ILUMYA™
tildrakizumab-asmn

ILUMYA SUPPORT

LIGHTING THE WAY™

Enrollment Form

Connect your patients to ILUMYA SUPPORT™ by completing and faxing this enrollment form

1. Please be sure to complete all required sections with your patients, including the Prescription Information and Patient HIPAA Authorization sections.
2. You must sign and date the form in order for the prescription to be processed. Stamped signatures cannot be accepted.
3. Patients applying for the Patient Assistance Program must fill out the appropriate section on the form.
4. Patients must review the Patient HIPAA Authorization section and then sign under the Patient Information section. A signature from the patients or their legal representatives is required.
5. Complete the form and fax pages 3 and 4 only to **877-872-6575**.

How to complete the **ILUMYA SUPPORT™** Enrollment Form

The **ILUMYA SUPPORT™ Enrollment Form** is the first step to getting your patients started with our comprehensive patient services. Use this guide to ensure your form is fully and accurately completed. Contact your Field Reimbursement Manager with any questions about prescribing ILUMYA™.

ILUMYA SUPPORT™

Patient Services Enrollment Form

ILUMYA SUPPORT™ Patient Services
PO Box 29051
Phoenix, AZ 85038-9051

Fax: 877-872-6575
Phone: 855-4ILUMYA (855-445-8692)

1 Requested Services

☐ **All services requested** ☐ **Benefits investigation and prior authorization assistance** ☐ **Financial assistance (co-pay services, EAP, PAP)** ☐ **Claim denial assistance** ☐ **Sending to SPP**

2 Patient Information (Required)

First name ___ MI ___ Last name ___ DOB (MM/DD/YYYY) ___/___/___ Gender ☐ M ☐ F

Address ___ City ___ State ___ Zip Code ___

Cell phone # (___) ___ Home phone # (___) ___ Email address ___

Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening Communication preference: ☐ Phone ☐ Email ☐ Mail ☐ OK to leave a detailed message

By signing below, you agree to receive communications from the ILUMYA SUPPORT™ Program and verify that you have read and agree to the Patient HIPAA Authorization on the back of this form.

- By providing my cell phone number, I agree to receive automated (and/or prerecorded) calls, texts, and emails about the ILUMYA SUPPORT™ Program. I confirm that I am the subscriber for the telephone number(s) provided and the authorized user for the email address(es) provided, and I agree to notify Sun Pharmaceutical Industries, Inc., promptly if any of my numbers or addresses change in the future. I understand that my wireless service provider's message and data rates may apply. I understand that no purchase is necessary to receive these calls, texts, or emails. I understand that I can opt out from receiving future text messages by texting STOP to 20808 from my mobile phone, and that I can request help by texting HELP to 20808. By signing below, I agree and certify that I am 18 years of age.
- I acknowledge that I have read and agree to the Patient HIPAA Authorization on the back of this form.

X

Patient Signature | **Print Patient Name** | **Signature of Personal Representative** (Legally authorized to act on behalf of the patient) | **Print Personal Rep Name (if applicable)** | **Date (MM/DD/YYYY)** ___/___/___

3 Patient Insurance Information (Required)

(Please attach a copy of both sides of the patient's insurance card[s]. If not available, please complete the information below.) Patients with no insurance for ILUMYA™ should complete Step 4 to be considered for the Patient Assistance Program.

Patient is insured? ☐ Yes ☐ No (If No, go to Step 4.) Veteran status? ☐ Yes ☐ No

Insurance type:

Primary insurance name ___
Beneficiary/cardholder name ___
Relationship to patient ___
Policy ID # ___ Group # ___
Primary insurance phone # (___) ___

If patient has a separate prescription coverage plan, please list it below. (Medicare patients please use Medicare Part D information.)

Pharmacy benefit plan name (if applicable) ___
Policyholder name ___ Relationship to patient ___
Policy ID # ___ Rx group # ___
Rx BIN ___ Rx PCN ___
Pharmacy benefit plan phone # (___) ___

Secondary insurance type (if applicable):

Secondary insurance name ___
Beneficiary/cardholder name ___
Relationship to patient ___
Policy ID # ___ Group # ___
Secondary insurance phone # (___) ___

Secondary pharmacy benefit plan name (if applicable) ___
Policyholder name ___ Relationship to patient ___
Policy ID # ___ Rx group # ___
Rx BIN ___ Rx PCN ___
Pharmacy benefit plan phone # (___) ___

4 Patient Financial Information (Required for Patient Assistance Program)

US resident? ☐ Yes ☐ No Disabled (longer than 2 years)? ☐ Yes ☐ No

☐ **Provider attestation:** Please contact the above-identified patient to explore alternate funding options, including the ILUMYA SUPPORT™ Patient Assistance Program. I understand that the patient will be asked for the following information:

- Total number of people living in the household including patient
- Total monthly income including all people contributing to the income

5 Healthcare Provider Information (Required)

First name ___ Last name ___
Facility/practice name ___ Specialty ___
Practice address ___ City ___ State ___ Zip code ___
Practice phone # (___) ___ Practice fax # (___) ___ NPI # ___ State license # ___ DEA # ___ Tax ID # ___
Practice contact first and last name ___ Practice contact phone # (___) ___ Practice contact email address ___

Preferred shipment location Choose one: ☐ Practice ☐ Alternative site of care

Location name ___ NPI ___
Address ___ City ___ State ___ Zip code ___

By signing below, I acknowledge that I have read and agree to the Provider Agreement on the back of this form.

X

Provider Signature **Date (MM/DD/YYYY)** ___/___/___

6 Prescription Information (To Be Completed by the Provider Only)

Primary diagnosis ☐ Plaque psoriasis (ICD-10 Code: L40.0) ☐ Other ___
Prescribed dose ILUMYA™ 1 single-dose prefilled syringe (100 mg at Week 0, Week 4, and every 12 weeks thereafter)
Quantity ___ # of refills ___
Scheduled injection date (if known) ___

Has your patient started therapy with ILUMYA™? ☐ Yes ☐ No
If Yes: How many treatments has the patient received? ___
What was the date of the first treatment? ___
What is the date of the next treatment? ___

Please attach your prescription if this form does not comply with your state laws.
☐ To my knowledge, the patient has not previously been treated with a biologic or systemic agent for the diagnosed condition.

If patient has been treated with a biologic or systemic agent, please provide information below.

Does this patient have a contraindication, intolerance, or allergy to Cosentyx®, Enbrel®, Humira®, Otezla®, Remicade®, Stelara®, Taltz®, Tremfya®, or other biologic/systemic treatment? ☐ Yes ☐ No
Does this patient have documented failure of adequate trial on Cosentyx®, Enbrel®, Humira®, Otezla®, Remicade®, Stelara®, Taltz®, Tremfya®, or other biologic/systemic treatment? ☐ Yes ☐ No
Check all that apply:
☐ Methotrexate ☐ Cosentyx® ☐ Enbrel® ☐ Humira® ☐ Otezla® ☐ Remicade® ☐ Stelara® ☐ Taltz® ☐ Tremfya® ☐ Other ___
The brands listed are registered trademarks of their respective owners and are not trademarks of Sun Pharmaceutical Industries, Inc.

Preferred specialty pharmacy (used if specialty pharmacy not payer mandated) ___
Preferred specialty pharmacy phone # (___) ___ Preferred specialty pharmacy fax # (___) ___
Note: Payer-mandated pharmacies will take first precedence, followed by preferred specialty pharmacy. ILUMYA SUPPORT™ will perform additional research to determine all options.

X

Provider Signature ***(Dispense as Written)*** **Date (MM/DD/YYYY)** ___/___/___

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1 **Choose "All services requested" or select from the individual services below:**

Benefits investigation (BI) and prior authorization (PA) assistance
ILUMYA SUPPORT™ will initiate a BI of the patient's insurance coverage for ILUMYA™ (tildrakizumab-asmn) and/or obtain information on any associated PA requests/appeals and/or route patient information to a specialty pharmacy.

Financial assistance

Co-pay services (eligible commercially insured patients): ILUMYA SUPPORT™ will determine a patient's eligibility and enroll him/her into the Co-pay Assistance Program for ILUMYA™.

Early Access Program (EAP)
ILUMYA SUPPORT™ will enroll patients facing a delay in coverage into the EAP. The EAP will provide free product for up to 2 years OR until coverage has been determined.

Patient Assistance Program (PAP)
Underinsured or uninsured: If applicable, ILUMYA SUPPORT™ will research alternate forms of funding (including the ILUMYA SUPPORT™ Patient Assistance Program) and, if the patient is eligible, will help with enrollment.

Claim denial assistance
ILUMYA SUPPORT™ will, if applicable, initiate review and research of a patient's denied claim.

Sending to specialty pharmacy provider (SPP)
If you prefer to send the prescription directly to your SPP, please check this box.

2 Complete all patient information, including communication preferences.

Have your patient read the Patient HIPAA Authorization in Section 8 and then sign here. ILUMYA SUPPORT™ cannot provide assistance without a signature from your patient or his/her personal representative.

3 Please attach a copy of both sides of your patient's insurance card(s). If you do not have a copy of your patient's insurance card(s), please fill out all the required information in this section.

4 If you would like to enroll your patient in the PAP, fill out this section. Let your patient know that additional information will be requested by ILUMYA SUPPORT™.

5 Be sure to fill out the required information about your practice and shipping preferences.

6 Fill out all the applicable prescription information for your patient. Provide detailed information about your patient's treatment history to help the ILUMYA SUPPORT™ team better assist your practice.

Providers must sign the enrollment form so that the prescription can be processed. Stamped signatures cannot be accepted.

ILUMYA SUPPORT™

Patient Services Enrollment Form

ILUMYA SUPPORT™ Patient Services
PO Box 29051
Phoenix, AZ 85038-9051

Fax: 877-872-6575
Phone: 855-4ILUMYA (855-445-8692)

1 Requested Services

☐ All services requested ☐ Benefits investigation and prior authorization assistance ☐ Financial assistance (co-pay services, EAP, PAP) ☐ Claim denial assistance ☐ Sending to SPP

2 Patient Information (Required)

First name ____________ MI ______ Last name ____________ DOB (MM/DD/YYYY) ___/___/___ Gender ☐ M ☐ F

Address ____________ City ____________ State ______ Zip Code ______

Cell phone # (_____) ____________ Home phone # (_____) ____________ Email address ____________

Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening Communication preference: ☐ Phone ☐ Email ☐ Mail ☐ OK to leave a detailed message

By signing below, you agree to receive communications from the ILUMYA SUPPORT™ Program and verify that you have read and agree to the Patient HIPAA Authorization on the back of this form.

- By providing my cell phone number, I agree to receive automated (and/or prerecorded) calls, texts, and emails about the ILUMYA SUPPORT™ Program. I confirm that I am the subscriber for the telephone number(s) provided and the authorized user for the email address(es) provided, and I agree to notify Sun Pharmaceutical Industries, Inc., promptly if any of my numbers or addresses change in the future. I understand that my wireless service provider's message and data rates may apply. I understand that no purchase is necessary to receive these calls, texts, or emails. I understand that I can opt out from receiving future text messages by texting STOP to 20808 from my mobile phone, and that I can request help by texting HELP to 20808. By signing below, I agree and certify that I am 18 years of age.
- I acknowledge that I have read and agree to the Patient HIPAA Authorization on the back of this form.

Patient Signature **Print Patient Name** **Signature of Personal Representative** (Legally authorized to act on behalf of the patient) **Print Personal Rep Name (if applicable)** **Date (MM/DD/YYYY)** ___/___/___

3 Patient Insurance Information (Required)

(Please attach a copy of both sides of the patient's insurance card[s]. If not available, please complete the information below.) Patients with no insurance for ILUMYA™ should complete Step 4 to be considered for the Patient Assistance Program.

Patient is insured? ☐ Yes ☐ No (If No, go to Step 4.) Veteran status? ☐ Yes ☐ No

Insurance type:

Primary insurance name ____________

Beneficiary/cardholder name ____________

Relationship to patient ____________

Policy ID # ____________ Group # ____________

Primary insurance phone # (_____) ____________

If patient has a separate prescription coverage plan, please list it below. (Medicare patients please use Medicare Part D information.)

Pharmacy benefit plan name (if applicable) ____________

Policyholder name ____________ Relationship to patient ____________

Policy ID # ____________ Rx group # ____________

Rx BIN ____________ Rx PCN ____________

Pharmacy benefit plan phone # (______) ____________

Secondary insurance type (if applicable):

Secondary insurance name ____________

Beneficiary/cardholder name ____________

Relationship to patient ____________

Policy ID # ____________ Group # ____________

Secondary insurance phone # (_____) ____________

Secondary pharmacy benefit plan name (if applicable) ____________

Policyholder name ____________ Relationship to patient ____________

Policy ID # ____________ Rx group # ____________

Rx BIN ____________ Rx PCN ____________

Pharmacy benefit plan phone # (______) ____________

4 Patient Financial Information (Required for Patient Assistance Program)

US resident? ☐ Yes ☐ No Disabled (longer than 2 years)? ☐ Yes ☐ No

☐ **Provider attestation:** Please contact the above-identified patient to explore alternate funding options, including the ILUMYA SUPPORT™ Patient Assistance Program. I understand that the patient will be asked for the following information:

- Total number of people living in the household including patient
- Total monthly income including all people contributing to the income

5 Healthcare Provider Information (Required)

First name ____________ Last name ____________

Facility/practice name ____________ Specialty ____________

Practice address ____________ City ____________ State ______ Zip code ______

Practice phone # (_____) ____________ Practice fax # (_____) ____________ NPI # ______ State license # ______ DEA # ______ Tax ID # ______

Practice contact first and last name ____________ Practice contact phone # (_____) ____________ Practice contact email address ____________

Preferred shipment location Choose one: ☐ Practice ☐ Alternative site of care

Location name ____________ NPI ____________

Address ____________ City ____________ State ______ Zip code ______

By signing below, I acknowledge that I have read and agree to the Provider Agreement on the back of this form.

Provider Signature **Date (MM/DD/YYYY)** ___/___/___

6 Prescription Information (To Be Completed by the Provider Only)

Primary diagnosis ☐ Plaque psoriasis (ICD-10 Code: L40.0) ☐ Other ____________

Prescribed dose ILUMYA™ 1 single-dose prefilled syringe (100 mg at Week 0, Week 4, and every 12 weeks thereafter)

Quantity ____________ # of refills ____________

Scheduled injection date (if known) ____________

Has your patient started therapy with ILUMYA™? ☐ Yes ☐ No

If Yes: How many treatments has the patient received? ____________

What was the date of the first treatment? ____________

What is the date of the next treatment? ____________

Please attach your prescription if this form does not comply with your state laws.

☐ To my knowledge, the patient has not previously been treated with a biologic or systemic agent for the diagnosed condition.

If patient has been treated with a biologic or systemic agent, please provide information below.

Does this patient have a contraindication, intolerance, or allergy to Cosentyx®, Enbrel®, Humira®, Otezla®, Remicade®, Stelara®, Taltz®, Tremfya®, or other biologic/systemic treatment? ☐ Yes ☐ No

Does this patient have documented failure of adequate trial on Cosentyx®, Enbrel®, Humira®, Otezla®, Remicade®, Stelara®, Taltz®, Tremfya®, or other biologic/systemic treatment? ☐ Yes ☐ No

Check all that apply:

☐ Methotrexate ☐ Cosentyx® ☐ Enbrel® ☐ Humira® ☐ Otezla® ☐ Remicade® ☐ Stelara® ☐ Taltz® ☐ Tremfya® ☐ Other ____________

The brands listed are registered trademarks of their respective owners and are not trademarks of Sun Pharmaceutical Industries, Inc.

Preferred specialty pharmacy (used if specialty pharmacy not payer mandated) ____________

Preferred specialty pharmacy phone # (_____) ____________ Preferred specialty pharmacy fax # (_____) ____________

Note: Payer-mandated pharmacies will take first precedence, followed by preferred specialty pharmacy. ILUMYA SUPPORT™ will perform additional research to determine all options.

Provider Signature *(Dispense as Written)* **Date (MM/DD/YYYY)** ___/___/___

7 Provider Agreement (Required)

Sun Pharmaceutical Industries, Inc., its affiliates, business partners, service providers, third-party contractors, and agents (together, "Sun Pharmaceutical Industries, Inc.") will use the information you provide to administer and improve ILUMYA SUPPORT™ Patient Services (the "Program").

By signing Section 5 on the front of this form, I (the prescriber) understand and agree that:

- I certify that the patient and physician information obtained in this enrollment form is complete and accurate to the best of my knowledge.
- I have prescribed ILUMYA™ based on my professional judgment of medical necessity.
- Any medications supplied by Sun Pharmaceutical Industries, Inc., as a result of this form are for use by the named patient only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third-party payer (private or government) for reimbursement.
- Sun Pharmaceutical Industries, Inc., may modify or terminate the program at any time without notice.
- I have received the necessary legal authorization from the patient to transmit the patient's personal health information, for the purposes provided on this form, to Sun Pharmaceutical Industries, Inc.
- I authorize ILUMYA SUPPORT™ Patient Services to transmit prescribing information to a third party(ies) to dispense the drug above to this patient.
- ILUMYA SUPPORT™ may contact me for additional information relating to the Program, including but not limited to via email, fax, and telephone.

I understand that the Early Access Program is designed to support patients who are experiencing a delay in obtaining insurance coverage for ILUMYA™ for up to 2 years or until such coverage is secured. I confirm that I will support the above-identified patient in seeking to secure such coverage as I deem appropriate. I understand that neither I nor the patient may seek reimbursement for free product received under the program.

8 Patient HIPAA Authorization

By signing Section 2 on the front of this form, I give permission for my health care providers (HCPs), my pharmacies, and my health insurer(s) to disclose my personal information, including information about my health insurance and payment/benefits, prescriptions, medical condition and treatment, and my demographic and contact information ("Personal Information") to Sun Pharmaceutical Industries, Inc., its affiliates, business partners, service providers, third-party contractors, and agents (together, "Sun Pharmaceutical Industries, Inc.") for the purposes described below.

I understand the purpose of this Authorization is to (i) enroll me in the ILUMYA SUPPORT™ Program (the "Program"), including to help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with ILUMYA™, coordinate my receipt of and payment for ILUMYA™, facilitate my access to ILUMYA™, and assist in an appeal, grievance, and/ or independent review request of a denial of insurance benefits and/or coverage; (ii) manage the Program, which may include conducting quality assurance and other internal business activities in connection with the Program; (iii) provide me with adherence reminders and treatment support; (iv) for marketing purposes which includes, but is not limited to, providing me with educational and promotional materials, information, special offers, and services related to my therapy or my medical condition, which may be funded or sent by a Program affiliate; and (v) for market research purposes, which includes contacting me to participate in focus groups, surveys, or interviews.

I understand that my Personal Information may be summarized for statistical or other purposes and provided to Sun Pharmaceutical Industries, Inc.

I give permission to Sun Pharmaceutical Industries, Inc., to contact me directly by mail, email, or by live, autodialed, and/or prerecorded messages and/or other electronic means at the address(es), email address(es), and telephone number(s) provided by me for the purposes described above.

I understand that my pharmacy, health insurer(s), and health care providers may receive remuneration (payment) from Sun Pharmaceutical Industries, Inc., in exchange for disclosing my Personal Information to Sun Pharmaceutical Industries, Inc., and/or for providing me with therapy support services.

While the Program will safeguard my Personal Information and only use it for intended purposes, I understand that once my Personal Information is disclosed it may no longer be protected by federal privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization at any time in the future by sending a written notice to PO Box 29051, Phoenix, AZ 85038-9051, or by calling 855-445-8692, but I understand that this revocation will only apply to my HCP(s), pharmacies, and health insurer(s) once they receive notification of my revocation and only to the extent they have not already taken action based on it. My refusal or future revocation will not affect the commencement or continuation of my treatment, payment for treatment, insurance enrollment, or eligibility for benefits; however, if I refuse to sign this Authorization or if I revoke this Authorization, I may no longer be eligible to participate in the Program. I understand that this Authorization will remain valid for five (5) years after the date of my signature, unless I revoke it earlier. I understand that I have the right to receive a copy of this Authorization.

To cancel participation in the ILUMYA SUPPORT™ program, please contact us at 855-4ILUMYA (855-445-8692).

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PM-US-ILY-0042 10/2018