AVYXASSIST™

Visit us at www.avyxa.com

ENROLLMENT FORM

Call us at **866-939-8927**
Monday - Friday
8:00 AM - 8:00 PM (EST)

Fax the completed enrollment form to **833-852-3420**

Support requested (check all that apply)

*Required Field

◯ Insurance Verification • Benefit Investigation • Prior Authorization • Appeal Assistance	◯ Free Product Assistance (PAP) (uninsured/underinsured)	◯ Bridge Supply (coverage delays)

Select Medication**

◯ DOCIVYX™ (docetaxel) injection, 10 mg/mL
◯ CYCLOPHOSPHAMIDE injection, 500 mg/mL
◯ POSFREA™ (palonosetron) injection, 0.05 mg/mL

Patient Information

First Name* _____ Last Name* _____ Date of Birth* _____ Male ◯

Height* _____ Weight* _____ Phone #* _____ Female ◯

Address* _____ City* _____ State* _____ Zip* _____

Alt. Contact First Name _____ Alt. Contact Last Name _____

Alt. Contact Relationship _____ Alt. Contact Phone # _____

Prescriber/Facility Information

First Name* _____ Last Name* _____ State Where Licensed* _____

State License #* _____ Prescriber Type* _____ NPI #* _____

Tax ID #* _____ PTAN#* _____

Facility Name* _____

Facility Address* _____ City* _____ State* _____ Zip* _____

Primary Contact Name* _____ Title/Role _____

Primary Phone #* _____ Primary Fax #* _____

Primary Email _____

Facility Information/Billing Entity: ◯ Infusion Clinic/Physician Office ◯ Hospital Outpatient ◯ Hospital Inpatient

**By submitting this form, I am requesting support services on behalf of the patient. Certain eligibility criteria and restrictions apply.

Insurance Information

◯ Medicare ◯ Medicaid ◯ Commercial/Private ◯ No Insurance ◯ Other: _____

Please attach a copy of both sides of the patient's insurance card.

Primary Insurance* _____ Policy ID* _____ Group* _____ Phone# * _____

Subscriber First Name* _____ Subscriber Last Name* _____

Subscriber Date of Birth* _____ Patient Relationship to Subscriber* _____

Secondary Insurance _____ Policy ID _____ Group _____ Phone# _____

Subscriber First Name _____ Subscriber Last Name _____

Subscriber Date of Birth _____ Patient Relationship to Subscriber _____

Clinical Information

Primary diagnosis ICD-10 Code* _____ Diagnosis* _____ Treatment Start Date* _____

Administration Code* _____ Product NDC* _____ FDA Approved Indication* ◯ Yes ◯ No

Previous Therapies (if applicable) _____

_____

Concurrent Therapies (if applicable) _____

_____

Secondary diagnosis ICD-10 Code _____ Diagnosis _____ Secondary Treatment Start Date _____

Financial Assistance

This section should only be completed for financial assistance or enrollment into the Patient Assistance Program (PAP). Patient financial information is required for financial assistance.

Annual Gross Household Income _____ Number of Persons in Household* _____

PAP Prescription Information

Please complete the embedded prescription if you are seeking support from AVYXASSIST™ PAP ONLY for patients who are uninsured, underinsured, or experiencing coverage delays (for eligibility, call 1-866-939-8927). Alternatively, please attach a separate prescription if this section does not comply with your state's prescription law.

Medication: _____ Strength: _____ Route of Administration _____

Instructions: Administer as: _____

Dosing: ◯ mg/kg ◯ mg/m^2 Dose _____ Days: _____ Total Vials per Schedule _____ Refills _____

Please list or attach a current list of medications (if applicable) _____

Other Known Medical Conditions (if applicable) _____

Known Drug Allergies (if applicable) _____

I authorize AVYXA™ Pharma, LLC (AVYXA™) and the designated non-commercial pharmacy to dispense AVYXA™ product directly to the Facility Setting address as part of the Patient Assistance Program.

Prescriber Name (Print): _____ Signature (No Stamps) _____

Date _____

Preferred Shipping Location (if different from Facility Setting Address)

Name _____ Street Address _____

City _____ State _____ Zip _____

Prescriber Certification and Authorization

I certify that, to the full extent required by applicable law, I have obtained written permission from my patient named above (or from the patient's legal representative) to release to the patient support program, AVYXASSIST™ ("the Program"), the patient's personal health information, both as provided on this form and such other personal health information as the Program may need (1) to perform a preliminary verification of the patient's insurance coverage for AVYXA™ product, (2) to assess the patient's eligibility for participation in the Program, (3) to enroll the patient in the Program, (4) to provide reimbursement support and other services to the patient in connection with the patient's prescription(s) on this form, and (5) for the other purposes identified on the Patient Authorization for Use and Disclosure of Personal Health Information. I authorize and appoint the Program to convey on my behalf the prescription(s) I signed for the patient and the other information included on this form to the dispensing pharmacy. I agree that the Program may contact me, including without limitation via email, fax, and telephone, to seek additional information relating to the Program, AVYXA™ product, or the prescription(s) contained on this form. I understand that any AVYXA™ product provided at no charge to the patient is provided on a complimentary basis. I will not submit or cause to be submitted any claims for payment or reimbursement for such products to any third-party payor, including a federal health care program. If I am or become in possession of such product, I will not resell or attempt to resell the product. 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 AVYXASSIST™ if I become aware of any such changes; I understand that I am under no obligation to prescribe any AVYXA™ Pharma drug and I have not received and will not receive any benefit from AVYXA™ Pharma for prescribing a AVYXA™ Pharma drug; the information contained in this form is complete and accurate to the best of my knowledge; and I will notify AVYXASSIST™ of any errors regarding the foregoing, and will make every effort to correct those errors.

HCP Name (Print): _____ Signature _____

Date _____

Patient Consent

I authorize my healthcare providers (including pharmacy providers) and health plans to disclose my personal health information related to this prescription form or my use or potential use of AVYXA™ Product, including my personal contact information on this form (collectively, my "Information"), to the patient support program called AVYXASSIST™ (the "Program") so that the Program may use and disclose the Information in order to: (1) establish my benefit eligibility; (2) communicate with my healthcare providers and health plans about my benefit and coverage status and my medical care; (3) provide support services, including facilitating the provision of AVYXA™ Product to me, as well as any information or materials related to such services or AVYXA™ products, including promotional or educational communications; (4) evaluate the effectiveness of AVYXA™ Product support programs; (5) report safety information, including in communications with the US Food and Drug Administration and other government authorities; (6) contact me regarding this prescription form or my use or potential use of AVYXA™ Product and provide me with related patient support communications, including through messages left for me that disclose that I take or may take AVYXA™ Product; and (7) allow AVYXA™ to analyze the usage patterns and the effectiveness of AVYXA™ products, services, and programs and help develop new products, services, and programs, and for other AVYXA™ general business and administrative purposes. I understand that my provider(s) may receive remuneration in exchange for the provision of my Information as authorized above, and that once my Information has been disclosed to the Program, federal privacy law may no longer restrict its use or disclosure and that it may be redisclosed to others. I also understand, however, that the Program plans to use and disclose my Information only for the purposes described above or as required by law. I understand that if I refuse to sign this Authorization, that will not affect my right to treatment or payment benefits for health care. If I qualify for and receive free medication from the "Program", I agree to comply with the Program's rules; and I will not get reimbursed for the assistance I receive from anyone else, including from an insurance program, another charity, or from a health savings, flexible spending, or other health reimbursement account. I understand that the "Program" help is temporary, I must reapply every year, and I may not be eligible if I have prescription drug coverage that will pay for my medication. To the best of my knowledge, (1) My insurance plan did not require me to apply to the Program and/or change or hide my insurance coverage to make me appear to be underinsured and eligible for the "Program"; (2) The Alternate Contact listed on my application (if any) is not associated with or a representative of my insurance company or the insurance company's business partners. I agree to immediately contact the "Program" at 1-866-939-8927 if my insurance, treatment, or financial situation changes in any way. I understand that the AVYXASSIST™ programs may be discontinued or the rules for participation may change at any time, without notice.

Consent to credit check (for Free Product Assistance Only) I also understand that AVYXASSIST™ may request documentation from me, my employer, my healthcare provider, or my insurance company to verify my financial information. AVYXA™ may obtain information from my credit profile from Experian Income View for the purpose of verifying my income eligibility for AVYXASSIST™. I understand that I am providing "written instructions" to AVYXA™, under the Fair Credit Reporting Act ("FCRA"), authorizing AVYXA™ to obtain information from my credit profile or other information from Experian Income View solely for the purpose of determining financial qualifications for AVYXASSIST™ and on an ongoing basis as needed for the duration of my participation in AVYXASSIST™. I understand that I am entitled to a copy of this Authorization upon request.

I also understand that if I sign, I may later withdraw this Authorization by sending written notice of my withdrawal from the Program to AVYXASSIST™, 1 Upper Pond Rd, Building E, 4th Floor, Parsippany, NJ 07054, and that such withdrawal will not affect any uses and disclosures of my Information prior to the Program's receipt of the notice. I am entitled to a copy of this signed Authorization, which expires 10 years from the date it is signed by me or such timeframe as allowed by law. Please note documentation proving Power of Attorney may be required.

Patient Name (Print): _____ Patient Signature _____

Date _____

AUTHORIZED REPRESENTATIVE CONSENT (Optional)
I further authorize AVYXASSIST™ to discuss my treatment with the following authorized representative(s).

Authorized Representative Name (Print) _____

Relationship to Patient: ◯ Spouse ◯ Child ◯ Other: _____

Authorized Representative Name (Print) _____

Relationship to Patient: ◯ Spouse ◯ Child ◯ Other: _____