UroGen Support™ Patient Enrollment Form for JELMYTO

For an overview of key steps, please visit www.JELMYTO.com/hcp/support

UroGen Support Program Offerings

Once completed, this enrollment form allows UroGen Support to provide access and reimbursement information and support to eligible JELMYTO patients. The program offerings include benefits investigation, informational support and assistance with prior authorization and coverage appeal process, billing and coding support, patient affordability programs, and logistical assistance around product acquisition, preparation, and delivery.

Jelmyto® (mitomycin) for pyelocalyceal solution | UroGen Support™

If you have questions regarding patient enrollment or require assistance, please call 855-JELMYTO (855-535-6986). Once completed, please fax this form to UroGen Support at 833-664-7216 or log into the portal at UroGenSupport.com.

ALL INFORMATION IS REQUIRED unless otherwise noted.

Patient Information

☐ **Check here if a copy of the patient's Face Sheet is included.** | ***If the patient's Face Sheet is not included, please complete this section.***

First Name: _____ Last Name: _____

DOB: _____ Gender: _____ US Resident: ☐ Yes ☐ No

Address: _____ City: _____ State: _____ ZIP: _____

Preferred Phone: _____ ☐ Home ☐ Mobile (☐ Check here if it is appropriate to leave a detailed voice message) Last 4 Digits SSN: _____

Email: _____ Patient Preferred Language (other than English): _____

EMR Chart ID: _____

Alt. Contact Name: _____ Alt. Contact Phone: _____ Relationship to Patient: _____

Patient Insurance Information

☐ **Please attach copies of primary and secondary insurance cards.**

☐ **Check here if the patient does not have insurance coverage.**

Medical Insurance Provider: _____ Insurance Provider Phone: _____

Primary Insurance Holder (if not the patient): _____ Primary Insurance Holder DOB: _____

Primary Insurance Holder Last 4 Digits SSN: _____ Policy Number: _____ Member ID: _____

Group Number: _____

Secondary Medical Insurance Provider: _____ Insurance Provider Phone: _____

Primary Insurance Holder (if not the patient): _____ Primary Insurance Holder DOB: _____

Primary Insurance Holder Last 4 Digits SSN: _____ Policy Number: _____ Member ID: _____ Group Number: _____

Prescriber Information (Office/Clinic)

Practice Name: _____ Prescriber Name: _____

Address 1: _____ Address 2: _____ City: _____ State: _____ ZIP: _____

Office Contact Name: _____ Phone Number: _____ Fax Number: _____

Email: _____ (Please indicate preferred method of communication) ☐ Phone ☐ Fax ☐ Email

PTAN: _____ NPI Number: _____ DEA Number: _____ State License Number: _____

Expiration Date: _____ Tax ID Number: _____ Medicaid Number: _____

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Diagnosis Information

☐ C65.1 Malignant neoplasm of right renal pelvis
☐ C65.2 Malignant neoplasm of left renal pelvis
☐ C65.9 Malignant neoplasm of unspecified renal pelvis
☐ C66.1 Malignant neoplasm of right ureter
☐ C66.2 Malignant neoplasm of left ureter
☐ C66.9 Malignant neoplasm of unspecified ureter

Other ICD-10 code(s): _____

Appointment Information

10-Digit JELMYTO NDC Number: 72493-103-03 **11-Digit JELMYTO NDC Number: 72493-0103-03**

First Appointment Date and Time: ____/____/_____ _____ AM/PM ☐ Appointment Confirmed

If date above is tentatively scheduled, please confirm the first appointment date and time and all subsequent appointments with UroGen Support.

Is 340B price requested? ☐ Yes ☐ No If Yes, please provide your 340B identifier number: _____

General Notes: _____

☐ Antegrade Instillation via Nephrostomy Tube

Prescription Information

Instructions to Pharmacy (Select all that apply)

☐ **Initial Course** Prepare ***one*** kit of JELMYTO 80 mg according to JELMYTO Instructions for Pharmacy for instillation via ureteral catheter or nephrostomy tube weekly for 6 completed instillations. ***Refills: 8*** (may dispense PRN for incomplete instillations)

☐ **Maintenance Course** Prepare ***one*** kit of JELMYTO 80 mg monthly according to JELMYTO Instructions for Pharmacy for instillation via ureteral catheter or nephrostomy tube. ***Refills: 10***

☐ **Initial Course Bilateral Disease/Second Kidney** Prepare ***one*** kit of JELMYTO 80 mg according to JELMYTO Instructions for Pharmacy for instillation via ureteral catheter or nephrostomy tube weekly for 6 completed instillations. ***Refills: 8*** (may dispense PRN for incomplete instillations)

☐ **Maintenance Course Bilateral Disease/Second Kidney** Prepare ***one*** kit of JELMYTO 80 mg monthly according to JELMYTO instructions for Pharmacy for instillation via ureteral catheter or nephrostomy tube. ***Refills: 10***

Pharmacy Shipping Address *If using Mixing Partner, address where product will be delivered for instillation/treatment (if known)*

Location Name: _____ Contact Name: _____

Address 1: _____ Address 2: _____ City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____ Email: _____

(Please indicate preferred method of communication) ☐ Phone ☐ Fax ☐ Email PO Number (if applicable): _____

By signing below, I certify that (1) the above therapy is medically necessary and in the best interest of the patient listed above; (2) I authorize UroGen Pharma, Inc. and its contractors and business partners ("Contractors") to (i) supply any information to the insurer of the above named patient, (ii) forward the above prescription by fax or other means of delivery to a licensed pharmacy, and (iii) verify benefits and coordinate the dispense of JELMYTO where appropriate; and (3) I represent to that I have obtained all necessary Federal and state authorizations and consents from my patient to allow me to release health information to UroGen Support and its contracted third parties; and (4) I agree to the Business Associate Agreement as presented at https://baa.urogensupport.com/.

Prescribing Physician Signature and Date (REQUIRED)*

_____ _____ _____

Prescribing Physician Signature **MM/DD/YYYY** **Printed Name**

*Prescriber's signature required. Signature stamps not acceptable.

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☐ **Check here if the site of care information is the *same* as the prescriber information on page 1.**

Site of Care Information (if different from Prescriber Information)

This is where the patient will be instilled with JELMYTO. If known, all information is required.

Site of Care Type: ☐Physician Office ☐Ambulatory Surgical Center ☐Hospital Outpatient ☐Other

Site of Care Name: _____ Site of Care Contact Name: _____

Address 1: _____ Address 2: _____ City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____ Email: _____

PTAN: _____ NPI Number: _____ DEA Number: _____ State License Number: _____

Expiration Date: _____ Tax ID Number: _____ Medicaid Number: _____

Administering Physician (if different from prescriber): _____

Administering Physician NPI Number: _____

Site of Care Scheduler Contact Name (if different than Site of Care Contact Name): _____

Phone Number: _____ Email: _____

Site of Care Benefits Contact Name (where patient insurance coverage results will be sent): _____

Phone Number: _____ Email: _____

Patient Assistance Program

☐Check here if you would like to enroll the patient in the UroGen Support Patient Assistance Program.

Total Gross Yearly Income:

Entire Household: $_____

How many people, including the patient, live in the household: _____

Visit www.JELMYTO.com/hcp/support for program eligibility criteria.

Commercial Copay Program

☐Check here if you would like to enroll the patient in the UroGen Support Commercial Copay Program.

Visit www.JELMYTO.com/hcp/support for program eligibility criteria.

UroGen Support™ Patient Enrollment Form for JELMYTO

Jelmyto® (mitomycin) for pyelocalyceal solution | UroGen Support™

Patient Name _____ DOB _____

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Patient Authorization

Health Insurance Portability and Accountability Act authorization

I authorize my healthcare providers (including those pharmacies that may receive my prescription for JELMYTO) and my health insurers to disclose personal health information (PHI) about me, including health information relating to my medical condition, treatment, prescription, financial, including results from a soft credit check, insurance coverage, as well as identifying information about me (e.g., name, address, and date of birth) to UroGen Pharma, Ltd., its affiliates, employees, representatives and its agents (collectively "UroGen") that have been hired to administer the UroGen Support program on its behalf in order for UroGen Support to (1) enroll me in UroGen Support; (2) determine my benefit eligibility and potential out-of-pocket costs for JELMYTO; (3) communicate with my healthcare providers and health plans about my treatment plan; (4) provide support offerings including patient education and access to financial assistance for JELMYTO; (5) help get JELMYTO prepared and delivered to my healthcare providers; and (6) facilitate my participation in JELMYTO patient programs that I have elected to receive information about, as indicated below. I agree that, using the contact information I provide, UroGen Support may contact me for reasons related to the UroGen Support program and support offerings and may leave messages for me that may disclose that I am on JELMYTO therapy. I consent to being contacted by a UroGen Support program representative in order for the program to obtain further information or clarification regarding any adverse event I may experience. UroGen may also use PHI about me for quality assurance purposes and to evaluate the operations and services of UroGen Support.

I understand that once my PHI has been disclosed to UroGen Support, it is no longer protected by federal privacy laws and UroGen Support may re-disclose it; however, UroGen Support has agreed to protect my PHI by using and disclosing it only for the purposes described above or as required by law.

I can withdraw this authorization by calling UroGen Support at 855-535-6986 or mailing a letter requesting such revocation to UroGen Support, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560, but it will not change any actions taken before I withdraw authorization. Withdrawal of authorization will end further uses and disclosures of PHI by the parties identified in this form except to the extent those uses and disclosures have been made in reliance upon my authorization. I understand that I may refuse to sign this form and, if I do so, I will not be able to participate in the UroGen Support program, but it will not affect my eligibility to obtain medical treatment or my ability to seek payment for this treatment or affect my insurance enrollment or eligibility for insurance coverage. Once this form is signed, my prescriber is authorized to send my enrollment to UroGen Support via email, fax, or text message and communicate information via phone in order to facilitate the sharing of marketing materials. This authorization expires three (3) years after the date I sign below, or the maximum period allowed under applicable law if less than three years. I understand that I will receive a copy of the signed authorization.

Marketing materials consent

☐ By checking this box, I authorize UroGen Support to send me relevant program and marketing materials that pertain to JELMYTO. This may include materials from UroGen Pharma or a third party working on UroGen Pharma's behalf.

UroGen Support Patient Assistance Program and Commercial Copay Program authorization

☐ By checking this box, I understand that UroGen Support will determine my eligibility for and enroll me in the Patient Assistance Program (PAP) if I am eligible. Generally, patients are eligible for PAP if they have been prescribed JELMYTO, do not have insurance coverage for JELMYTO, and have a household adjusted gross income level less than or equal to 400% of the federal poverty level based on their household size.

☐ By checking this box, I understand that UroGen Support will determine my eligibility and enroll me in the Commercial Copay Program if I am commercially insured with a valid prescription for JELMYTO. Enrolled patients will receive a combined maximum annual benefit of $13,800 in total, and a maximum benefit of $4,000 per dose. Patient is responsible for $50 per dose, and any remaining costs after any maximum monthly and/or annual benefit is reached. I also certify that information submitted for any affordability program is accurate, that expenses requested for payment are eligible, actually incurred, and that they were not and will not be paid by my insurance, Flexible Spending Account (FSA), Health Savings Account (HSA), Health Reimbursement Account (HRA), or any other payer or discount/copay program. I certify that submitted rebate claims will not be paid by Medicare, Medicaid, Tricare, CHAMPUS, VA, or any other government (state or federally funded) program, and that I am not covered under any of these programs. I understand that I am liable for any misrepresentations herein to the full extent of applicable law. Offer good only in the United States and its territories.

PRIVACY NOTICE: For more information on what data we collect about you and how we use it, as well as information about the rights you may have under the California Consumer Privacy Act, please see our Privacy Policy available at www.urogen.com.

Patient Signature (REQUIRED) | By signing this document, I authorize the release of my information as set for the above.

Patient Signature _____ MM/DD/YYYY **Printed Name** _____

Patient DOB: _____ Phone Number: _____

If applicable: Authorized Representative Name: _____

Relationship to Patient: _____ Phone Number: _____

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