Helsinn Cares Patient Support Program
Patient Enrollment Form

Please complete all fields with black ink and fax form to 1-844-357-4669.
For help, please call 1-84-HELSINN-U (1-844-357-4668).

Patient Information

Name: (First) ________________________ (Last) ________________________

DOB: (mm/dd/yyyy) ____/____/____ Gender: ☐ Male ☐ Female

Address: ____

City: ________________________ State: ________ ZIP Code: __________

Home Phone: (_____)_____-________ Mobile Phone: (_____)_____-________

Email: ____

Preferred Language: ☐ English ☐ Spanish ☐ Other: ______________

Preferred Contact Method (If Available): ☐ Phone ☐ Email ☐ Text Message

If you are unavailable when we call, may we leave a message including the prescription name? ☐ Yes ☐ No

Comments: ____
____

Prescriber Information

Prescriber Name: (First) ____________________ (Last) ____________________

State License #: ____________________ NPI # : ____________________

Prescriber Phone: (_____)_____-________

Name of Facility: ____

Facility Street Address: ____

City: ______________________ State: _______ ZIP Code: ___________

Office Contact Name: (First) __________________ (Last) __________________

Title/Position: ____

Office Contact Phone: (_____)_____-________ Fax: (_____)_____-________

Preferred Contact Method (If Available): ☐ Phone ☐ Fax ☐ Email ☐ Text

Email: ____

Insurance Information

Please complete all that apply and include front and back copy of Insurance card for each type of Insurance

☐ Patient has no insurance ☐ Medicaid ☐ VA/DOD ☐ Medicare (Part A Part B Part D Medicare Advantage)

Primary medical insurance: __________________ Policy ID#: ___________

Insurance telephone number: __________________ Group #: ___________

Policy holder name (First, Last): ______________________________

Relationship to patient: ____________________ Date of birth: ___________

Secondary medical insurance: _________________ Policy ID#: ___________

Insurance telephone number: __________________ Group #: ___________

Policy holder name (First, Last): ______________________________

Relationship to patient: ____________________ Date of birth: ___________

Prescription / Pharmacy Drug Plan Name: ______________________________ Phone number: ____________________

Policy ID#: ____________________ Group #: ____________________ Rx BIN #: ____________________ Rx PCN #: ____________________

Financial Information

Is the patient a U.S. resident? Yes No

Annual household income: $_________ **Please Attach Documentation†**

How many people including the patient live in the household: ___________

Source of income: (Check all that apply) Job Family Public Assistance SSI/SSDI Other (please explain): ______________

Is the patient currently enrolled/enrolling in Medicaid? Yes No

† Financial documentation is required to assess program eligibility. Acceptable documentation includes 1040 Tax return, SSA-1099, W2, Social Security benefit statement, unemployment or disability statement, or one month of paycheck stubs. Patient may be asked to provide a copy of government issued identification (e.g. driver's license, military ID, passport, etc).

Procurement Method

☐ **AKYNZEO® (capsule)**
☐ Buy and Bill (Medicare Part B/DME)
☐ On-site Pharmacy Dispense ☐ Specialty Pharmacy

AKYNZEO® (for injection)
Buy and Bill (IV) Medicare Part B
☐ Commercial (Medical) ☐ Medicaid

Comments:
____
____

Patient Clinical Information

ICD-10-CM Code: ______________________________

Names of Prior Therapies: ______________________________ Current Chemotherapy Class: ______________________________

Prescription Information

☐ **AKYNZEO® (netupitant 300mg/palonosetron 0.5mg) capsule**

Dosing Instructions: ______________________________
____

Start Date: ____/____/____ Refills: _______ Number of Capsules: ________

AKYNZEO® (fosnetupitant 235mg/palonosetron 0.25mg) for injection

Chemotherapy Regimen: ______________________________
____

_ Start Date: ____/____/____ Number of Cycles: ______ Every ______ Days

PATIENT NAME [FIRST, MI, LAST]: DATE OF BIRTH:

Patient Authorization For Use/Disclosure of Health Information

I understand that I am submitting this application to TrialCard, or my doctor's office is submitting it on my behalf, to see if I qualify for financial assistance and other services to help me find possible sources of financial assistance, or to assess whether I have insurance coverage for Akynzeo® (netupitant/palonosetron) capsule. I understand that before you can assist me, you may need to collect, use, and disclose information about me that is requested on this application, including my Protected Health Information ("PHI" as defined by the Health Insurance Portability and Accountability Act of 1996 as amended ("HIPAA")), my financial information and other personal information about me (collectively "My Personal Information"). PHI that will be disclosed includes any information related to my healthcare insurance or plan benefits, including coverage limits and other information related to my health.

I understand that by signing this form, I am permitting my doctor's office, my healthcare plan or insurance company, my pharmacies, as well as other entities that may hold my PHI, to release My Personal Information, including my PHI, to TrialCard and to TrialCard's agents who may be assisting with the administration of the patient assistance programs. I understand that to provide the support for the patient assistance programs, TrialCard and the TrialCard Agents may need to further disclose My Personal Information to and communicate with other TrialCard Agents involved with patient assistance programs, my doctor's office or other health care providers, including my insurance company or health plan or pharmacies.

I further understand that TrialCard and the TrialCard Agents will use My Personal Information in the following manner: (1) to review my application for patient assistance programs; (2) to help determine my healthcare plan coverage for Akynzeo and other procedures as part of my therapy by conducting reimbursement verification and obtaining payment from my Health Plan(s); (3) to contact me or my doctor's office or other of my health care providers, as necessary, to conduct such services; and (4) providing me with educational support services by mail, text, messaging, email and/or telephone and (5) referring me to, or determining my eligibility for, other programs, foundations or alternative sources of funding or coverage to help me with the cost of Aknyzeo.

I understand that I do not have to sign this consent, but if I do not, Helsinn Cares cannot provide the described assistance. I understand that I might need to pay for Akynzeo on my own, whether I sign this form or not. I understand that once my doctors, healthcare plan, pharmacies, or others who have my Protected Health Information release it, my information may no longer be covered by Federal Privacy Law (for example, HIPAA).

This authorization allows those who rely on it to release my Protected Health Information for 10 years from the date I have signed it. I understand that I can withdraw it at any time by sending a written request to the mailing address below. My withdrawal goes into effect once it is received by the program. I also understand that by withdrawing, I may not receive or I may stop receiving the services provided under this program.

Patient's Signature: ____________________ Date of Signature: _____/_____/__________

Printed Name: ____________________

Parent/Guardian/Legal Representative's Signature: ____________________ Date of Signature: _____/_____/__________

Printed Name: ____________________ Relationship to Patient: ____________________

Patient Authorization To Disclose To Others

In order to protect your privacy we will not share your information with anyone you do not authorize. Please list names of anyone you would like to have access to your medical information. Only the names listed below will be given any information regarding your medical condition.

I hereby authorize TrialCard, its staff and providers to disclose my protected health information to the following representative:

Name: ____________________ Phone Number: (______)______-_________

Relationship to Patient: ____________________

Patient's Signature: ____________________ Date of Signature: _____/_____/__________

Prescriber Attestation

By signing below, I verify that the information provided in this Helsinn Cares Patient Support Program Form is complete and accurate to the best of my knowledge. I understand that Helsinn reserves the right at any time and for any reason, without notice, to modify this Helsinn Cares Patient Support Program Form or to modify or discontinue any assistance provided through Helsinn Cares Patient Support Program. Finally, I authorize Helsinn and TrialCard, Inc. to use and disclose health information as necessary to verify the accuracy of any information provided, to provide reimbursement assistance through Helsinn Cares Patient Support Program and (as applicable) to assess my patient's eligibility for copay assistance. My patient has provided a signed HIPAA Authorization that allows me to share protected health information with Helsinn and TrialCard, Inc. for purposes of the Helsinn Cares Patient Support Program.

Prescriber's Signature: ____________________ Date of Signature: _____/______/______

Mail us at
Patient Support
2250 Perimeter Park Drive
Suite 300
Morrisville, NC 27560

Call us at
1-84-HELSINN-U
Monday - Friday, 8 AM - 8 PM ET

Fax us at
1-844-357-4669