

Healthcare Provider Request Form for Tivdak[®] (tisotumab vedotin-tftv) 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[®]. 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. Seagen Secure does not guarantee that submission of these forms will result in patient assistance, coverage, or reimbursement.

Physician/Provider Information

PHYSICIAN NAME		PHYSICIAN NPI	
NAME OF GROUP/HOSPITAL	GROUP/HOSPITAL NPI	TAX ID #	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?

DOSE FOR TIVDAK PER ADMINISTRATION:

Y N

TIVDAK TREATMENT FREQUENCY:

Q3W
 Other: _____

IS THE PATIENT RECEIVING ANYTHING IN RELATION TO THE PREMEDICATION AND REQUIRED EYE CARE?

- Topical corticosteroid eye drops
- Topical ocular vasoconstrictor drops
- Cold packs
- Topical lubricating eye drops

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.

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 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.