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 start assisting this patient, a completed and signed Patient Authorization Form must also be submitted.

Please check if applicable:

☐ Patient is requesting an Oncology Nurse Advocate only. No additional assistance is requested.

Physician/Provider Information

PHYSICIAN NAME

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

CORRESPONDENCE ADDRESS | CITY | STATE | ZIP

OFFICE CONTACT NAME | PHONE | EXTENSION

CONTACT'S EMAIL ADDRESS | FAX

Patient Information

◯ Male ◯ Female

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

◯ Home ◯ Cell ( ) -

PREFERRED CONTACT NUMBER | EMAIL

ADDRESS | CITY | STATE | ZIP

DIAGNOSIS | ICD-10 | 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: _____

◯ Monotherapy ◯ Combination
IF IN COMBINATION, WITH WHAT DRUGS?

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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			

Complete only if patient is uninsured

PATIENT'S EMPLOYER: _____

DOES PATIENT'S EMPLOYER OFFER HEALTH INSURANCE? ◯ Y ◯ N ◯ N/A

DOES PATIENT'S SPOUSE HAVE AN EMPLOYER WHO OFFERS HEALTH INSURANCE? ◯ Y ◯ N ◯ N/A

HAS PATIENT ATTEMPTED TO ENROLL IN A HEALTH INSURANCE EXCHANGE (HIE) PLAN? ◯ Y ◯ N

HAS PATIENT ATTEMPTED TO APPLY FOR HIS/HER STATE MEDICAID? ◯ Y ◯ N

If patient has been denied Medicaid or has Emergency Medicaid, please send a copy of letter with enrollment.
Note: Medicaid and/or HIE application is required regardless of eligibility.
Patient Assistance Program enrollment begins on a temporary basis.

By providing the Patient Information (including Health Insurance Information) below, you represent that you have the patient's consent to provide his/her information for purposes of verifying benefits and/or patient assistance program consideration for the selected Seagen's product as indicated above, and that you have written patient authorization(s) as required by applicable state or federal law to release the Patient Information on this form.

MD OR HEALTHCARE PROVIDER CONTACT 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, 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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Patient Authorization Form for ADCETRIS® (brentuximab vedotin) for Injection

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

Seagen Secure® is a service provided, free of charge, from Seagen by its authorized agents. Seagen Secure is here to help you navigate access to Seagen's products. I authorize Seagen Secure to contact me, my physician(s), and insurance provider(s) for the purposes outlined here. Seagen Secure may:

(i) assist me with my enrollment into Seagen Secure and evaluate my eligibility for participation in the Commercial Out-of-Pocket Assistance Program(s) and if found eligible enroll me;

(ii) contact me by phone, mail, or email to request or provide additional information;

(iii) provide educational and other pertinent materials and information, related to Seagen Secure;

(iv) verify, investigate, and assist me with obtaining coverage for ADCETRIS from my health insurance plan;

(v) assess my eligibility for participation in the patient assistance program, if necessary;

(vi) refer me to other independent programs or alternative sources that may be available to aid me as allowed under the law, if necessary;

(vii) for Seagen's internal business purposes, including quality control and support enhancing survey.

I consent to Seagen Secure contacting me, my physician(s), and insurance provider(s) for the purposes described above.

In order to assist you as described above, Seagen Secure must have access to protected health information (PHI). This means information including, but not limited to, my name, address, contact number, medical condition, and health insurance may be disclosed. I authorize to have my doctors, pharmacies, and other healthcare providers, as well as my health insurance plan, to disclose to Seagen ("Company"),

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and its third-party suppliers, vendors, and other service providers supporting Seagen Secure (collectively, the "Service Providers") my protected health information to help me get access to my prescribed medication. I also authorize Seagen Secure to access my credit information for the purposes of verifying my income as part of the eligibility screening for the PAP. I understand that completing this form does not guarantee that I will qualify for and be enrolled into the Seagen PAP. I understand that I can refuse to sign this Authorization which will have no impact on my treatment, payment for treatment, or insurance coverage but Seagen Secure will be unable to assist me. This authorization will last for two years from the date on which I agree to this authorization (or such shorter period as applicable state law may require).

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. I understand that I may revoke this authorization at any time by providing written notice to Seagen Secure at 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067. Cancellation of this authorization will be valid when received by the administrators of Seagen Secure.

Patient Information

PATIENT NAME **DATE OF BIRTH (MM/DD/YYYY)**

ADDRESS **CITY** **STATE** **ZIP**

EMAIL ADDRESS **PHONE**

PREFERRED METHOD OF CONTACT: ◯ **PHONE** ◎ **EMAIL** ◎ **MAIL**

ALTERNATE CONTACT **RELATIONSHIP** **CONTACT'S PHONE**

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Financial Information

This section is only required for patients enrolling in the Seagen Secure Patient Assistance Program for free medicine. If all criteria are met, you may be eligible to receive your medication free of charge.

HOUSEHOLD SIZE FOR MOST RECENT TAX YEAR

ANNUAL HOUSEHOLD INCOME FOR MOST RECENT TAX YEAR*

By signing this form, as described herein, I agree to allow Seagen Secure to use my personal information. I understand that I am entitled to receive a copy of this authorization after I have provided my signature.

SIGNATURE (PATIENT OR LEGALLY AUTHORIZED PERSON)

DATE SIGNED

LEGALLY AUTHORIZED PERSON PRINTED NAME

RELATIONSHIP TO PATIENT

DATE SIGNED

Optional Oncology Nurse Advocate Program

____ Please initial here if you wish to be contacted by an Oncology Nurse Advocate.† The Oncology Nurse Advocate Program can connect you with an oncology nurse, who can help you navigate through care and other available resources. The Oncology Nurse Advocate is here to connect you to support beyond your medication, including psychosocial, personal, and support services if you need it. Your Oncology Nurse Advocate is here to talk Monday-Friday, 8 AM-8 PM ET.

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*Seagen Secure reserves the right to request documentation proving income.

†By opting-in to the Oncology Nurse Advocate Program, you are selecting to be contacted by a registered oncology nurse. Opting-out of this program will not impact Seagen Secure's ability to help you access treatment.