

# PRESCRIPTION AND ENROLLMENT FORM FOR OPZELURA



TO SUBMIT, COMPLETE AND FAX THIS FORM TO **1-877-801-3840**.

**SELECT PROGRAM**

**Commercial Access Program for OPZELURA**  
Complete pages 1 and 2

**IncyteCARES for OPZELURA Patient Assistance Program**  
Complete pages 1, 2, and 3

**1. PATIENT INFORMATION**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Phone \_\_\_\_\_  Home  Mobile Best time to call  8 am-12 pm  12-4 pm  4-8 pm  
 Email \_\_\_\_\_ Is patient a resident of the United States or Puerto Rico?  Yes  No  
 Caregiver Contact (If Applicable) Full Name \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_ Phone \_\_\_\_\_

**2. PATIENT INSURANCE INFORMATION**

CHECK IF PATIENT DOES NOT HAVE PRESCRIPTION INSURANCE

**Primary Insurance**

Primary Insurance Name \_\_\_\_\_ Primary Insurance Phone \_\_\_\_\_  
 Policyholder Name \_\_\_\_\_ Policyholder Date of Birth \_\_\_\_\_  
 Policy ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

**Prescription (Rx) Insurance**

Rx Insurance Name \_\_\_\_\_ Rx Policy ID Number \_\_\_\_\_ Rx Group ID Number \_\_\_\_\_ Rx BIN \_\_\_\_\_ Rx PCN \_\_\_\_\_

**For Medicare Part D plans** – please provide address:

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**3. PRESCRIBER INFORMATION**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
 Practice Name \_\_\_\_\_ State License Number \_\_\_\_\_ NPI Number \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Practice Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

**4. PRESCRIPTION FOR OPZELURA**

**Primary Diagnosis ICD-10 Code(s)**  L20 Atopic Dermatitis  L80 Vitiligo  Other ICD-10 \_\_\_\_\_

Medication Name: **OPZELURA (ruxolitinib) cream, 1.5%** Tube size: 60 gram Number of Tubes \_\_\_\_\_ Refill(s) \_\_\_\_\_  
 Directions \_\_\_\_\_

**I certify that** I am the Healthcare Professional who has prescribed this medication, that it is medically necessary for the patient, and that the information provided is accurate to the best of my knowledge. I authorize Incyte, and its affiliates, agents, and service providers to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

*If you are a prescriber based in New York state, please use a New York state prescription form.*

**PRESCRIBER SIGNATURE** X

Dispense as written

X

Substitutions allowed

Date

**5. PRESCRIBER DECLARATION**

**By my signature, I certify that** I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Incyte and its employees or agents for purposes relating to Incyte's patient support programs.

**FOR COMMERCIAL ACCESS PROGRAM ENROLLMENT ONLY – PA Denial Information Required for Commercial Access Program Only**

**FOR PATIENTS WITH ATOPIC DERMATITIS:**

**By checking this box, I certify** my patient has mild to moderate atopic dermatitis, has tried and failed a topical prescription therapy, and the Prior Authorization (PA) was denied.

**FOR PATIENTS WITH NONSEGMENTAL VITILIGO:**

**By checking this box, I certify** my patient has nonsegmental vitiligo and that the Prior Authorization (PA) was denied.

PA Denial Date: \_\_\_\_\_ PA Denial Reason: \_\_\_\_\_

**PRESCRIBER SIGNATURE** X

Date

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Provide a copy of the HIPAA authorization to your patient for their records.

## HIPAA AUTHORIZATION

By signing this form, you are giving your permission to your physicians, pharmacies, laboratories, and other healthcare providers (“Healthcare Professionals”) and your health insurers to share your health information with Incyte, its agents, and the IncyteCARES for OPZELURA program (collectively, “Incyte”). You understand that your health information includes information relating to your medical condition, treatment, and insurance coverage, as well as identifying information about you (including, for example, your name, address, and date of birth). Your health information will be shared with Incyte so that Incyte may provide you with various support and information to help you access OPZELURA, which may include the following (collectively, “Patient Support Programs”):

- Providing benefits investigations/verification and reimbursement support, including assisting with identification of your insurer’s prior authorization requirements and requirements for appealing a denied claim
- Determining your eligibility for and helping you access copay support for OPZELURA
- Communicating with your Healthcare Professionals about OPZELURA and Patient Support Programs
- Providing you with financial assistance resources and information if you are eligible

You agree to be contacted by the Incyte regarding the Patient Support Programs using phone, email, text, or an autodialer or prerecorded voice using the information provided to enable fulfillment of the Patient Support Programs described above.

You understand that you do not have to sign this form and choosing not to sign will not affect your ability to receive treatment from your Healthcare Professionals or payment from your health insurer.

However, if you do not sign this form, IncyteCARES for OPZELURA will not be able to provide you with assistance.

You understand that once your health information is shared, it may no longer be protected by federal privacy law. However, Incyte agrees to protect your health information and to use it only for the purposes described in this form or as required or permitted by law.

You understand that this form will remain in effect for 1 year from the date of your signature unless you provide written notice that you would like to withdraw your authorization to share your health information sooner.

If you would like to withdraw your authorization, you may contact IncyteCARES for OPZELURA at 1-800-932-1720 or 6000 Park Lane, Pittsburgh, PA 15275. You understand that if you withdraw your authorization, no new information will be collected from you; however, information collected prior to your withdrawal of authorization may continue to be used or kept to provide services previously described. You understand you may receive a copy of this form.

Incyte also may use your health information for quality assurance purposes and to evaluate and improve its operations and services. You also understand that the information you provide may be combined with that of other registrants to create aggregated, anonymized data and to use and share only the anonymized data for any legitimate business purpose.

You can learn more about how Incyte processes your personal information at [www.incyte.com/privacy-policy](http://www.incyte.com/privacy-policy).

PATIENT SIGNATURE **X**

(If the patient is under 18 years of age a legal representative should sign and print name)

Date

Legal Representative Name (Print) \_\_\_\_\_

# PRESCRIPTION AND ENROLLMENT FORM FOR OPZELURA



TO SUBMIT, COMPLETE AND FAX THIS FORM TO **1-877-801-3840**.

Patient First Name \_\_\_\_\_ MI \_\_\_\_\_ Patient Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**PATIENT ASSISTANCE PROGRAM APPLICANTS ONLY** – For patients who are uninsured or underinsured with Medicare Part D coverage may be eligible to receive OPZELURA at no cost

### Financial Information

Current Annual Household Income \_\_\_\_\_ Number of People in Household \_\_\_\_\_

### Authorization for Electronic Income Verification

I, the applicant named above, understand that I am providing “written instructions” to IncyteCARES for OPZELURA under the Fair Credit Reporting Act authorizing IncyteCARES for OPZELURA or their designated agent to obtain information from my credit profile or other information from Experian® Income View<sup>SM</sup> to verify my annual income (learn more at: <https://www.experian.com/consumer-information/income-view>). I authorize IncyteCARES for OPZELURA to obtain such information solely for the purpose of determining financial qualifications for the IncyteCARES for OPZELURA Patient Assistance Program. I also agree to provide additional financial documentation in a timely manner to IncyteCARES for OPZELURA which is solely necessary for determining my financial qualification for the program, if so requested. I understand that I am entitled to a copy of this authorization upon request. This authorization shall be valid for one (1) year from the date of the signature of this form (unless a shorter period is prescribed by law). I understand that I may cancel this authorization at any time by mailing a letter requesting such cancellation to IncyteCARES for OPZELURA at 6000 Park Lane, Pittsburgh, PA 15275. I understand that if I cancel my authorization, no new information will be collected from me; however, information collected prior to such cancellation may continue to be used or kept to fulfill the services described.

**Providing your SSN allows IncyteCARES to confirm your income. You will not need to submit additional income or financial documentation.**

Social Security Number \_\_\_\_\_

**PATIENT SIGNATURE** X

\_\_\_\_\_  
(If the patient is under 18 years of age a legal representative should sign and print name)

\_\_\_\_\_  
Date

Legal Representative Name (Print) \_\_\_\_\_

Please note: If you do not provide an authorization signature, you are required to submit income verification via fax to 1-877-801-3840, or mail to IncyteCARES for OPZELURA at 6000 Park Lane, Pittsburgh, PA 15275.

### Financial Attestation and Disclosure

By signing below, I certify that I cannot afford my medication, and I affirm that my answers are complete, true, and accurate to the best of my knowledge.

**I understand that:** Completing this form does not guarantee that I will qualify for the Patient Assistance Program. IncyteCARES may verify the accuracy of the information I have provided and may ask for more financial and insurance information. OPZELURA supplied by the IncyteCARES for OPZELURA Patient Assistance Program shall not be sold, traded, bartered, or transferred. IncyteCARES for OPZELURA reserves the right to change its Patient Assistance Program or terminate my enrollment at any time. The support provided through this program is not contingent on any future purchase. If I am enrolled in a Medicare Part D Plan and am eligible for the Patient Assistance Program, IncyteCARES for OPZELURA will notify my Part D Plan of my enrollment in the program.

I certify and attest that if I receive OPZELURA provided through the IncyteCARES for OPZELURA Patient Assistance Program, I will promptly contact IncyteCARES for OPZELURA at 1-800-932-1720 if my financial status or insurance coverage changes. I will not seek to have OPZELURA or any cost from it counted in my Medicare Part D true out-of-pocket costs for prescription drugs. I will not seek reimbursement or credit for OPZELURA from my prescription insurance provider or payor, including Medicare Part D plans. I will notify my insurance provider of the receipt of OPZELURA through the IncyteCARES for OPZELURA Patient Assistance Program. For more information about Incyte and its privacy practices please go to [www.incyte.com/privacy-policy](http://www.incyte.com/privacy-policy).

**PATIENT SIGNATURE** X

\_\_\_\_\_  
(If the patient is under 18 years of age a legal representative should sign and print name)

\_\_\_\_\_  
Date

Legal Representative Name (Print) \_\_\_\_\_

### PATIENT OPT-IN FOR ONGOING EDUCATION AND SUPPORT (OPTIONAL)

By checking this box, I consent to Incyte and its agents to use my contact information (phone and email) to provide education and ongoing support services related to product, disease, and other related areas of interest. I understand that I may revoke my consent to be contacted for any of these purposes at any time by emailing [privacy@incyte.com](mailto:privacy@incyte.com).

By checking this box, I am indicating that I would also like to be contacted for future opportunities to participate in market research regarding my condition. I understand that I may revoke my consent to be contacted to participate in such market research at any time by emailing [privacy@incyte.com](mailto:privacy@incyte.com).

X \_\_\_\_\_  
Patient Signature (If the patient is under 18 years of age a legal representative should sign and print name)

\_\_\_\_\_  
Date

Legal Representative Name (Print) \_\_\_\_\_

