Seagen Secure®
Patient Assistance Program

Phone: 855-4SECURE (855-473-2873)
SeagenSecure.com

Healthcare Provider Request Form for Tivdak™ (tisotumab vedotin-tftv) for Injection

Complete and fax to 855-557-2480 or email to CaseManager@seagensecure.com

This is 1 of 2 required forms to enroll a patient into Seagen Secure®. All fields on this form are required to complete enrollment in Seagen Secure. To start assisting this patient, a completed and signed Patient Authorization Form must also be submitted.

Physician/Provider Information

PHYSICIAN NAME

NAME OF GROUP/HOSPITAL | TAX ID # | NPI | EXPIRATION

CORRESPONDENCE ADDRESS | CITY | STATE | ZIP

OFFICE CONTACT NAME | PHONE | EXTENSION

CONTACT'S EMAIL ADDRESS | FAX

Patient Information

PATIENT NAME | WEIGHT | DATE OF BIRTH (MM/DD/YYYY)

◯ Home ◯ Cell ( ) -
PREFERRED CONTACT NUMBER | EMAIL

ADDRESS | CITY | STATE | ZIP

DIAGNOSIS | ICD-10 | STAGE | TREATMENT START DATE (MM/DD/YYYY)

WHAT LINE OF THERAPY IS TIVDAK?

DID PATIENT EXPERIENCE DISEASE PROGRESSION ON OR AFTER CHEMOTHERAPY?

◯ Y ◯ N

DOSE FOR TIVDAK PER ADMINISTRATION:

TIVDAK TREATMENT FREQUENCY:

◯ Q3W

◯ Other: _____

IS THE PATIENT RECEIVING ANYTHING IN RELATION TO THE PREMEDICATION AND REQUIRED EYE CARE?

☐ Topical corticosteroid eye drops

☐ Topical ocular vasoconstrictor drops

☐ Cold packs

☐ Topical lubricating eye drops

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Health Insurance Information

You may also attach copies of insurance cards

PLEASE CHECK ONE: ◯ Commercial/Private Insurance ◯ Medicare/Medicaid/TRICARE ◯ No Insurance ◯ Other

	Primary Medical Insurance	Secondary Medical Insurance	Pharmacy Insurance
INSURANCE COMPANY NAME			
POLICY NUMBER			
GROUP NUMBER			
TELEPHONE NUMBER			
POLICYHOLDER'S NAME			
POLICYHOLDER'S DOB			
BIN/PCN NUMBER			

Patient Assistance Program enrollment begins on a temporary basis.

By providing the Patient Information (including Health Insurance Information) above, you represent that you have the patient's consent to provide his/her information for purposes of verifying benefits and/or patient assistance program consideration for the selected Seagen's product as indicated above, and that you have written patient authorization(s) as required by applicable state or federal law to release the Patient Information on this form.

MD OR HEALTHCARE PROVIDER CONTACT SIGNATURE **DATE SIGNED**

The healthcare provider and patient remain fully responsible for all claims made to private insurers or government programs, including the accuracy of all information submitted. All claims for Seagen products should be made in accordance with legal and contractual requirements. Many factors influence reimbursement, and the policies and practices of private and public payers may change without notice. Seagen reserves the right to modify or discontinue the program, without notice, at any time.

Upon reasonable notice in writing, and not more than once per coverage year, Seagen Inc. shall have the right to audit and examine all documents, correspondence and records related to enrolled patients and product shipments. Upon request, a representative duly authorized by Seagen Inc. may contact you by phone or email with an audit request for all or some of your enrolled patients. Complete responses to an audit are required within 30 days of said request. Non-compliance may lead to the possibility of program discontinuation for all or some of your patients.

Seagen Inc. and Seagen Secure will utilize this patient information solely for the purposes of a benefits investigation and patient assistance assessment. The program will not sell, rent, or otherwise distribute any patient information outside of Seagen Inc. or its agents.

I have been made aware that the privacy statement of Seagen, available at www.seagen.com/privacy, describes its privacy practices, including how I may exercise certain rights with respect to my data.

Seagen®