CELGENE PATIENT SUPPORT®

Celgene Patient Support® Enrollment Form

Phone: 1-800-931-8691
Fax: 1-800-822-2496
Website: www.celgenepatientsupport.com
E-mail: patientsupport@celgene.com

*Indicates required field.

SERVICES OFFERED

Insurance-related Services:

- Benefits Investigation
- Prior Authorization/Precertification
- Appeals Assistance
- Fast Track for First Prescription®

Financial Assistance:

- Celgene Commercial Co-pay Program
- Information on Independent Third-party Co-pay Assistance Organizations
- Celgene Patient Assistance Program (PAP)

FAST TRACK for FIRST PRESCRIPTION®

Fast Track for First Prescription® is the unique quick-start program designed to accelerate patient access to their first prescription for a Celgene oral medication. To be eligible, patients must be prescribed their first prescription for an approved indication of a Celgene oral product, must have documented proof of insurance, and be enrolled in a Celgene Risk Evaluation and Mitigation Strategy (REMS) program, if applicable.

Fast Track for First Prescription®: ☐ Yes ☐ No Patient's Celgene REMS Authorization Number _____

Celgene Patient Support® has discretion to disqualify a patient from the Fast Track program if the patient or prescription does not meet Fast Track criteria, or the doctor's office or patient does not follow the program process, cannot be reached by Celgene Patient Support® or specialty pharmacy, or is not available to accept delivery of product. Your Specialist will inform the doctor's office of any patient who becomes ineligible.

PATIENT INFORMATION

*First Name _____ Middle Name _____
*Address 1 _____
Address 2 _____
*City _____
*State _____ *Zip Code _____
*E-mail _____

*Last Name _____
*Phone Number _____ ☐ Home ☐ Mobile ☐ Work
*Gender _____ *Date of Birth _____
Social Security Number _____
Marital Status _____
*Does the Patient Permanently Reside in the US or a US Territory? ☐ Yes ☐ No

DRUG INFORMATION

*Drug _____
*Diagnosis/ICD-10-CM _____
In Combination With (if applicable) _____

Start Date _____ Dosage _____
Number of Prior Therapies for This Diagnosis _____

Name(s) of Prior Therapies _____

CAREGIVER INFORMATION

First Name _____ Last Name _____
E-mail _____

Phone Number _____
Relationship to Patient _____

INSURANCE INFORMATION

*Does patient have insurance through (check all that apply)?

☐ **Medicare Part A (Hospital)** ☐ **Medicare Part B (Medical)** ☐ **Medicare Part D (Prescription)** ☐ **Medicare Advantage** **Medicare ID** _____

☐ **Medicaid** ☐ **VA or Military** ☐ **Commercial/Private Insurance** ☐ **State Assistance Program for Medication** ☐ **None** **Other** _____

Insurance Name:	Phone #:	Member ID/Policy #:	Group #:	Policy Cardholder:	PCN #:
Primary Insurance					
Secondary Insurance					
Prescription Insurance					
Other Insurance					

PATIENT FINANCIAL INFORMATION (REQUIRED FOR FINANCIAL ASSISTANCE)

Celgene Patient Assistance Program Eligibility Criteria:

1. Annual family gross income (before taxes and deductions) must be equal to or less than 650% of the current Federal Poverty Level.

or

2. Patient's out-of-pocket (OOP) prescription spend for the current calendar year totals 3% or more of the total family gross income.

Number of people living in household who contribute to or are dependent on your household income: _____

Gross annual household income† (numerical value required): $ _____ ☐ **Yearly** ☐ **Monthly**

†Gross household income is the total income before income tax deductions from all people living in your household. Gross income refers not only to the salaries and benefits received, but also to the receipts from any personal business, investments, dividends, and other income.

Include the following documentation to verify household income:

Federal Income Tax Return

or

At least one of the following: Social Security award letter for the current calendar year, unemployment letter, W-2 or 1099 forms, last 3 consecutive pay stubs, and/or pension statement

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*Indicates required field. Patient Name _____ Date of Birth _____

HEALTHCARE PROVIDER INFORMATION

*Prescriber First Name _____ *Prescriber Last Name _____ DEA # _____ NPI # _____

Medicaid Provider # _____ Tax ID # _____ PTAN # _____

*Facility Name _____ *Address 1 _____

Address 2 _____ *City _____ *State _____ *Zip Code _____

Contact First and Last Name _____ Contact E-mail _____ Contact Title _____

Preferred Method of Contact _____ *Fax Number _____ *Phone Number _____ Ext _____

HCP AUTHORIZATION

I hereby represent, covenant, and certify as follows:

a) I have prescribed the Celgene drug based on my professional judgment of medical necessity and that I will supervise the patient's medical treatment

☐ With respect to REBLOZYL® (luspatercept-aamt), I have reviewed the Prescribing Information, which states that safety and effectiveness in pediatric patients have not been established. Based on findings in juvenile animals, REBLOZYL is not recommended for use in pediatric patients. Please see Section 13 - Non-Clinical Toxicology of the Prescribing Information for further information. See www.reblozylpro.com for full Prescribing Information. By my signature below, I hereby verify I have reviewed the above information and I am aware of the risk for pediatric patients, and have decided to prescribe the product for the patient identified above.

b) I have obtained from my patient his or her consent and any required authorization to release to Celgene Patient Support® and its representatives/agents all patient information needed for this application, including, without limitation, my patient's financial and medical information in accordance with applicable privacy laws

c) I understand that this information is for the sole use of Celgene Patient Support® and its representatives/agents to assess the patient's eligibility for participation in Celgene Patient Support®.

d) I allow Celgene and its representatives/agents to utilize my personal information provided in this authorization including my NPI/Tax ID for the patient's Benefit Verifications;

e) I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible under this program. I will notify Celgene Patient Support® if I become aware of any such changes;

f) I understand that I am under no obligation to prescribe any Celgene drug and I have not received and will not receive any benefit from Celgene for prescribing a Celgene drug;

g) I certify that the information contained in this form is complete and accurate to the best of my knowledge;

h) I will notify Celgene Patient Support® of any errors regarding the foregoing, and will make every effort to correct those errors.

i) I authorize Celgene Patient Support® to forward the prescription by fax or other modes of delivery to the pharmacy chosen by the above named patient

For the Celgene Patient Assistance Program (PAP), I certify that:

- I have not received, nor will I seek or accept reimbursement from any federal, state, or private payers for any drug provided for my patient by the Celgene Patient Assistance Program (PAP)
  - I understand that the insurance claim that's submitted on behalf of my patient to their insurance provider for payment for Celgene medication(s) may have the Celgene medication(s) listed separately from any bill or claim for drug administration or any other items or services provided to the patient depending on the insurance provider's criteria for reimbursement
- I understand that the drug provided for my patient cannot be returned for credit;

For the Celgene Commercial Co-pay Program, I certify that:

- I have not received, nor will I seek or accept payment from my patient for any co-insurance amount paid for by the Celgene Commercial Co-pay Program for a Celgene product;
- I acknowledge and agree to the terms and conditions of the respective program. I also understand that I can access the terms and conditions of the program on www.celgenepatientsupport.com.

Prescriber Signature _____ Date _____

DOCUMENTATION

Please copy the front and back of medical insurance and prescription drug plan cards to include with fax or e-mail, and list all additional paperwork you will be providing with this enrollment form.

☐ Prescription ☐ Income Documentation ☐ Other _____

Please visit www.reblozylpro.com to view the full Prescribing Information for REBLOZYL.

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PATIENT CONSENT AND AGREEMENT

1. What information will be used and disclosed? My personal information will be disclosed, including:

- Information on this application form
- My contact information and date of birth
- Social security number (which is voluntary)
- Financial and income information
- Insurance benefit information
- Health records and information, including medications prescribed to me

2. Who will disclose, receive, and use the information? This consent permits my caretakers (which includes my healthcare providers, pharmacists, health plans, and health insurers who provide services to me, as well as other people that I say can help me apply) to disclose my personal information to Celgene and its authorized agents and assignees ("Administrators"). Celgene and its Administrators may also share my information with my caretakers and with other healthcare providers, pharmacists, and health insurers to determine if I am eligible for, or enrolled in, another plan or program.

3. What is the purpose for the use and disclosure? My personal information will be used by and shared with the persons and organizations described in this consent in order to:

- Provide me with Celgene-sponsored treatment support services, including online support, financial assistance services, co-pay assistance, reimbursement services, nurse services, and compliance and persistency services, as well as any information or materials related to such services or Celgene products, including promotional or educational communications
- Contact my caretakers and me about the Celgene Patient Support Program and the services that are available
- Contact other healthcare providers and to determine if I am eligible for, or enrolled in, another plan or program
- Provide me with information about, or ask me about my experience with or thoughts about, products, services, and programs that Celgene offers or sponsors, including treatment support services
- Communicate with me by mail, email, phone, fax or otherwise about my prescription, including through product adherence and refill reminder messages
- Provide marketing and/or educational information or materials related to my illness, medicine, and the Program services
- Allow Celgene to analyze the usage patterns and the effectiveness of Celgene products, services, and programs and help develop new products, services, and programs, and for other Celgene general business and administrative purposes
- Improve and develop the Program's services
- Utilize my information to generate payer information reports

4. When will this consent expire? This consent will be effective for 5 years unless it expires earlier by law or I cancel it in writing. I may cancel this consent by writing to:

Celgene Corporation
Attn. Celgene Patient Support
86 Morris Ave.
Summit, NJ 07901

- I may also cancel this consent by sending an email to patientsupport@celgene.com, or by calling 1-800-931-8691 to cancel with a specialist over the phone
- If I cancel this consent, I will no longer be able to participate in the Celgene Patient Support Program. The Celgene Patient Support Program will stop using or disclosing my information for the purposes listed in this consent as necessary to end my participation or as required or allowed by law. This cancellation will not invalidate any reliance the organization has on the usage or disclosure of my information prior to my cancellation. I understand there may be a delay for the cancellation take effect
- My treatment (including with a Celgene product), insurance enrollment, and eligibility for insurance benefits are not conditioned upon my signing this Consent

5. Notices

- Once my health information has been disclosed to Celgene and its authorized agents and assignees ("Administrators"), I understand that the Health Insurance Portability and Accountability Act (HIPAA) may no longer restrict its use or disclosure, in certain instances. However, I understand that Celgene and its Administrators authorized to receive my health information pursuant to this consent agree to protect my health information by using and disclosing it only for purposes authorized in this consent or as required by law or regulations. I further understand that I may refuse to sign this consent and that if I refuse, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to the Celgene Patient Support Program. I have a right to receive a copy of this consent after I have signed it

6. Patient Certifications

- I certify that the personal information that I provide to the Celgene Patient Support Program is true and complete.
- If I qualify for and receive assistance for my medicine from the Celgene Commercial Co-pay Program:
  - I agree that at any time during my participation in the Celgene Patient Support Program, the Program may request additional documentation to verify my personal information. If there is missing information or I do not respond to requests for additional documents, the Program may delay my participation or decide I can no longer participate
  - I agree that I will not get reimbursed for it from anyone else, including from an insurance program, charity assistance or assistance through an independent third-party organization, or from a health savings, flexible spending, or other health reimbursement account

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PATIENT CONSENT AND AGREEMENT *(CONTINUED)*

- I understand and agree that the Program benefits are nontransferable, the offer is not conditioned on any past, present, or future purchase, including additional doses
- I agree not to combine the Program benefits with any other coupon, rebate, voucher, free trial, cash/discount card, or similar offer
- I understand and agree that acceptance of this offer confirms that this offer is consistent with my insurance and that I will report the value of the co-pay assistance I receive, as it may be required by my insurance provider

• If I qualify for and receive assistance for my medicine from the Celgene Patient Assistance Program:
- I agree that I will not get reimbursed for it from anyone else, including from an insurance program, charity assistance, or from a health savings, flexible spending, or other health reimbursement account
- I understand if I have Medicare Part D, I will also not count any free medication I receive towards my true out-of-pocket costs (TrOOP)
- I understand that receiving assistance for my medicine is temporary, and that I have the option to reapply in the respective program. I understand I may not be eligible if I have prescription drug coverage that will pay for my medication

• I agree to immediately contact the Celgene Patient Support Program at 1-800-931-8691 if my insurance or financial situation changes in any way (e.g. start to receive benefits from a federal, state, or government funded program). I understand if my insurance or financial situation changes in any way that I may not be eligible to participate in this program
• I understand and agree that Celgene Patient Support® may periodically contact me by phone, email or other methods to verify that my eligibility for the Program has not changed.
• I understand that the Celgene Patient Support Program may be discontinued or the rules for participation may change at any time, without notice.

For REBLOZYL® (luspatercept-aamt) Patients (check below if applicable)

☐ My child has been prescribed REBLOZYL® (luspatercept-aamt). I hereby acknowledge that I am aware that REBLOZYL is not approved by the Food and Drug Administration (FDA) for use in children (patients under the age of 18) and the FDA-approved labeling does not recommend use in children. I have discussed this information with my child's doctor.

I have read this consent and agree to its terms:

Print Name of Patient or Personal Representative _____

Description of Personal Representative's Authority _____

Signature of Patient or Personal Representative _____ Date _____

Please visit www.reblozylpro.com to view the full Prescribing Information for REBLOZYL.