Seagen Secure® Patient Assistance Program

855-4-SECURE (855-473-2873)
Monday-Friday, 8 AM-8 PM ET

Instructions for TUKYSA® (tucatinib) Tablets Healthcare Provider Request and Patient Authorization Forms

Healthcare Provider Request Form

Please use the information below to guide you to fill out the Healthcare Provider Request Form for TUKYSA.

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Seagen Secure® Patient Assistance Program

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

TUKYSA® (tucatinib) Tablets Healthcare Provider Request Form

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® to evaluate which services they may be eligible to receive. To start assisting this patient, Seagen Secure must also receive a completed and signed Patient Authorization Form. Seagen Secure does not guarantee that submission of these forms will result in patient assistance, coverage, or reimbursement.

As it pertains specifically to Prior Authorization, please check all that apply:

- ☐ Please consider my patient for a *Quick Start Request*
  (Quick Start is a short-term free product that may be available to eligible patients who face a delay [at least 5 days] in insurance determination of coverage for TUKYSA)
- ☐ My patient's insurance requires a Prior Authorization and I have not yet submitted the Prior Authorization request for my patient
- ☐ I do not know if my patient's insurance requires a Prior Authorization

☐ Prior Authorization facilitated by:
○ Healthcare Provider ○ Biologics ○ Onco360

Physician/Provider Information

PHYSICIAN NAME _____ NPI _____

NAME OF GROUP/HOSPITAL _____ NPI FOR GROUP/HOSPITAL _____ TAX ID # _____ EXPIRATION _____

CORRESPONDENCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

OFFICE CONTACT NAME _____ PHONE _____ EXTENSION _____

CONTACT'S EMAIL ADDRESS _____ FAX _____

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If you have questions on the Healthcare Provider Request Form, please call 855-4SECURE for support.

Your patient's insurance may require a prior authorization (PA).

Check here if you wish to have your patient enrolled in the Quick Start program. To complete Quick Start enrollment, please check if the PA has been submitted and by whom. Remember to then complete the prescription information on page 3 for Quick Start Request.

Seagen Secure®
Patient Assistance Program

Healthcare Provider Request Form (cont'd)

Please use the information below to guide you to fill out the Healthcare Provider Request Form for TUKYSA® (tucatinib) tablets.

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CONTACT'S EMAIL ADDRESS _____ FAX _____

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Complete where the PA has been initiated if you would like Seagen Secure to assist your patient in securing access to treatment.

Select "Healthcare Provider" if you or an integrated pharmacy started the PA.

Select one of our in-network specialty pharmacies if they have started processing the prescription.

Complete all sections in full to the best of your ability. Missing information may delay the initiation of support and require additional outreach to you in an attempt to obtain it.

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Healthcare Provider Request Form (cont'd)

Please use the information below to guide you to fill out the Healthcare Provider Request Form for TUKYSA® (tucatinib) tablets.

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Patient Assistance Program

PATIENT FULL NAME

PATIENT DATE OF BIRTH (MM/DD/YYYY)

Patient Information

PATIENT NAME | ◯ Male ◯ Female SEX | DATE OF BIRTH (MM/DD/YYYY)

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

ADDRESS | CITY | STATE | ZIP

PATIENT REPRESENTATIVE NAME | REPRESENTATIVE PHONE

CARE PARTNER NAME | PHONE

CARE PARTNER ADDRESS | CITY | STATE | ZIP

Health Insurance Information

You may also attach copies of insurance cards

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

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

Page 2 of 4

Complete all sections in full to the best of your ability. Missing information may delay the initiation of support and require additional outreach to you in an attempt to obtain it.

The information here can be replaced by legible copies of insurance cards or a patient face sheet that documents pharmacy benefit information if available.

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Healthcare Provider Request Form (cont'd)

Please use the information below to guide you to fill out the Healthcare Provider Request Form for TUKYSA® (tucatinib) tablets.

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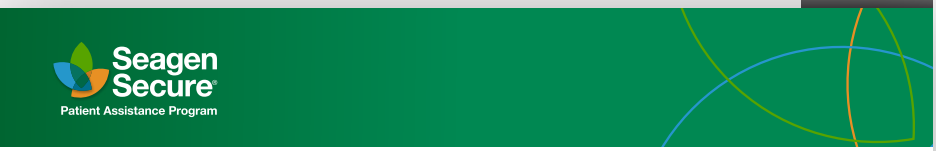

PATIENT FULL NAME _____ PATIENT DATE OF BIRTH (MM/DD/YYYY) _____

Clinical Information

PLEASE CHECK ONE: ◯ Breast ◯ Colorectal ◯ Other _____

DIAGNOSIS: REQUIRED | ICD-10: REQUIRED

DOES PATIENT HAVE HER2+ DISEASE? ◯ Y ◯ N ◯ Unknown

DOES PATIENT HAVE BRAIN METASTASES? ◯ Y ◯ N ◯ Unknown

DOES PATIENT HAVE RAS WILD-TYPE DISEASE (CRC ONLY)? ◯ Y ◯ N ◯ Unknown

TARGET TREATMENT START DATE: _____

PATIENT'S PREVIOUS THERAPIES:

PLEASE COMPLETE THE RELEVANT PRESCRIPTION INFORMATION SECTION BELOW. PRESCRIBERS MUST COMPLY WITH ALL STATE-SPECIFIC PRESCRIPTION REQUIREMENTS, INCLUDING THOSE GOVERNING E-PRESCRIBING.

Quick Start Prescription Information

DATE:	DRUG NAME:	STRENGTH:	DOSAGE FORM:
DIRECTIONS (eg, take 2 caps 2× per day with food):		DAYS' SUPPLY: *15 days*	REFILLS: *N/A*

Commercial/Patient Assistance Program (PAP) Prescription Information

DATE:	DRUG NAME:	STRENGTH:	DOSAGE FORM:
DIRECTIONS (eg, take 2 caps 2× per day with food):		DAYS' SUPPLY: *30 days*	REFILLS:

HEIGHT: _____ WEIGHT: _____

CURRENT OR PREFERRED PHARMACY: ◯ Biologics ◯ Onco360 ◯ Healthcare Provider ◯ No Preference

Selection will be honored if permitted by patient's insurance coverage.

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Please select the indication in which TUKYSA will be used for this patient.

Diagnosis and ICD-10 fields are required fields to determine if the patient is eligible to receive Seagen Secure support.

Please complete clinical history information here.

Complete this if your patient faces a payer-related delay and you would like their eligibility reviewed to receive a free 15-day supply through our Quick Start Program.

This section can be completed for patients receiving a dispense through a specialty pharmacy or the Patient Assistance Program (PAP).

Select which specialty pharmacy you would like to dispense TUKYSA for your insured patient.

Contact information:

Biologics, Inc.
P: (800) 850-4306
F: (800) 823-4506
biologics.mckesson.com

Onco360 Oncology Pharmacy
P: (877) 662-6633
F: (877) 662-6355
www.onco360.com

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PATIENT FULL NAME

PATIENT DATE OF BIRTH (MM/DD/YYYY)

Prescriber Declaration

By signing below, you acknowledge and attest that: (1) you are the healthcare professional who prescribed the treatment identified in this form, (2) the information provided in this form is true and accurate to the best of your knowledge, (3) you have obtained from the patient, or when applicable their authorized legal representative, consent to provide the above information to Seagen Secure to determine the patient's eligibility to participate in Seagen Secure, (4) you have obtained written patient authorization(s) in the form and manner required by applicable state and federal law to release the Patient Information on this form, (5) any medication supplied by Seagen as a result of this enrollment form is only for the use of the patient named on this form and shall not be sold, traded, transferred, returned for credit, or submitted to any third-party payer for reimbursement, and (6) you have prescribed the above-referenced medication for this patient based on your independent clinical judgment that this treatment is medically necessary and in the best interests of the patient.

PRESCRIBER'S SIGNATURE

DATE SIGNED

Licensed member of the practice must sign here if the above prescriptions are completed. Otherwise, an authorized representative of the practice may sign.

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's 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, with or 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.

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Patient Authorization Form

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Seagen Secure® is a service provided to you, free of charge, from Seagen by its authorized agents. Seagen Secure is here to help you navigate through access to Seagen's products. Seagen Secure may:

(i) assist me with my enrollment in Seagen Secure and assess my eligibility for participation in the Commercial Out-of-Pocket Assistance Program(s) and if eligible enroll me;

(ii) contact me by phone, mail, or email to request further information;

(iii) provide me with educational and other materials, information, and support related to Seagen Secure;

(iv) verify, investigate, and assist me with obtaining coverage for the Seagen product my physician indicated on the enrollment form from my health insurance plan;

(v) assess my eligibility for participation in the patient assistance program, if necessary;

(vi) refer me to other independent programs or alternative sources that may be available to provide assistance to me as allowed under the law, if necessary;

(vii) for Seagen's internal business purposes, including quality control and support enhancing survey.

I consent to Seagen Secure contacting me, my physician(s), and insurance provider(s) for the purposes described above.

In order to assist you in the manner described above, Seagen Secure must have access to protected health information, or "PHI." This means information including, but not limited to, my name, address, contact number, medical condition, and health insurance provider may be disclosed. I authorize my doctors, pharmacies, and other healthcare providers, as well as my health insurance plan, to disclose to Seagen

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If you have questions on the Patient Authorization Form, please call 855-4SECURE for support.

This form must be submitted to enroll a patient into Seagen Secure. It can be submitted via fax, phone, or email.

It is recommended that the Healthcare Provider Request Form and Patient Authorization Form are submitted at the same time.

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Patient Authorization Form (cont'd)

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("Company"), and its third-party suppliers, vendors, and other service providers supporting Seagen Secure (collectively, the "Service Providers"), my protected health information to help me get access to my prescribed medication. I also authorize Seagen Secure to access my credit information for the purposes of verifying my income as part of the eligibility screening for the Patient Assistance Program (PAP). I understand that completing this form does not guarantee that I will qualify for and be enrolled into the Seagen PAP. I understand that I can refuse to sign this Authorization which will have no impact on my treatment, payment for treatment, or insurance coverage but Seagen Secure will not be able to assist me in accessing my medication. This Authorization will last for two years from the date on which I agree to this Authorization (or such shorter period as applicable state law may require).

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. I understand that I may revoke this Authorization at any time by providing written notice to Seagen Secure at PO Box 5490, Louisville, KY 40255. Cancellation of this Authorization will be valid when received by the administrators of Seagen Secure.

Patient Information

PATIENT NAME _____ **DATE OF BIRTH (MM/DD/YYYY)** _____

ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

EMAIL ADDRESS _____ **PHONE** _____

PREFERRED METHOD OF CONTACT: ○ **PHONE** ○ **EMAIL** ○ **MAIL**

ALTERNATE CONTACT _____ **RELATIONSHIP** _____ **CONTACT'S PHONE** _____

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Please have the patient complete the demographics information and indicate preferred form of contact. Option to designate a care partner.

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Financial Information

This section is only required for patients enrolling in the Seagen Secure Patient Assistance Program for free medicine. If all criteria are met, you may be eligible to receive your medication free of charge.

HOUSEHOLD SIZE FOR MOST RECENT TAX YEAR

ANNUAL HOUSEHOLD INCOME FOR MOST RECENT TAX YEAR*

Completion of this section is required for a Patient Assistance Program (PAP) evaluation.

I understand that I am entitled to receive a copy of this Authorization after I have provided my signature.

SIGNATURE (PATIENT OR LEGALLY AUTHORIZED PERSON) **DATE SIGNED**

Must be signed by patient or legal representative.

LEGALLY AUTHORIZED PERSON PRINTED NAME

RELATIONSHIP TO PATIENT **DATE SIGNED**

*Seagen Secure reserves the right to request documentation proving income.

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