myBeiGene™

Patient Enrollment Form

Complete the following form to enroll in myBeiGene today.

Oncology Nurse Advocates are available Monday through Friday from 8 AM to 8 PM Eastern Time (ET) at **1-833-BeiGene (1-833-234-4363)** to provide information and answer any questions you might have regarding the myBeiGene patient support program.

myBeiGene
PO Box 5490
Louisville, KY 40255

Please fax completed forms to
myBeiGene at 1-877-828-5593

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myBeiGene™ | Brukinsa™ 80 mg zanubrutinib capsules

What is myBeiGene?

The myBeiGene program is a comprehensive patient support program designed to provide appropriate information and assistance to patients, including:

Reimbursement/ payment support

- Assists with insurance verification and prior authorization support
- Co-pay as little as $0/prescription for commercial patients*
- Bridge supply for insurance coverage delays†
- Free product for uninsured and underinsured patients‡

Education and support

- Helps provide information about their disease and treatment with BRUKINSA™ (zanubrutinib)
- Patient and caregiver follow-up support
- Dedicated Oncology Nurse Advocates for practices, patients, and caregivers

Connections to third-party advocacy organizations

- Assists patients and caregivers with practical help through advocacy groups and local/national free resources such as:
  - Counseling services
  - Support group information
  - Transportation/lodging assistance

*No patient income requirement. Annual benefit limit of $25,000. Patients are ineligible if prescriptions are payable by any state or other federally funded programs, including, but not limited to, Medicare, Medicaid, VA, or TRICARE, or where prohibited by law. Eligibility criteria and restrictions apply.

†15-day supply of medication (for on-label use only) in case of a coverage delay lasting longer than 5 days. Eligibility criteria and restrictions apply.

‡Certain financial and eligibility criteria apply.

What is required to receive support through myBeiGene?

Please complete this enrollment form for the type(s) of support requested. Failure to include all information will delay the process. (If you have questions about filling out this form, contact a myBeiGene Oncology Nurse Advocate.) Please see required information below for each requested type of support. These requirements apply only to support through myBeiGene and are not intended to limit any treatment, payment, or benefit activities with your pharmacy or other healthcare providers.

Insurance verification

- Complete sections 1 2 3 4 5 7
- Fax a copy of the front and back of the patient's insurance card with the enrollment form
- Physician and patient signatures are required

Bridge supply*

- Complete sections 1 2 3 4 5 7
- Physician and patient signatures are required

Free product assistance*

- Complete sections 1 2 3 4 5 6 7
- Physician and patient signatures are required

Co-pay/co-insurance assistance*
(for commercially insured patients)

- Complete sections 1 2 3 4 5 7
- Physician and patient signatures are required

Patient and caregiver support

- Complete sections 1 2 3 4 5 7
- Physician and patient signatures are required

*Certain eligibility criteria and restrictions apply.

What to expect after submitting the enrollment form?

Upon submission of the enrollment form to myBeiGene, an Oncology Nurse Advocate will confirm receipt to initiate the support you requested.

FAX THE COMPLETED FORM TO 1-877-828-5593

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SUPPORT REQUESTED (check all that apply and note required sections)

- ☐ Insurance verification
- ☐ Bridge supply
- ☐ Free product assistance
- ☐ Co-pay/co-insurance assistance
- ☐ Patient and caregiver support

SECTION 1 PATIENT INFORMATION

Patient Name (First, M.I., Last)	**Date of Birth** (MM/DD/YYYY)	**Primary Language**
Street Address	**Gender** ☐ Male ☐ Female ☐ Other	
City / State / ZIP	**Email**	
Primary Phone (please include area code) ☐ Home ☐ Mobile ☐ Work	**Best Time to Call** ☐ AM ☐ PM	
Secondary Phone (please include area code) ☐ Home ☐ Mobile ☐ Work	**Best Time to Call** ☐ AM ☐ PM	
Alternate Contact/Caregiver Name	**Alternate Contact/Caregiver Phone** (please include area code)	
Allergies		
Has Treatment With BRUKINSA™ (zanubrutinib) Been Started? ☐ Yes Date: _____ ☐ No		

MANDATORY FIELDS

Diagnosis Code (ICD-10 Code)

Prior Therapy

Please verify patient has received at least 1 prior therapy for mantle cell lymphoma:

☐ Yes ☐ No

If yes, please specify: _____

SECTION 2 PRESCRIBER INFORMATION

Physician Name (First, M.I., Last)		
NPI #		
Specialty ☐ Hematologist ☐ Oncologist ☐ Other: _____		
Site/Facility Name		
Street Address		
City / State / ZIP		
Office Contact	**Phone** (please include area code)	**Best Time to Call** ☐ AM ☐ PM
Fax	**Office Contact Email**	

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PATIENT NAME (First, M.I., Last) _____ **DATE OF BIRTH** (MM/DD/YYYY) _____

SECTION 3 INSURANCE INFORMATION Please provide copy of front and back of insurance card

Primary Insurer	**Phone** (please include area code)
Policy ID #	**Group #**
Subscriber Name (First, M.I., Last)	**Date of Birth** (MM/DD/YYYY)
Relationship to Subscriber	
Secondary Insurer	**Phone** (please include area code)
Policy ID #	**Group #**
Subscriber Name (First, M.I., Last)	
Relationship to Subscriber	
Prescription Card Name	**Prescription Card Phone** (please include area code)
Primary Cardholder Name (First, M.I., Last)	**Primary Cardholder Date of Birth** (MM/DD/YYYY)
Relationship to Patient (write "self" if you are the cardholder)	

Member ID	**RxBIN #**	**RxPCN #**	**RxGRP #**

SECTION 4 PHARMACY*

☐ Specialty Pharmacy ☐ Onsite Dispensing Pharmacy

Pharmacy Name	**Pharmacy NPI #**
Phone (please include area code)	**Contact**

*Unless the patient requests otherwise or the patient's insurance provider requires the patient to use a specific pharmacy, the prescription will be directed to the authorized pharmacy providing the lowest cost sharing for the patient under the patient's insurance plan.

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PATIENT NAME (First, M.I., Last) _____ **DATE OF BIRTH** (MM/DD/YYYY) _____

SECTION 5	PRESCRIPTION

☐ BRUKINSA™ (zanubrutinib) / **80 mg (120 capsules)**

Refill

Directions

☐ Bridge Rx

BRUKINSA™ (zanubrutinib) / **80 mg (60 capsules)** / Dispense: 15-day Supply

Refill

Directions

Prescriber Certification and Authorization: By signing below, I certify that: (1) the above therapy is medically necessary for this patient and that I, as the prescriber, have made the decision to prescribe BRUKINSA™ (the "Product"); (2) I have reviewed the current Product prescribing information before prescribing; and (3) to the full extent required by applicable law, I have obtained written permission from the patient named above (or from the patient's legal representative) to release the patient's personal health information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder, as well as other state and/or federally protected personal information) both as provided on this form and such other PHI that BeiGene, myBeiGene, the contracted dispensing pharmacy, or other contractors may require (a) to perform a preliminary verification of the patient's insurance coverage for the Product and (b) to assess the patient's eligibility for participation in the myBeiGene program. I authorize and appoint myBeiGene to convey on my behalf the prescription(s) I signed for the patient and the other information included on this form to the dispensing pharmacy chosen by or for the patient. I agree that myBeiGene may contact me, including, without limitation, via email, fax, and telephone to seek additional information relating to myBeiGene, the Product, or the prescription(s) contained on this form.

I understand that any Product provided at no charge to the patient is provided on a complimentary basis. I will not submit or cause to be submitted any claims for payment or reimbursement for such Product to any third-party payor, including, without limitation, a federal health care program. If I am or become in possession of such Product, I will not resell or attempt to resell the Product. I agree to comply with the myBeiGene guidelines and understand that BeiGene, at its sole and absolute discretion, reserves the right to modify or discontinue patient support programs, including such programs provided through myBeiGene, at any time. I certify that the information contained in this form is complete and accurate to the best of my knowledge.

Prescriber Signature*

Sign and Date Here

_____ **Date** _____

(Original signature required)

*Prescriber shall comply with applicable state prescribing requirements, such as e-prescribing, state-specific prescription form(s), fax language, etc. Non-compliance with applicable state prescribing requirements could result in additional communications from myBeiGene or other contractors to the prescriber.

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PATIENT NAME (First, M.I., Last) _____ **DATE OF BIRTH** (MM/DD/YYYY) _____

SECTION 6 FREE PRODUCT ASSISTANCE*

Patient Financial Information

Current Annual Household Adjusted Gross Income	**US Resident**
$	☐ Yes ☐ No
Household Size (including you)	

*Eligibility criteria apply.

Patient Certification: I certify that, as of the date of my signature, the information provided on this form is complete and accurate to the best of my knowledge and that all of the insurance plans and programs through which I obtain health care coverage are listed above or have been provided separately to myBeiGene. I further certify that I am not insured for (or am rendered uninsured through the payer denial of) BRUKINSA™ (the "Product") and that I am a legal resident of the United States. In order to qualify for the free product program ("Program"), I understand that certain eligibility criteria will apply. I will be ineligible to participate in the Program unless I provide proof of income within 30 days after this form is submitted. I also understand that: (1) myBeiGene may request documentation from me, my employer, my health care provider, or my insurance company to verify my financial or insurance information; (2) completion of this form and the provision of requested documentation does not guarantee that I will be approved to participate in the Program; (3) any free Product provided to me through the Program is contingent upon my meeting myBeiGene's eligibility criteria; (4) if I am eligible to participate in the Program, there is no purchase requirement associated with such assistance; and (5) myBeiGene reserves the right to make an independent determination of my financial need. BeiGene reserves the right at any time, and without notice, to modify or discontinue myBeiGene and any assistance provided to me. I will not submit or cause to be submitted any claims for payment or reimbursement from any third-party payer, including any federal health care program such as Medicare or Medicaid, or any private or other insurance plan, or from any other person or entity for a free supply of the Product supplied under this Program, regardless of whether a payer subsequently determines that it will cover such supply of BRUKINSA™. I will not sell, trade, or distribute or otherwise transfer the Product supplied under the Program. The cost of the Product provided under the Program will not count toward any Medicare true out-of-pocket ("TrOOP") costs. I agree to notify myBeiGene if: (1) I obtain coverage through another source (federal, state, or private program), (2) I no longer meet the income criteria for the Program, or (3) I find any errors in this application form. If I am approved, as required by my insurance or other benefit provider, I will notify such provider of my receipt of any free Product received through the Program. I understand that I must re-apply for the Program annually and there is no guarantee I will qualify at this time or in future periods.

Signature of Patient or Legal Representative†

Sign and Date Here

_____ **Date** _____

Name of Patient or Legal Representative _____

(If signed by representative, explain authority to act on behalf of patient and relationship)

†By signing on behalf of the patient, as representative or guardian, I attest that I am legally able to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such representative's or guardian's authority to act for the patient, such as power of attorney or legal court order, may be requested.

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PATIENT NAME (First, M.I., Last) _____ **DATE OF BIRTH** (MM/DD/YYYY) _____

SECTION 7 PATIENT AUTHORIZATION For release of information to myBeiGene

I authorize my health care providers (including pharmacy providers) and health plans to release or disclose, in electronic or other form, my personal health information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder, as well as other state and/or federally protected personal information), including my personal contact and other information on this form, all medical records and financial information, with respect to my treatment, my eligibility for assistance, the coordination of my treatment, and receipt of my medication (collectively, my "Information") to myBeiGene, including any third parties engaged to assist BeiGene in administering myBeiGene, for the purposes of: (1) establishing my benefit eligibility for BRUKINSA™ (the "Product"); (2) communicating with my health care providers and health plans about my eligibility for support through myBeiGene, my benefit and coverage status, and/or my medical care; (3) providing support through myBeiGene, including facilitating the provision of the Product to me, as well as any information or materials related to such support or BeiGene products, including promotional or educational communications; (4) evaluating the effectiveness of myBeiGene; (5) reporting safety information, including communications with the U.S. Food and Drug Administration and other government authorities; (6) contacting me regarding this enrollment form or my use or potential use of the Product and providing me with related patient support communications, including through messages left for me that disclose that I take or may take the Product; and (7) administering, evaluating, and improving myBeiGene, including by analyzing the usage patterns and the effectiveness of BeiGene products, services, and programs and helping to develop new products, services, and programs, and for other BeiGene general business and administrative purposes.

I understand that my pharmacy provider(s) may receive remuneration for the use or disclosure of my Information, as authorized above, and that, once my Information has been disclosed to myBeiGene, my Information may not be subject to all of the protections and safeguards provided by HIPAA or other federal and state privacy laws. I also understand, however, that myBeiGene plans to use and disclose my Information only for the purposes described above or as required by law.

I understand that I may refuse to sign this Authorization and that my refusal to sign this Authorization will not affect my right to treatment or payment of benefits for health care. I understand that if I refuse to sign, I will not be eligible to receive assistance through BeiGene. I may later withdraw this Authorization by sending written notice of my withdrawal from myBeiGene to PO Box 5490, Louisville, KY 40255. Withdrawal of this Authorization will end further uses and disclosures of my Information by BeiGene, except to the extent those uses and disclosures have been made in reliance on this Authorization and as permitted by applicable law. I am entitled to receive a copy of this signed Authorization, which expires 5 years after the date it is signed by me unless otherwise specified by law or revoked earlier in writing.

Signature of Patient or Legal Representative*

Sign and Date Here

_____ **Date** _____

Name of Patient or Legal Representative _____

(If signed by representative, explain authority to act on behalf of patient and relationship)

*By signing on behalf of the patient, as representative or guardian, I attest that I am legally able to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient may be requested such as power of attorney or legal court order.

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