: _____
Office Contact: _____
Phone: _____ Fax: _____

4 Early Access Program (*REQUIRED)

When a commercial insurer requires authorization that may result in a delay in starting treatment with LEQSELVI, the Early Access Program (EAP) is designed to support eligible patients with up to 11 refills while authorization is being obtained.

LEQSELVI (deuruxolitinib) 8 mg tablets; SIG: 1 tablet (8 mg) orally twice daily Quantity: 60 Refills: _____ (No more than 12 fills in a calendar year)

PRESCRIBER CERTIFICATION: I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I certify that I am the prescriber who has prescribed LEQSELVI to the previously identified patient and that I provided the patient with a description of the LEQSELVI Early Access Program. I authorize LEQSELVI SUPPORT to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy. I understand that the no-charge resource through LEQSELVI SUPPORT may support patients who are experiencing a delay in insurance coverage for LEQSELVI until coverage is obtained, and I confirm that I will support the above-identified patient in seeking to secure such coverage as I deem appropriate. I certify that I will not seek reimbursement from any third-party payer for any no-charge product dispensed by a SUN PHARMACEUTICAL INDUSTRIES, INC. authorized pharmacy.

Prescriber Signature (REQUIRED)*: _____ Today's Date*: _____

5 Prescription and Authorization (*REQUIRED)

This prescription has been sent to an SP (add SP details, then skip to section 6) Date sent: _____ SP name: _____ SP phone: _____

*Primary Diagnostic Code: L63.0 L63.1 L63.2 L63.8 L63.9

Description: LEQSELVI (deuruxolitinib) 8 mg tablets; SIG: 1 tablet (8 mg) orally twice daily

Quantity: 60 # of refills _____

*Allergies: No known allergies Yes (please list) _____

By signing below and submitting this form, I certify that: (a) the person named on this form is my patient (the "Patient"); the information provided, to the best of my knowledge, is complete and accurate; and therapy with LEQSELVI is medically necessary for the Patient; (b) my office received the Patient's authorization to release the information above and other of the Patient's protected health information (as defined under the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to SUN PHARMACEUTICAL INDUSTRIES, INC., LEQSELVI SUPPORT Patient Services, the contracted dispensing pharmacy, and other contractors of SUN PHARMACEUTICAL INDUSTRIES, INC. for the purpose of (i) requesting reimbursement support services such as benefits investigation, prior authorization, appeals, and co-pay support; (ii) seeking enrollment of the Patient in the Patient Assistance Program; and (iii) assisting in the Patient obtaining or continuing therapy; (c) product provided at no cost through LEQSELVI SUPPORT Patient Services (if applicable) shall only be used for the Patient, and I will not attempt to resell, barter, transfer, trade, or return the product for credit, nor will I or my office seek reimbursement for free product provided to the Patient from any third-party payer (private or government, including but not limited to Medicare and Medicaid); (d) my office will maintain any free product separately from commercial inventory and administer the free product only to the Patient; (e) if the Patient is no longer on therapy or otherwise cannot use the free product, I will promptly contact LEQSELVI SUPPORT Patient Services to arrange for product return or disposal; (f) I authorize LEQSELVI SUPPORT Patient Services to transmit the above prescription to the appropriate specialty pharmacy for my patient; (g) I understand that I am under no obligation to prescribe any SUN PHARMACEUTICAL INDUSTRIES, INC. product and that I have not received nor will I receive any benefit from SUN PHARMACEUTICAL INDUSTRIES, INC. for doing so. Special Note: CA, MA, NC, and PR: Interchange is mandated unless prescriber writes the words "No Substitution." ATTN: New York and Iowa prescribers, please submit electronic prescription. The prescriber is to comply with the prescriber's state-specific prescription requirements.

→ _____ Today's Date

*Original Signature (Dispense as Written)

Fax: 1-855-216-6223 | Phone: 1-855-327-3007 | Please see full Prescribing Information, including BOXED WARNING, and Medication Guide at LeqselviHCP.com and full Terms and Conditions for the participation in LEQSELVI SUPPORT Patient Services Programs at LeqselviHCP.com/support. See Privacy Policy at <https://sunpharma.com/privacy-policy-new/>

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