Benefits Investigation and Prescription Enrollment Form

Yesintek™ (ustekinumab-kfce)

My Biocon Biologics™

Patients can be enrolled into the My Biocon Biologics YESINTEK™ (Ustekinumab-kfce) patient service program by either:
1. Fax – Complete this Enrollment and Prescription Form in its entirety and fax it to 1-833-726-4848.

2. E-Prescription – Send an electronic prescription for YESINTEK through your EHR directly to Phyz (21134 Market Ridge, Ste. 101, San Antonio, Texas, 78258; NCPDP: 5928809). Please make sure your patient's cell phone number* is on file in your EHR so it is included with the e-prescription. By submitting this form or e-prescribing to YESINTEK, you are requesting patient access specialist's support services on behalf of the patient named below. Services include but are not limited to: benefits verification, prior authorization assistance, assistance with appeals, copay assistance, quick start and bridge program.

1. PATIENT INFORMATION (REQUIRED)

Patient Full Name _____ Date Of Birth (MM/DD/YYYY) _____ Gender at Birth: ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Preferred Phone Number _____ ☐ Home Phone no. ☐ Cell Phone no. Email Address _____

2. INSURANCE INFORMATION (REQUIRED)

Fax both sides of your patient's medical and prescription benefit insurance card ☐ Patient has no insurance

Card Holder Name: First Name _____ Middle Initial _____ Last Name _____

Relationship of card holder to patient: ☐ Self ☐ Legal Guardian Date Of Birth (MM/DD/YYYY) _____ Phone Number _____

Medical Insurance: Policy Number _____ Group Number _____

Pharmacy Insurance: Member ID _____ PCN (If Applicable) _____

Group ID _____ BIN _____

Pharmacy Benefit Manager Phone Number (optional) _____

3. PRODUCT INFORMATION AND SERVICES REQUESTED

Select Product: ☐ YESINTEK ☐ Ustekinumab-kfce Primary ICD-10 Code (Required) _____

☐ IV Induction Dose ☐ SQ Maintenance Dose ☐ Both

Services requested: ☐ BV ☐ PA ☐ Copay

If PA support is being requested, submit all supporting clinical information with the prescription. The ability to initiate Prior Authorizations may vary by plan.

4. PRESCRIBER INFORMATION (REQUIRED)

Prescriber Name (First, Last) _____ NPI# _____

Practice Name _____ Office Contact _____

Tax Id# _____ Address _____ City _____

State _____ Zip Code _____ Phone _____ Fax _____

COMPLETE FOR INDUCTION DOSE (GI INDICATIONS ONLY)

5. SINGLE IV INDUCTION PRESCRIPTION

DATE OF INFUSION

INDUCTION DOSE (Required) _____

Patient Weight _____ lb _____ kg

☐ 55 kg or less	260 mg (2 x 130 mg/26 mL vials) at Week 0
☐ more than 55 kg to 85 kg	390 mg (3 x 130 mg/26 mL vials) at Week 0
☐ more than 85 kg	520 mg (4 x 130 mg/26 mL vials) at Week 0

SITE OF INFUSION (REQUIRED IF DIFFERENT FROM PRESCRIBER'S OFFICE)

☐ Hospital outpatient ☐ Infusion center ☐ Other

Physician Or Infusion Provider Name _____

Practice/Facility Name _____ NPI # _____ TAX ID # _____

Address _____ City _____

State _____ Zip Code _____ Phone _____ Fax _____

Patient Name _____ Date Of Birth (MM/DD/YYYY) _____

COMPLETE FOR MAINTENANCE DOSE (GI INDICATIONS ONLY)

6. YESINTEK Rx MAINTENANCE THERAPY

☐ 90 mg/mL single-dose prefilled syringe ☐ 45 mg/0.5 mL single-dose prefilled syringe ☐ 45 mg/0.5 mL vials

SHIP TO: ☐ Office ☐ Patient ☐ Hospital outpatient ☐ Other

NOTE: Shipments cannot be sent to P.O. Boxes

Address _____ City _____

State _____ Zip Code _____ Phone _____ Fax _____

DATE OF INFUSION INDUCTION DOSE (if known) _____

☐ 1 single-use prefilled syringe; 90 mg/mL SC every 8 weeks Refills #_____

☐ Two 45 mg/0.5 mL vials; 90 mg/mL SC every 8 weeks Refills #_____

_____
Preferred Specialty Pharmacy

I authorize My Biocon Biologics to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by me, the patient, or the patient's plan.

_____ _____ _____
Prescriber Signature Prescriber Name Date

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with YESINTEK is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current YESINTEK Prescribing Information.

COMPLETE FOR OTHER INDICATIONS

7. PRESCRIPTION INFORMATION

☐ 90 mg/mL single-dose prefilled syringe ☐ 45 mg/0.5 mL single-dose prefilled syringe ☐ 45 mg/0.5 mL vials

SITE OF CARE: ☐ Prescriber's office ☐ Hospital outpatient ☐ Other

Address _____ City _____

State _____ Zip Code _____ Phone _____ Fax _____

YESINTEK Rx DIRECTIONS (Select all that apply)

VIAL STARTER DOSE for plaque psoriasis and active psoriatic arthritis (ages 6-17) weighing less than 60 kg

VIAL MAINTENANCE THERAPY for plaque psoriasis and active psoriatic arthritis (ages 6-17) weighing less than 60 kg

Patient weight: _____ Dose (0.75 mg per kg): _____

☐ 1 single-dose 45 mg/0.5 mL vial at ☐ Week 0 ☐ Week 4 ☐ 1 single-dose 45 mg/0.5 mL vial every 12 weeks Refills #_____

PREFILLED SYRINGE STARTER DOSE

☐ 1 single-dose 45 mg/0.5 mL SC prefilled syringe (≤ 100 kg) ☐ Week 0 ☐ Week 4

☐ 1 single-dose 90 mg/mL SC prefilled syringe (> 100 kg) ☐ Week 0 ☐ Week 4

PREFILLED SYRINGE MAINTENANCE THERAPY

☐ 1 single-dose 45 mg/0.5 mL SC prefilled syringe every 12 weeks Refills # _____

☐ 1 single-dose 90 mg/mL SC prefilled syringe every 12 weeks Refills # _____

I authorize My Biocon Biologics to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by me, the patient, or the patient's plan.

_____ _____ _____
Prescriber Signature Prescriber Name Date

Patient Name _____ Date Of Birth (MM/DD/YYYY) _____

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with YESINTEK is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current YESINTEK Prescribing Information.

By completing and transmitting this form, I am certifying that I have received from my patient and have on file the patient's HIPAA consent and all other necessary permissions from my patient authorizing the release of the patient's identification and insurance information, including the information I have provided above, to Biocon Biologics Inc., its affiliates, its program administrator, and their respective agents and service providers (collectively, "My Biocon Biologics") for them to use in providing the patient with benefit verification and patient support services as described herein.

In the absence of ERX, if required by applicable state law, please attach copy of prescription on official state prescription form. (Ex. Official NY State Prescription ONYSRX)

YESINTEK QUICK START AND BRIDGE PROGRAM PRESCRIPTION

When commercial insurance coverage is delayed >5 business days after enrollment, My Biocon Biologics offers eligible patients one dose of YESINTEK or at no cost. By enrolling the patient for this support, I certify that I agree to the program requirements and will take any necessary action described in the requirements for my patient.

☐ 90 mg/mL prefilled syringe for SC ☐ 45 mg/ 0.5 mL prefilled Syringe for SC ☐ 45 mg/ 0.5 mL vial for SC ☐ 130 mg/26 mL vial for infusion

Quantity required _____ Refills 0 Ship to: ☐ Office ☐ Patient ☐ Other

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Prescriber Signature _____ Prescriber Name _____ Date _____

For My Biocon Biologics Quick Start and Bridge Eligibility Terms and Conditions, click here or visit https://yesintekhcp.com/bridgeprogramtermsandconditions

Patient Name _____ Date Of Birth (MM/DD/YYYY) _____

MY BIOCON BIOLOGICS PATIENT SERVICES AUTHORIZATION FORM

By signing this Authorization, I authorize each of my "Healthcare Providers" (eg, my physicians, pharmacists, specialty pharmacies, other healthcare providers, and their staff) and "Insurers" (eg, my health insurance plans) to disclose my Protected Health Information as described on this Form. My "Protected Health Information" includes any and all information related to my medical condition, treatment, prescriptions, and health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and or group numbers (together, "Protected Health Information") to Biocon Biologics, its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Biocon Biologics") including service providers supporting Yesintek Patient Services and My Biocon Biologics patient services.

Specifically, I authorize disclosure of my Protected Health Information in order to:

- Enroll me in, and contact me about My Biocon Biologics Patient services program
- Communicate with my Healthcare Providers and Insurers about benefits, coverage, and medical care, including compliance with Product treatments
- Facilitate dispensing of my prescription by a commercial pharmacy and non-commercial pharmacy
- Provide me with educational materials, information and services related to my treatment experience with my prescribed medication and my condition
- Verify, investigate, and coordinate with my Insurers regarding my prescribed medication
- Contact me as otherwise required or permitted by law.

Biocon Biologics agrees to protect my Protected Health Information by using and disclosing it only for the purposes described in this Authorization or as permitted by law. I understand that I may refuse to sign this Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me, but I will not have access to the Biocon Biologics and the services provided by Biocon Biologics, under the Program. If I refuse to sign the Authorization, or revoke my Authorization later, I understand that this means I will not be able to participate or receive assistance from the Program.

I understand that my signed Authorization is valid for 10 years from date of signature, and that I may revoke this Authorization at any time in the future, except to the extent that actions have been taken in reliance on the Authorization. I understand that to revoke this Authorization I may mail a request to My Biocon Biologics, fax to 1-833-726-4848, or by calling 1-833-61-BIOCON. I understand that revoking this Authorization will end further uses and disclosure of my Protected Health Information by the parties identified above except to the extent those uses and disclosures have been made in reliance upon this Authorization as permitted by applicable law. I am entitled to receive a copy of this Authorization.

My signature certifies that I have read and understand the above statements and agree to the outlined terms.

Signature: _____ Date: _____

For privacy rights and choices specific to California residents, please see Biocon's California privacy notice available at https://www.bioconbiologics.com/privacy-policy-bbl/.

Permission for text communications:

Yes, I would like to receive text messages. ☐

Patient Name (Print): _____

_____

Patient or Patient Authorized Representative Signature

Date: _____

If Patient Representative, Print Name: _____

Relationship to Patient: _____