Seagen Secure®
Patient Assistance Program

Phone: 855-4SECURE (855-473-2873)
SeagenSecure.com

Healthcare Provider Request Form for ADCETRIS® (brentuximab vedotin) for Injection

Complete and fax to 855-557-2480 or email to CaseManager@seagensecure.com

This is 1 of 2 required forms to enroll a patient into Seagen Secure® to evaluate which services they may be eligible to receive. To start assisting this patient, Seagen Secure must also receive a completed and signed Patient Authorization Form. Seagen Secure does not guarantee that submission of these forms will result in patient assistance, coverage, or reimbursement.

Physician/Provider Information

PHYSICIAN NAME | NPI

NAME OF GROUP/HOSPITAL | NPI FOR GROUP/HOSPITAL | TAX ID # | EXPIRATION

CORRESPONDENCE ADDRESS | CITY | STATE | ZIP

OFFICE CONTACT NAME | PHONE | EXTENSION

CONTACT'S EMAIL ADDRESS | FAX

Patient Information

◯ Male ◯ Female

PATIENT NAME | SEX | HEIGHT | WEIGHT | DATE OF BIRTH (MM/DD/YYYY)

◯ Home ◯ Cell ( ) -

PREFERRED CONTACT NUMBER | EMAIL

ADDRESS | CITY | STATE | ZIP

PATIENT REPRESENTATIVE NAME | REPRESENTATIVE PHONE

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PATIENT FULL NAME

PATIENT DATE OF BIRTH (MM/DD/YYYY)

Health Insurance Information

You may also attach copies of insurance cards

PLEASE CHECK ONE: ◯ Commercial/Private Insurance ◯ Medicare/Medicaid/TRICARE ◯ No Insurance ◯ Other

	Primary Medical Insurance	Secondary Medical Insurance	Pharmacy Insurance
INSURANCE COMPANY NAME			
POLICY NUMBER			
GROUP NUMBER			
TELEPHONE NUMBER			
POLICYHOLDER'S NAME			
POLICYHOLDER'S DOB			
BIN/PCN NUMBER			

Patient Assistance Program enrollment begins on a temporary basis.

Clinical Information

DIAGNOSIS REQUIRED | ICD-10 REQUIRED | STAGE | TREATMENT START DATE (MM/DD/YYYY)

HAS THE PATIENT RECEIVED A TRANSPLANT?
◯ Y ◯ N

IF YES, WAS THE TRANSPLANT AUTOLOGOUS OR ALLOGENEIC?
◯ Autologous ◯ Allogeneic

IS ADCETRIS BEING USED AS CONSOLIDATION THERAPY?
◯ Y ◯ N

WHAT LINE OF THERAPY IS ADCETRIS?

WHICH PREVIOUS AGENT REGIMEN(S) HAS THE PATIENT RECEIVED?

DOSE FOR ADCETRIS PER ADMINISTRATION:

ADCETRIS TREATMENT FREQUENCY:
◯ Weekly ◯ Q2W ◯ Q3W Other: _____

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PATIENT FULL NAME

PATIENT DATE OF BIRTH (MM/DD/YYYY)

Prescriber Declaration

By signing below, you acknowledge and attest that: (1) you are the healthcare professional who prescribed the treatment identified in this form, (2) the information provided in this form is true and accurate to the best of your knowledge, (3) you have obtained from the patient, or when applicable their authorized legal representative, consent to provide the above information to Seagen Secure to determine the patient's eligibility to participate in Seagen Secure, (4) you have obtained written patient authorization(s) in the form and manner required by applicable state and federal law to release the Patient Information on this form, (5) any medication supplied by Seagen as a result of this enrollment form is only for the use of the patient named on this form and shall not be sold, traded, transferred, returned for credit, or submitted to any third-party payor for reimbursement, and (6) you have prescribed the above-referenced medication for this patient based on your independent clinical judgment that this treatment is medically necessary and in the best interests of the patient.

PRESCRIBER'S SIGNATURE

DATE SIGNED

The healthcare provider and patient remain fully responsible for all claims made to private insurers or government programs, including the accuracy of all information submitted. All claims for Seagen products should be made in accordance with legal and contractual requirements. Many factors influence reimbursement, and the policies and practices of private and public payers may change without notice. Seagen reserves the right to modify or discontinue the program, with or without notice, at any time.

Upon reasonable notice in writing, and not more than once per coverage year, Seagen Inc. shall have the right to audit and examine all documents, correspondence and records related to enrolled patients and product shipments. Upon request, a representative duly authorized by Seagen Inc. may contact you by phone or email with an audit request for all or some of your enrolled patients. Complete responses to an audit are required within 30 days of said request. Non-compliance may lead to the possibility of program discontinuation for all or some of your patients.

Seagen Inc. and Seagen Secure will utilize this patient information solely for the purposes of a benefits investigation and patient assistance assessment. The program will not sell, rent, or otherwise distribute any patient information outside of Seagen Inc. or its agents.

I have been made aware that the privacy statement of Seagen, available at www.seagen.com/privacy, describes its privacy practices, including how I may exercise certain rights with respect to my data.

Seagen®