Patient Enrollment Form

Yesintek® (ustekinumab-kfce) | My Biocon Biologics®

Patients can be enrolled into the My Biocon Biologics Yesintek® (ustekinumab-kfce) patient support program by:

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).

Have questions? Please call 1-833-61-BIOCON Monday to Friday, 8 am to 8 pm ET.

By submitting this form or e-prescribing YESINTEK, you are requesting patient support on behalf of the patient named below. Services include: benefits verification, prior authorization assistance, assistance with appeals, copay assistance, quick start, and bridge program.

☐ Check if requesting Copay Assistance Program only

PATIENT INFORMATION (REQUIRED) *Fields marked with an * are required.* Reset

First Name* _____ Middle Initial _____ Last Name* _____

DOB (MM/DD/YYYY)* ___/___/_____ Gender Assigned at Birth* M ☐ F ☐ Email* _____

Address* _____ City* _____ State* _____ Zip* _____

Preferred Phone* Cell ☐ Home ☐ (___)____–_____

INSURANCE INFORMATION (REQUIRED) *Please fax copies of the front and back of the patient's medical and prescription drug insurance card(s).* Reset

☐ Patient has no insurance

Beneficiary First Name* _____ Middle Initial _____ Beneficiary Last Name* _____

Medical Insurance:

Payer Name _____ Group Number _____ Phone Number(___)____–_____

Prescription Drug Insurance:

Payer Name* _____ PCN (If Applicable) _____ Group ID _____

Member ID* _____ BIN (If Applicable)_____ Pharmacy Benefit Manager Phone Number (___)____–_____

PRESCRIBER INFORMATION Reset

First Name* _____ Last Name* _____

NPI #* _____ Practice NPI # _____ Tax ID # _____

Practice Name _____

Address* _____ City* _____ State* _____ Zip* _____

Practice Phone Number (___)_____–_____ Practice Fax Number (___)_____–_____

Primary Office Contact* _____ Preferred Email* _____

COMPLETE FOR INDUCTION DOSE (GI INDICATIONS ONLY) Reset

Preferred Specialty Pharmacy (For Maintenance Therapy): _____

Site of Infusion: ☐ Prescriber's Office ☐ Hospital Outpatient ☐ Infusion Center ☐ Other _____

Shipping Information for Induction Therapy
(Note: Shipments cannot be sent to PO boxes) Site Name _____

Address _____ City _____ State _____ Zip _____

Phone (___)_____–_____

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For Adult Patients With Crohn's Disease or Ulcerative Colitis

In the absence of eRx, if required by applicable state law, please attach copy valid prescription form (eg, Official NY State Prescription ONYSRX).

☐ IV Loading Dose
☐ Subcutaneous Maintenance Dose

Date of Anticipated Infusion Induction Dose (if known) ____/____/____ Date of Last Dose (if known) ____/____/____

Initial Therapy	Reset
Weight Range	**Dose** (given as a single intravenous infusion)
≤55 kg	☐ 260 mg (2 x 130 mg/26 mL vials)
>55 kg to ≤85 kg	☐ 390 mg (3 x 130 mg/26 mL vials)
>85 kg	☐ 520 mg (4 x 130 mg/26 mL vials)

Maintenance Therapy Reset

☐ 90 mg single-dose prefilled syringe administered subcutaneously 8 weeks after the initial intravenous dose, then every 8 weeks thereafter

Qty: ____ **Refills:** ____

For Patients With Plaque Psoriasis or Psoriatic Arthritis

Date of Last Dose (if known) ____/____/____

Indication	Patient Weight	Initial Therapy	Maintenance Therapy	Reset
Plaque Psoriasis *Adult*	≤100 kg	☐ 45 mg single-dose prefilled syringe administered subcutaneously initially and 4 weeks later	☐ 45 mg single-dose prefilled syringe administered subcutaneously every 12 weeks	**Qty:** ____ **Refills:** ____
	>100 kg	☐ 90 mg single-dose prefilled syringe administered subcutaneously initially and 4 weeks later	☐ 90 mg single-dose prefilled syringe administered subcutaneously every 12 weeks	**Qty:** ____ **Refills:** ____
Plaque Psoriasis *Pediatric Patients (6 to 17 years old)*	<60 kg	☐ 45 mg/0.5 mL vial for subcutaneous administration Patient's Weight: ____ lbs. _____ kg Dose (0.75 mg per kg): _____		**Qty:** ____ **Refills:** ____
	≥60 kg to ≤100 kg	☐ 45 mg single-dose prefilled syringe administered subcutaneously initially and 4 weeks later	☐ 45 mg single-dose prefilled syringe administered subcutaneously every 12 weeks	**Qty:** ____ **Refills:** ____
	>100 kg	☐ 90 mg single-dose prefilled syringe administered subcutaneously initially and 4 weeks later	☐ 90 mg single-dose prefilled syringe administered subcutaneously every 12 weeks	**Qty:** ____ **Refills:** ____
Psoriatic Arthritis *Adult*	All adult patients	☐ 45 mg single-dose prefilled syringe administered subcutaneously initially and 4 weeks later	☐ 45 mg single-dose prefilled syringe administered subcutaneously every 12 weeks	**Qty:** ____ **Refills:** ____
	Patients weighing >100 kg (with co-existent moderate-to-severe plaque psoriasis)	☐ 90 mg single-dose prefilled syringe administered subcutaneously initially and 4 weeks later	☐ 90 mg single-dose prefilled syringe administered subcutaneously every 12 weeks	**Qty:** ____ **Refills:** ____
Psoriatic Arthritis *Pediatric Patients (6 to 17 years old)*	<60 kg	☐ 45 mg/0.5 mL vial for subcutaneous administration Patient's Weight: ____ lbs. _____ kg Dose (0.75 mg per kg): _____		**Qty:** ____ **Refills:** ____
	≥60 kg	☐ Based on body weight, the recommended dose is 45 mg single-dose prefilled syringe given subcutaneously at weeks 0 and 4, then every 12 weeks	☐ 45 mg single-dose prefilled syringe administered subcutaneously every 12 weeks	**Qty:** ____ **Refills:** ____
	Patients weighing >100 kg (with co-existent moderate-to-severe plaque psoriasis)	☐ Based on body weight, the recommended dose is 90 mg single-dose prefilled syringe given subcutaneously at weeks 0 and 4, then every 12 weeks	☐ 90 mg single-dose prefilled syringe administered subcutaneously every 12 weeks	**Qty:** ____ **Refills:** ____

Patient First Name _____ Patient Last Name _____ DOB (MM/DD/YYYY) ____/____/____

Prescriber's Signature: _____ Date ____/____/____

Supervising Physician's Signature: (Where Required) _____ Date ____/____/____

☐ Check if sent to specialty pharmacy

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My Biocon Biologics Patient Services Authorization Form

Reset

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.

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/.

Patient First Name _____ Patient Last Name _____

Patient Signature _____ Date ____/____/____

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YESINTEK Quick Start and Bridge Program Prescription

Reset

When commercial insurance coverage is delayed >5 business days after enrollment, My Biocon Biologics offers eligible patients one dose of YESINTEK at no cost.

Patient's First Name* _____ Patient's Last Name* _____ Patient's Date of Birth* ___/___/___

Patient's Preferred Phone* (___)_____ – _____ Patient's Preferred Email* _____

Yesintek (ustekinumab-kfce): Please select 1 formulation option ONLY:

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

Quantity: 1 Refills 0 Ship to: ☐ Physician Office ☐ Infusion Center ☐ Patient (not applicable for 130mg vial) ☐ Other _____

Shipment Address* _____

Shipment City* _____ Shipment State* _____ Shipment Zip* _____

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.

_____	_____	_____	___/___/___
Prescriber Signature	Prescriber First Name	Prescriber Last Name	Date

For My Biocon Biologics Quick Start and Bridge Eligibility Terms and Conditions,
Visit https://yesintekhcp.com/bridgeprogramtermsandconditions/

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