Seagen Secure®
Patient Assistance Program

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

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"),

Seagen Secure®
Patient Assistance Program

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 PO Box 5490, Louisville, KY 40255. 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**

Seagen Secure®
Patient Assistance Program

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*

Patient Consent

By signing this form, as described herein, I agree to allow Seagen Secure to use my personal information. I confirm that I have read (or been read) and understood all of the information contained in this form. I also understand that I am entitled to receive a copy of this authorization after I have provided my signature.

PATIENT SIGNATURE (PATIENT OR PERSONAL REPRESENTATIVE OF PATIENT)

IF PERSONAL REPRESENTATIVE, INDICATE RELATIONSHIP

DATE

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

Seagen®