Seagen Secure®
Patient Assistance Program

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

TUKYSA® (tucatinib) Tablets Healthcare Provider Request Form

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.

As it pertains specifically to Prior Authorization, please check all that apply:

☐ Please consider my patient for a *Quick Start Request*

(Quick Start is a short-term free product that may be available to eligible patients who face a delay [at least 5 days] in insurance determination of coverage for TUKYSA)

☐ My patient's insurance requires a Prior Authorization and I have not yet submitted the Prior Authorization request for my patient

☐ I do not know if my patient's insurance requires a Prior Authorization

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☐ Prior Authorization facilitated by:

○ Healthcare Provider ○ Biologics ○ Onco360

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	

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PATIENT FULL NAME

PATIENT DATE OF BIRTH (MM/DD/YYYY)

Patient Information

PATIENT NAME

SEX ◯ Male ◯ Female

DATE OF BIRTH (MM/DD/YYYY)

PREFERRED CONTACT NUMBER ◯ Home ◯ Cell ( ) -

EMAIL

ADDRESS

CITY

STATE

ZIP

PATIENT REPRESENTATIVE NAME

REPRESENTATIVE PHONE

CARE PARTNER NAME

PHONE

CARE PARTNER ADDRESS

CITY

STATE

ZIP

Health Insurance Information

You may also attach copies of insurance cards

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

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

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PATIENT FULL NAME

PATIENT DATE OF BIRTH (MM/DD/YYYY)

Clinical Information

PLEASE CHECK ONE: ◯ Breast ◯ Colorectal ◯ Other ____________

DIAGNOSIS: REQUIRED

ICD-10: REQUIRED

DOES PATIENT HAVE HER2+ DISEASE?
◯ Y ◯ N ◯ Unknown

DOES PATIENT HAVE RAS WILD-TYPE DISEASE (CRC ONLY)?
◯ Y ◯ N ◯ Unknown

DOES PATIENT HAVE BRAIN METASTASES?
◯ Y ◯ N ◯ Unknown

TARGET TREATMENT START DATE: ____________

PATIENT'S PREVIOUS THERAPIES:

PLEASE COMPLETE THE RELEVANT PRESCRIPTION INFORMATION SECTION BELOW. PRESCRIBERS MUST COMPLY WITH ALL STATE-SPECIFIC PRESCRIPTION REQUIREMENTS, INCLUDING THOSE GOVERNING E-PRESCRIBING.

Quick Start Prescription Information

DATE:	DRUG NAME:	STRENGTH:	DOSAGE FORM:
DIRECTIONS (eg, take 2 caps 2× per day with food):		DAYS' SUPPLY: *15 days*	REFILLS: *N/A*

Commercial/Patient Assistance Program (PAP) Prescription Information

DATE:	DRUG NAME:	STRENGTH:	DOSAGE FORM:
DIRECTIONS (eg, take 2 caps 2× per day with food):		DAYS' SUPPLY: *30 days*	REFILLS:

HEIGHT: ____________ WEIGHT: ____________

CURRENT OR PREFERRED PHARMACY: ◯ Biologics ◯ Onco360 ◯ Healthcare Provider ◯ No Preference

Selection will be honored if permitted by patient's insurance coverage.

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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 payer 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's 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.

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