Danziten™ (nilotinib) tablets 71mg, 95mg

PATIENT ASSISTANCE PROGRAM

Danziten CONNECT℠

For assistance, please complete this form and fax it to **1-832-601-6158**. You can also call **1-877-765-1130**, Mon-Fri 8am–8pm ET, to speak with a Danziten CONNECT℠ Team Member. Please visit the website at www.danziten.com for more information

PATIENT ASSISTANCE PROGRAM FORM

*Indicates required field

Please attach insurance card image.

PATIENT INFORMATION

*Patient Name (Last, First):

*Check if First Time Applicant ☐ *Check if Reapplying Applicant ☐

*Date of Birth: *Gender: M ☐ F ☐

*Address:

*City: *State: *Zip:

Legal Guardian Name, if applicable (Last, First):

Email:

Phone: Secondary Number:

PHARMACY INSURANCE INFORMATION (IF APPLICABLE)

Insurance Name:	Pharmacy Help Desk #:
Policyholder Name:	Relationship to Policy Holder:
Member ID #:	Group ID #:
Rx BIN #:	PCN #:

MEDICAL INSURANCE INFORMATION (IF APPLICABLE)

Primary Insurance:	Phone:
Member ID:	Group ID:
Secondary Insurance:	Phone:
Member ID:	Group ID:

PRESCRIBER INFORMATION

*Prescriber Name (Last, First):

*NPI:

*Prescriber Phone: *Fax:

*Address:

*City: *State: *Zip:

PRESCRIPTION

*Drug: **Danziten™ (nilotinib)** **71 mg** ☐ **95 mg** ☐ *Date:

*Quantity: *Refills:

*Directions:

*Prescriber Signature:

INDICATION INFORMATION:

☐ Adult patients with newly diagnosed Philadelphia chromosome positive chronic myeloidleukemia (Ph+ CML) in chronic phase

☐ Adult patients with chronic phase (CP) and accelerated phase (AP) Ph+CML resistant to or intolerant to prior therapy that included imatinib.

Primary Diagnosis Code†

☐ C92.10 Chronic myeloid leukemia, BCR::ABL-positive, not having achieved remission
☐ C92.11 Chronic myeloid leukemia, BCR::ABL-positive, in remission
☐ C92.12 Chronic myeloid leukemia, BCR::ABL-positive, in relapse
☐ Other:

PRESCRIBER OFFICE CONTACT INFORMATION

*Office Contact Name (Last, First):

*Phone:

Do you have the patient's HIPAA consent on file authorizing the release of the patient's identification and insurance information to Azurity Pharmaceuticals, Inc. and their agents and representatives for patient assistance services?

☐ YES ☐ NO (Confirmation of written patient HIPAA consent is required for patient assistance services)

By signing this form I hereby confirm that I have properly obtained the required consent and authorization (if needed) that are required under Federal HIPAA and other State and Federal privacy laws, to release and share certain protected health information to the Danziten Connect PAP Program managed by its contracted third party ("the PAP"). I further certify that the information provided is complete and accurate to the best of my knowledge.

I verify that I am a practicing healthcare provider, authorized to request, prescribe and receive prescription medications at the address identified herein. I will notify the PAP if any changes occur to my status in this regard. I further verify that I understand the PAP program may make product available to eligible patients (as determined by the PAP). I may not dispense or use product provided by the PAP for any other purpose.

I further verify that I shall not bill, sell, seek reimbursement from the government or any third party or file any claim for the drug product provided under the PAP. I also acknowledge that my patient's approval and participation in the PAP was not in exchange for any promise or reward or other explicit or implicit agreement with Azurity for or relating to past or future use, ordering, prescribing, recommending or referring of any Azurity products.

***Prescriber's Signature** ***Date of Signature**

Please see Important Safety Information available at www.Danziten.com and the accompanying full Prescribing Information including Boxed Warning.

CONTINUE ➡

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PATIENT ASSISTANCE PROGRAM FORM

PATIENT ASSISTANCE PROGRAM

Total number of people in household: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other: Annual Household income $:

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

This "Authorization" is hereby provided for the purpose of providing permission for the use and disclosure of my protected health information, including but not limited to my name, medication be treated for, application into the Danziten Connect PAP Program, insurance and financial information and other relevant information. I hereby request and authorize my healthcare providers and insurers to disclose any healthcare, treatment, insurance and other information that pertains to my medication to Azurity Pharmaceuticals, Inc. and its third party vendors ("Azurity") for the purpose of (a) processing my application for access to the Danziten Connect Patient Assistance Program ("PAP"); determining my eligibility in the PAP; (c) determining my ongoing eligibility status and future transfers, withdrawals or cancellations, including case reviews, audits, assessments and other verification procedures. Upon receipt of my healthcare information, I hereby authorize Azurity to disclose such information to my healthcare providers and insurers as necessary to determine my eligibility in the PAP and if approved, to notify of enrollment in the PAP. I understand that my future treatment, prescriptions and medical care from healthcare providers and insurers are NOT contingent upon signing this Authorization and that I am not required to sign this Authorization. However, I understand that if I do not sign this Authorization, I will not be eligible for the PAP. I further understand that I may cancel this Authorization by faxing a letter to 832-601-6158. Upon providing such notification, Azurity may not further disclose my health information and I will not be eligible for the PAP as of the notification date.
This Authorization shall be valid for 10 years from the date set forth below, unless required to be shorter by State Law. Upon signing this Authorization my health information will no longer be protected under HIPAA and is subject to re-disclosure.

PATIENT ATTESTATION FOR GOVERNMENT PRESCRIPTION DRUG PLAN

If I am eligible for a Government Prescription Drug Plan, but that plan does not cover the Azurity drug products, I may be eligible for the PAP if:

- I agree I will file no claim with any Government Insurer for the drug product provided to me under the PAP (e.g. Medicare, Medicaid, Puerto Rico's Government Health Plan Mi Salud, or any Government Insurer).
  - I obtain confirmation from my plan that it will not cover the Azurity drug product.
  - If eligible, I have applied for Puerto Rico's Government Health Plan Mi Salud and have been denied.
  - I agree to send notification to my plan provider that I have received free product under the Danziten Connect PAP in order to ensure that no payment for the product is made under the Government Plan.
- I further verify that if my insurance or financial information changes in any material respect (e.g. change in employment, insurance/medical expenses or total household number), I will immediately notify Azurity.

CERTIFICATION FOR PATIENT ASSISTANCE

Print Patient Name

Print Name Of Legal Guardian

Signature Date

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PATIENT ASSISTANCE PROGRAM

TERMS AND CONDITIONS

- Patient and Legal Guardian must be a United States (U.S) citizen or resident and must physically reside in the U.S or U.S territory
- Patient has been prescribed a valid prescription for Danziten.
- Prescriber must complete and submit a PAP enrollment form for every patient.
- Patients whose health insurance plan or employer requires them to go through a third-party Alternative Funding Program (AFP) and apply to the PAP as a condition of, requirement for, or prerequisite to coverage of Danziten will not be eligible for assistance from this program.
- Income criteria that demonstrate qualifying financial needs and proof of income documentation.
- Medical Expenses: Acceptable medical expenses submitted to the program should contain the amount and date of the transaction.

Azurity reserves the right to cancel or modify the program at any time.

DOCUMENTATION REQUIREMENTS

- Please complete all the sections of this form
- Please submit a copy of health insurance provider denial of coverage, if applicable
- Please have the Legal Guardian sign this form for the Danziten Connect Patient Assistance Program
- Proof of income is required: Submit an acceptable form of income documentation (If not required to file a US income tax return, IRS Form 4506-T may be required)
  - Copy of W-2 (from all employers) or most recently filed US Income Tax (IRS Form 1040, 1040A, 1040EZ, 1040NR, or 1040PR)

    or
  - Copy of most recent pay stub plus most recent US Income Tax Return,

    or
  - Copy of most recent IRS Form-1099 plus most recent US Income Tax Return,

    or
  - Copy of most recent SSA-1099 plus most recent US Income Tax Return

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