

# Instructions for Tivdak™ (tisotumab vedotin-tftv) 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 Tivdak.

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

### Healthcare Provider Request Form for Tivdak™ (tisotumab vedotin-tftv) for Injection

Complete and fax to 855-557-2480 or email to [CaseManager@seagensecure.com](mailto:CaseManager@seagensecure.com)

This is 1 of 2 required forms to enroll a patient into Seagen Secure®. All fields on this form are required to complete enrollment in Seagen Secure. To start assisting this patient, a completed and signed Patient Authorization Form must also be submitted.

#### 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

PATIENT NAME	WEIGHT	DATE OF BIRTH (MM/DD/YYYY)	
<input type="radio"/> Home <input type="radio"/> Cell ( ) -			
PREFERRED CONTACT NUMBER	EMAIL		
ADDRESS	CITY	STATE	ZIP
DIAGNOSIS	ICD-10	STAGE	TREATMENT START DATE (MM/DD/YYYY)

WHAT LINE OF THERAPY IS Tivdak?	DID PATIENT EXPERIENCE DISEASE PROGRESSION ON OR AFTER CHEMOTHERAPY? <input type="radio"/> Y <input type="radio"/> N	DOSE FOR Tivdak PER ADMINISTRATION:
Tivdak TREATMENT FREQUENCY: <input type="radio"/> Q3W <input type="radio"/> Other: _____	IS THE PATIENT RECEIVING ANYTHING IN RELATION TO THE EYE CARE PLAN? <input type="checkbox"/> Preservative-free steroid eye drops <input type="checkbox"/> Preservative-free ocular vasoconstrictor drops <input type="checkbox"/> Cold packs <input type="checkbox"/> Preservative-free lubricating eye drops	

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.

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

Please complete medication lists or clinical history information here.

## Healthcare Provider Request Form (cont'd)

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

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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			

*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](http://www.seagen.com/privacy), describes its privacy practices, including how I may exercise certain rights with respect to my data.

The information here can be replaced by legible copies of insurance cards or a patient face sheet that documents medical benefit information only. Please do not send chart notes.

Authorized member of the practice must sign here.

## Patient Authorization Form

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

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SeagenSecure.com

### Patient Authorization Form for Tivdak™ (tisotumab vedotin-tftv) for Injection

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Seagen Secure<sup>®</sup> 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 Tivdak 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"),

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

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.

## Patient Authorization Form (cont'd)

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

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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 one year 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](http://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: <input type="radio"/> PHONE <input type="radio"/> EMAIL <input type="radio"/> 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.

## Patient Authorization Form (cont'd)

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

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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

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

Must be signed by patient or legal representative.

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



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