PADCEV® enfortumab vedotin-ejfv Injection for IV infusion 20 mg & 30 mg vials

SUPPORT SOLUTIONS℠

Patient Enrollment Form

Healthcare Providers: Please complete this form, including the patient's and healthcare provider's signatures, and fax it to PADCEV Support Solutions℠ at **1-877-747-6843** or enroll via the Prescriber Portal at **PADCEVSupportSolutions.com**. You can call PADCEV Support Solutions at **1-888-402-0627**, Monday–Friday, 8:30 AM–8:00 PM ET.

PATIENT INFORMATION

First Name:	Last Name:	Date of Birth:	Sex: ☐ Male ☐ Female
Home Address:		City: State:	ZIP:
Cell Phone:	Home Phone:	Email:	

PATIENT AUTHORIZATION STATEMENT

Please read the Patient Authorization Statement on pages 2 and 3 and provide your signature to certify that you have read, understand, and agree to the terms.

PATIENT MEDICAL INFORMATION

Primary ICD-10-CM Diagnosis Code:	Patient Dose per Administration: _____ mg
Secondary ICD-10-CM Diagnosis Code:	

Specify previous therapies patient has received:

Platinum-containing chemotherapy: _____

Programmed death receptor-1 (PD-1) inhibitor: _____

Programmed death-ligand 1 (PD-L1) inhibitor: _____

CURRENT INSURANCE INFORMATION — Please include front and back copies of all medical and pharmacy cards when submitting this enrollment form.

☐ Patient has no insurance

	Primary Medical Insurance	Secondary Medical Insurance	Prescription Insurance
	☐ Medicare Part B ☐ Medicare Advantage ☐ Medicaid ☐ Private/Commercial	☐ Medicare Part B ☐ Medicare Advantage ☐ Medicaid ☐ Private/Commercial ☐ Medicare Supplement Insurance (Medigap)	☐ Private/Commercial
Insurer/Policy Name			
Subscriber Name			
Policy ID #			
Group #			
Rx BIN #	N/A	N/A	
Phone			

PRESCRIBER AND PRACTICE INFORMATION

Prescriber Name (First, Last):	Specialty (optional):	Tax ID #:
Medicare/Medicaid Provider #:	UPIN/NPI #:	State License #:
Practice or Facility Name:	Phone:	Fax:
Site of Administration: ☐ Physician Office ☐ Outpatient Hospital Setting ☐ Other: _____		
Address:		
City:	State:	ZIP:
Office Contact:	**Office Contact Phone:**	**Office Contact Email:**

PRESCRIBER CERTIFICATION AND ATTESTATION STATEMENT

Please read the Prescriber Certification and Attestation Statement on page 4 and provide your signature to certify that you have read, understand, and agree to the terms and conditions.

Patient Authorization Statement

By signing below, I authorize my doctors, pharmacies and other healthcare providers, as well as my health insurance plan, to disclose to Astellas Pharma US, Inc. ("Company") and its third-party suppliers, vendors, and other service providers supporting PADCEV Support Solutions℠ (collectively, the "Service Providers") personally identifiable information about me (my "Personally Identifiable Information") (for example, my name, Social Security number, address, insurance policy number, and income) and my medical condition (for example, my diagnosis or medications). This Personally Identifiable Information can include spoken or written facts about my health and insurance benefits. It can include copies of records from my healthcare providers or health plans about my health or healthcare.

I understand that my healthcare providers and my pharmacy may receive remuneration, or payment, for disclosing my Personally Identifiable Information pursuant to this Authorization.

I understand that PADCEV Support Solutions is a component of Astellas Pharma Support Solutions℠ and that the Service Providers may be compensated by Company.

Company and/or the Service Providers may use and disclose my Personally Identifiable Information to:

(i) assist me with my enrollment in PADCEV Support Solutions and assess my eligibility for participation in the Copay Assistance Program ("CAP") and, if eligible, enroll me in the CAP;
(ii) contact me by phone or mail to request further information;
(iii) provide me with educational and other materials, information, and support related to PADCEV Support Solutions;
(iv) verify, investigate, and assist me with obtaining coverage for PADCEV 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; and
(vii) help analyze the efficiencies and performance of the services provided by Service Providers.

I specifically authorize Company and the Service Providers to use and disclose my Personally Identifiable Information for the purposes described above. If I am deemed eligible and enrolled in the CAP, I certify that I have private commercial insurance and I am not insured by any federal or state health care program, including, but not limited to, Medicare, Medicaid, TRICARE, or Veterans Affairs. I agree to immediately notify PADCEV Support Solutions if there is a change in the status of my insurance coverage.

If an application is submitted to determine my eligibility under the PADCEV Patient Assistance Program (PAP), I also authorize Company and Service Providers to use my Personally Identifiable Information, including, but not limited to, my Social Security number, date of birth, name, and/or address as needed to access my credit information and information derived from public and other sources, including information from a consumer reporting agency (credit bureau), to estimate my income in conjunction with the eligibility determination process performed to determine my eligibility under the PAP. I agree to notify my healthcare providers if I become aware in the future of changes that would affect my eligibility, including, but not limited to, changes in health insurance status or coverage, financial status, and United States residing status. I understand that completing this enrollment form does not guarantee that I will qualify for the PADCEV PAP.

In some instances the Service Providers may de-identify my Personally Identifiable Information and use or disclose the de-identified information (in individual or aggregated form) for legitimate business purposes. I understand that the Company and the Service Providers will make reasonable efforts to keep my Personally Identifiable Information private; however, I understand that once information has been disclosed to the Service Providers, it may no longer be protected under federal privacy law and could be disclosed to others.

This authorization will last for three (3) years from the date on which I agree to this authorization (or such shorter period as applicable state law may require). My choice as to whether to sign this authorization will not change the way my doctors, healthcare providers, or payers treat me, but if I decline to sign it, I will not be able to have my insurance coverage verified, have alternate sources of assistance researched, or access other support provided by or on behalf of PADCEV Support Solutions.

I understand that I may revoke this authorization at any time by providing written notice to PADCEV Support Solutions at 290 West Mount Pleasant Avenue, Building 2, 4th Floor, Suite 4210, Livingston, NJ 07039. Cancellation of this authorization will be valid when received by the administrators of PADCEV Support Solutions. I understand that a cancellation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

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

This Authorization Statement is governed by and interpreted in accordance with the laws of the state of Illinois, excluding Illinois conflict of law rules, and applicable federal law.

My signature below certifies that I have read, understand, and agree to the Patient Authorization Statement.

Patient Name (please print): _____

Patient Signature X _____ Date: _____

If signed by a representative, please describe the representative's authority to act on behalf of the patient: _____

(Note: Office personnel cannot sign on behalf of the patient.)

I am acting for another person and I hereby affirm that I have the legal right to do so, that I am the parent or legal guardian of the patient, or that I otherwise have a valid power of attorney to act on behalf of the patient.

Representative Signature X _____ Date: _____

Prescriber Certification and Attestation Statement

By signing below, I hereby attest that I am the prescribing healthcare provider, I have determined that PADCEV is medically appropriate for this patient, and I have explained such to my patient. I certify that I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act [HIPAA] of 1996) to Company and its third-party suppliers, vendors, and other service providers supporting PADCEV Support Solutions (collectively, the "Service Providers") for the purpose of providing access and reimbursement support and the evaluation of the patient's eligibility for support. I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient.

I agree to notify the Service Providers if I become aware at any time in the future of changes in my patient's circumstances that would affect their eligibility, including, but not limited to, changes in health insurance status or coverage, financial status, United States residency status, or the indication for which PADCEV has been prescribed for this patient. My signature certifies that I have read, understand, and agree to this Prescriber Certification and that the information being disclosed on this enrollment form is complete and accurate to the best of my knowledge.

I understand my personal information will be used and disclosed by Company in accordance with its privacy policy, available at www.astellas.com/us/privacy-policy.

I certify that a copy of the Patient Authorization Statement has been given to the patient named on page 1 and his/her representative and that I have provided my patient with a description of PADCEV Support Solutions.

Prescriber Signature

X _____ Date: _____

(This form cannot be processed without an original signature.)

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SUPPORT℠ SOLUTIONS

If you have questions or need assistance regarding access and reimbursement for PADCEV® (enfortumab vedotin-ejfv), go to PADCEVSupportSolutions.com or call PADCEV Support Solutions at 1-888-402-0627, Monday–Friday, 8:30 AM–8:00 PM ET.

PLEASE CLICK HERE FOR FULL PRESCRIBING INFORMATION, INCLUDING BOXED WARNING.

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