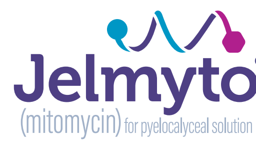
UroGen Support™ Patient Enrollment Form for JELMYTO

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, patient affordability, and logistical assistance around product acquisition, preparation, and delivery.

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 email it to Contact@UroGenSupport.com.

Patient Information (REQUIRED)

☐ **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 How many people, including the patient, live in the household? ________

Address: ________ City: ________ State: ________ ZIP: ________

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

Patient Preferred Language (other than English): ________ Alternate Contact Name: ________

Relationship to Patient: ________ Alternate Contact Phone: ________

EMR Chart ID: ________

Patient Insurance Information (REQUIRED)

☐ **Check here if front and back copies of the patient's medical insurance card are included.** | ***If the patient's medical insurance card is not included, please complete this section.***

☐ **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: ________

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

Prescriber Information (REQUIRED)

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: ________

Diagnosis Information (REQUIRED)

☐ C65.9 Malignant neoplasm of unspecified renal pelvis

☐ C65.2 Malignant neoplasm of left renal pelvis

☐ C65.1 Malignant neoplasm of right renal pelvis

Other ICD-10 code(s): ________

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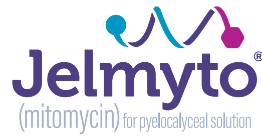

Patient Name ______________________ DOB __________

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Prescription, Appointment, and Preparation Information | *Please complete as much of this section as possible.*

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

Appointment Dates and Times:
1) ___/___/_____ _____ AM/PM 2) ___/___/_____ _____ AM/PM 3) ___/___/_____ _____ AM/PM
4) ___/___/_____ _____ AM/PM 5) ___/___/_____ _____ AM/PM 6) ___/___/_____ _____ AM/PM

☐ Check here if you would like UroGen Support to call the patient to remind him or her of upcoming appointments.

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

General Notes: __________

☐ Antegrade Instillation via Nephrostomy Tube

Product Preparation

Check the appropriate box for the way in which you would like to receive the product:

- ☐ Prepared and sent to the "site of care" address
- ☐ Not prepared and sent to this address provided in this section (if different than site of care address below)

Instructions to pharmacy
Prepare according to JELMYTO Instructions for Pharmacy. Physician to instill via ureteral catheter or nephrostomy tube weekly for 6 weeks.
Refills: 5

☐ **Maintenance course**
Prepare according to JELMYTO Instructions for Pharmacy. Physician to instill via ureteral catheter or nephrostomy tube monthly for a maximum of 11 additional instillations.
Refills: 10

Pharmacy Shipping Address

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 Site of Care Order ID: __________

I certify that JELMYTO is medically necessary for the above-named patient and that the information provided is accurate to the best of my knowledge. By my signature, I appoint UroGen Support to assist in obtaining coverage for JELMYTO and to assist in initiating the therapy. By my signature below, I also appoint UroGen Support, on my behalf, to convey this order to the pharmacy/distributor for distribution and, as appropriate, pharmacy mixing and for the pharmacy/distributor to distribute/dispense per its customary and usual procedures. I further certify that (a) any product support provided through UroGen Support on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use the above therapy or any other UroGen Support product or service for anyone, and (b) my decision to prescribe the above therapy was based solely on my determination of medical necessity as set forth herein, and that (c) I will not seek reimbursement for any medication or service provided by or through UroGen Support from any government program or third-party insurer as it relates to the UroGen Support Patient Assistance Program and/or the UroGen Support Commercial Copay Program.

Prescribing Physician Signature (REQUIRED)*

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

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

☐ **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) | *Please complete as much of this section as possible.*

Site of Care Name: __________ Site of Care Contact Name: __________

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

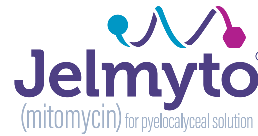
Phone Number: __________ Fax Number: __________ Email: __________

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: __________



Patient Authorization

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 email it to Contact@UroGenSupport.com.

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, prescription, financial, including results from a soft credit check, and insurance coverage, to UroGen Pharma, Ltd., its affiliates, and its agents 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 services 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 services 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.

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 1 year after the date I sign below. I understand that I will receive a copy of the signed authorization.

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: ______________________________

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 if I am uninsured. Patients are eligible 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. Additionally, 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 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.

855-JELMYTO (855-535-6986) | 833-664-7216 | www.JELMYTO.com/hcp/support | Contact@UroGenSupport.com

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