Seagen Secure®
Patient Assistance Program

855-4-SECURE (855-473-2873)
Monday-Friday, 8 AM-8 PM ET

Instructions for ADCETRIS® (brentuximab vedotin) for Injection Healthcare Provider Request and Patient Authorization Forms

Healthcare Provider Request Form

Please use the information below to guide you to fill out the Healthcare Provider Request Form for ADCETRIS.

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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 _____

If you have questions on the Healthcare Provider Request Form, please call 855-4SECURE for support.

Complete all sections in full to the best of your ability. Missing information may delay the initiation of support and require additional outreach to you in an attempt to obtain it.

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Healthcare Provider Request Form (cont'd)

Please use the information below to guide you to fill out the Healthcare Provider Request Form for ADCETRIS.

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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.

The information here can be replaced by legible copies of insurance cards or a patient face sheet that documents medical benefit information.

Clinical Information

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

Diagnosis and ICD-10 fields are required fields to determine if the patient is eligible to receive Seagen Secure support.

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: _____

Please complete medication lists or clinical history information here.

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Healthcare Provider Request Form (cont'd)

Please use the information below to guide you to fill out the Healthcare Provider Request Form for ADCETRIS.

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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

Prescriber must sign here.

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.

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Patient Authorization Form

Please use the information below to guide you to fill out the Patient Authorization Form for ADCETRIS.

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

If you have questions on the Patient Authorization Form, please call 855-4SECURE for support.

Patient Authorization Form for ADCETRIS® (brentuximab vedotin) for Injection

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

This form must be submitted to enroll a patient into Seagen Secure. It can be submitted via fax, phone, or email.

It is recommended that the Healthcare Provider Request Form and Patient Authorization Form are submitted at the same time.

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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Patient Authorization Form (cont'd)

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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 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** _____

Please have the patient complete the demographics information and indicate preferred form of contact. Option to designate a care partner.

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Patient Authorization Form (cont'd)

Please use the information below to guide you to fill out the Patient Authorization Form for ADCETRIS.

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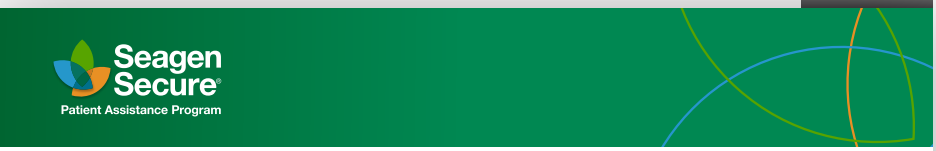

Financial Information

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*

Completion of this section is required for a Patient Assistance Program (PAP) evaluation.

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

Must be signed by patient or legal representative.

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

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