Seagen Secure®
Patient Assistance Program

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

TUKYSA® (tucatinib) Tablets Healthcare Provider Request Form

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 for which services they may be eligible to receive. To start assisting this patient, a completed and signed Patient Authorization Form must also be submitted.

As it pertains specifically to Prior Authorization, please check all that apply:

- ☐ Please consider my patient for a *Quick Start Request*
  (Quick Start is a short-term free product that may be available to patients who face a delay [at least 5 days] in insurance determination of coverage for TUKYSA)
- ☐ I have not yet submitted the Prior Authorization request for my patient
- ☐ I do not know if my patient's insurance requires a Prior Authorization
- ☐ Prior Authorization facilitated by:
  - ◯ Healthcare Provider
  - ◯ Biologics ◯ Onco360

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

CARE PARTNER NAME/CONTACT INFO

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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

	Pharmacy Insurance	Medical 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

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

DOES PATIENT'S EMPLOYER OFFER HEALTH INSURANCE?
◯ Y ◯ N ◯ N/A
IF YES, NAME OF EMPLOYER:

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.

Clinical Information

DIAGNOSIS: REQUIRED

ICD-10: REQUIRED

DOES PATIENT HAVE HER2+ MUTATION?
◯ Y ◯ N ◯ Unknown

DOES PATIENT HAVE BRAIN METASTASES?
◯ Y ◯ N ◯ Unknown

TARGET TREATMENT START DATE: _____

PATIENT'S CONCOMITANT MEDICATION LIST:

PATIENT'S PREVIOUS THERAPIES:

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PATIENT FULL NAME

PATIENT DATE OF BIRTH (MM/DD/YYYY)

Quick Start Request

DATE:	DRUG NAME:	STRENGTH:	DOSAGE FORM:
DIRECTIONS (eg, take 2 caps 2× per day with food):		DAYS' SUPPLY: *15 days*	REFILLS: *N/A*

(Insert prescription here) If using a Specialty Pharmacy, complete the prescription below.

Commercial/PAP Prescription Information

DATE:	DRUG NAME:	STRENGTH:	DOSAGE FORM:
DIRECTIONS (eg, take 2 caps 2× per day with food):		DAYS' SUPPLY: *30 days*	REFILLS:

HEIGHT: _____ **WEIGHT:** _____

CURRENT OR PREFERRED SPECIALTY PHARMACY: ◯ **Biologics** ◯ **Onco360** ◯ **Healthcare Provider** ◯ **No Preference**

Selection will be honored if permitted by patient's insurance coverage.

Healthcare Provider Declaration

Seagen Secure® offers a comprehensive reimbursement and access program for patients. By providing the Patient Information (including Health Insurance Information), you represent that you have the patient's consent to provide his/her information for purposes of verifying benefits and/or PAP consideration for the Seagen's product as indicated in the title of this form 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's 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 TUKYSA® (tucatinib) Tablets

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

Seagen Secure® is a service provided to you, free of charge, from Seagen by its authorized agents. Seagen Secure is here to help you navigate through access to Seagen's products. Seagen Secure may:

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

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

(iii) provide me with educational and other materials, information, and support related to Seagen Secure;

(iv) verify, investigate, and assist me with obtaining coverage for the Seagen product my physician indicated on the enrollment form 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 provide assistance to 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 in the manner described above, Seagen Secure must have access to protected health information, or "PHI." This means information including, but not limited to, my name, address, contact number, medical condition, and health insurance provider may be disclosed. I authorize my doctors, pharmacies, and other healthcare providers, as well as my health insurance plan, to disclose to Seagen

("Company"), 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 Patient Assistance Program (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 not be able to assist me in accessing my medication. 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*

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**

Oncology Nurse Advocate Program Optional Opt-in

☐ Please check box 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.