XOSPATA® gilteritinib 40mg tablets SUPPORT SOLUTIONS℠

XOSPATASupportSolutions.com
Phone: 1-844-632-9272
Fax: 1-844-730-8816

XOSPATA Support Solutions® Patient Enrollment Form

Instructions for Healthcare Providers:

- Complete this enrollment form on behalf of your patient. **Please note:** All fields denoted with an asterisk (*) are required fields. Missing information will delay enrollment
- Have the patient read the Patient Authorization Statement on pages 4-6 and provide their signature and date to certify they have read, understand, and agree to the Statement
- Read the Prescriber Certification Statement on pages 2-3 and provide your signature and date to certify that you have read, understand, and agree to the Statement
- Complete the prescription drug information and provide your signature and date
- Fax the completed form to XOSPATA Support Solutions at 1-844-730-8816, fax it to a specialty pharmacy in the authorized XOSPATA® (gilteritinib) network, or visit the Prescriber Portal at **XOSPATASupportSolutions.com** to enroll online

If you have questions or need assistance, call XOSPATA Support Solutions at 1-844-632-9272, **Monday–Friday, 8:30 AM–8:00 PM ET**.

WHAT TYPE OF PATIENT SUPPORT IS NEEDED?

☐ Benefits investigation Support | ☐ Astellas Patient Assistance Program (PAP) | ☐ Other Programs

PATIENT INFORMATION

First Name*:	Last Name*:	Date of Birth (MM/DD/YYYY)*:		Sex: ☐ Male ☐ Female
Home Address*:	Unit #:	City*:	State*:	ZIP*:
Phone #*:	Phone Type: ☐ Home ☐ Work ☐ Cell		Voicemail Allowed: ☐ Yes ☐ No	
Email Address:	Preferred Language: ☐ English ☐ Spanish ☐ Other If Other, please specify:			
Authorized Caregiver or Alternate Contact Name:		Relationship to Patient:		
Alternate Contact Phone #:	Voicemail Allowed: ☐ Yes ☐ No	Alternate Contact Email Address:		

PHARMACY INSURANCE INFORMATION* (Please include front and back copies of pharmacy insurance card)

Patient Pharmacy Insurance Plan

Patient has: ☐ No Insurance ☐ Medicare Part D ☐ Private/Commercial ☐ Medicare Advantage

Pharmacy Insurer:	Patient Pharmacy Insurance Card ID:	Patient Pharmacy Insurance Card Phone:

ASSESSMENT FOR ASTELLAS PATIENT ASSISTANCE PROGRAM*

Does the patient want to be assessed for PAP?

☐ Yes ☐ No

PRESCRIBER INFORMATION

Prescriber Name*:	Specialty:	Email Address:	
Practice Name*:	Street Address*:		Suite #:
City*:	State*:	ZIP*:	
Office Phone #*:	Office Fax #*:		
MD NPI #*:	Tax ID #*:	State License #*:	
Medicare/Medicaid Provider #*:	Office Contact Name:		
Office Contact Phone #:	Office Contact Email Address:		

Preferred Specialty Pharmacy (if any):

☐ Self-Dispensing Practice (Please check this box if you are a self-dispensing practice)

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PATIENT INFORMATION		
First Name*:	Last Name*:	Date of Birth (MM/DD/YYYY)*:

PATIENT MEDICAL INFORMATION/DIAGNOSIS/PRESCRIPTION INFORMATION*

Primary ICD-10-CM Diagnosis Code: _____

Description: _____

Patient Relapse and FLT3 Test Dates of Patient Refractory FLT3 Test

☐ Patient Relapse or Refractory Date: _____

☐ FLT3 Test Date: _____

Product Name: XOSPATA® (gilteritinib) 40-mg tablets

Instructions: Take _____ 40-mg tablets per _____ for _____ days

Dispense: _____-day supply Refills: _____

Prescriber Name (please print): _____

Prescriber Signature: X _____ Date: _____

Stamped signatures not accepted. Dispense as written.

Prescriber Certification and Attestation Statement

By signing below, I hereby attest that I am the prescribing healthcare provider and I agree to submit requests to XOSPATA Support Solutions® because I have determined that XOSPATA® (gilteritinib) is medically appropriate for this patient and I have explained such to my patient. To the best of my knowledge, the patient and physician information in this form is complete and accurate. I certify that I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act [HIPAA] of 1996) to Company and its third-party suppliers, vendors, and other service providers supporting XOSPATA Support Solutions (collectively, the "Service Providers") for the purpose of providing access and reimbursement support, assisting in initiating or continuing therapy, and/or the evaluation of the patient's eligibility for support. I authorize Service Providers, as my designated agent and on behalf of my patients, to forward a prescription for XOSPATA by fax or other mode of delivery, to a pharmacy within the XOSPATA Support Solutions network.

I also certify that this prescription complies with all applicable state and local laws. I agree to notify the Service Providers if I become aware at any time in the future of changes in my patient's circumstances that would affect their eligibility, including but not limited to changes in health insurance status or coverage, financial status, United States residency status, or the indication for which XOSPATA has been prescribed for this patient.

PATIENT INFORMATION		
First Name*:	Last Name*:	Date of Birth (MM/DD/YYYY)*:

Prescriber Certification and Attestation Statement (Continued)

I understand that Astellas reserves the right to change or terminate the Astellas Patient Assistance Program at any time, or to refuse to provide XOSPATA® (gilteritinib) under the Astellas Patient Assistance Program to any patient. I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. If my patient obtains XOSPATA via the Astellas Patient Assistance Program, I understand that (a) any medication supplied under the Astellas Patient Assistance Program is for the use of the patient named on this form only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (including the patient or any third-party payer) for reimbursement; (b) I will receive and secure my patient's medication at my office separate from commercially purchased medication until it is dispensed to my patient, when applicable; (c) I will comply with and abide by my State Practitioner Dispensing Laws for authorized prescribers, when applicable; and (d) the provision of free drug as part of the Astellas Patient Assistance Program is not contingent on any future purchase or prescribing of XOSPATA. I understand that Astellas reserves the right to change or terminate the Astellas Patient Assistance Program at any time, or to refuse to provide XOSPATA under the Astellas Patient Assistance Program to any patient.

I acknowledge I may be contacted by email, postal mail, or fax using the information I've provided, and I understand my personal information will be used and disclosed by Astellas in accordance with Astellas' privacy policy, available at **www.astellas.com/us/privacy-policy**.

I certify that a copy of the Patient Authorization Statement has been given to the patient named on page 1 and/or their representative and that I have provided my patient with a description of XOSPATA Support Solutions®.

My signature below certifies that I have read, understand, and agree to the Prescriber Certification and Attestation Statement on pages 2-3.

Prescriber Name (please print): _____

Prescriber Signature: X _____ Date: _____

(Enrollment cannot be processed without an original signature)

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PATIENT INFORMATION		
First Name*:	Last Name*:	Date of Birth (MM/DD/YYYY)*:

Patient Authorization Statement

By signing below, I authorize my doctors, pharmacies and other healthcare providers, as well as my health insurance plan, to disclose to Astellas Pharma US, Inc. ("Company") and its third-party suppliers, vendors, and other service providers supporting XOSPATA Support Solutions® (collectively, the "Service Providers") personally identifiable information about me (my "Personally Identifiable Information") (for example, my name, Social Security number, address, insurance policy number, and income) and my medical condition (for example, my diagnosis or medications). This Personally Identifiable Information can include spoken or written facts about my health and insurance benefits. It can include copies of records from my healthcare providers or health plans about my health or healthcare.

I understand that my healthcare providers and my pharmacy may receive remuneration, or payment, for disclosing my Personally Identifiable Information pursuant to this Authorization.

I understand that XOSPATA Support Solutions is a component of Astellas Pharma Support Solutions℠ and that the Service Providers may be compensated by Company.

Company and/or the Service Providers may use and disclose my Personally Identifiable Information to:

(i) assist in my enrollment in XOSPATA Support Solutions and to contact me and/or the person legally authorized to sign on my behalf;

(ii) provide me and/or the person legally authorized to sign on my behalf with educational and other materials, information, and support related to XOSPATA Support Solutions;

(iii) verify, investigate, assist with, and coordinate my coverage for XOSPATA from my health insurance plan;

(iv) coordinate prescription fulfillment;

(v) assess my eligibility for participation in the patient assistance program, if necessary;

(vi) refer me to other independent programs or alternative sources that may be available to provide assistance to me as allowed under the law, if necessary; and

(vii) help analyze the efficiencies and performance of the services provided by Service Providers.

If an application is submitted to determine my eligibility under the Astellas Patient Assistance Program (PAP), I also authorize Company and Service Providers to use my Personally Identifiable Information, including, but not limited to, my Social Security number, date of birth, name, and/or address as needed to access my credit information and information derived from public and other sources, including information from a consumer reporting agency (credit bureau), to estimate my income in conjunction with the eligibility determination process performed to determine my eligibility under the Astellas PAP. I agree to notify my healthcare providers if I become aware in the future of changes that would affect my eligibility, including, but not limited to, changes in health insurance status or coverage, financial status, and United States residing status. I understand that completing this enrollment form does not guarantee that I will qualify for the Astellas PAP.

PATIENT INFORMATION		
First Name*:	Last Name*:	Date of Birth (MM/DD/YYYY)*:

Patient Authorization Statement (Continued)

In some instances, the Service Providers may de-identify my Personally Identifiable Information and use or disclose the de-identified information (in individual or aggregated form) for legitimate business purposes. I understand that the Company and the Service Providers will make reasonable efforts to keep my Personally Identifiable Information private; however, I understand that once information has been disclosed to the Service Providers, it may no longer be protected under federal privacy law and could be disclosed to others.

This authorization will last for three (3) years from the date on which I agree to this authorization (or such shorter period as applicable state law may require). My choice as to whether I sign this authorization will not change the way my doctors, healthcare providers, or payers treat me, but if I decline to sign it, I will not be able to have my insurance coverage verified, have alternate sources of assistance researched, or access other support provided by or on behalf of XOSPATA Support Solutions®.

I understand that I may revoke this authorization at any time by providing written notice to XOSPATA Support Solutions at PO Box 5490 Louisville, KY 40255. Cancellation of this authorization will be valid when received by the administrators of XOSPATA Support Solutions. I understand that a cancellation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I understand that I am entitled to receive a copy of this authorization after I have provided my signature.

If your application is approved, XOSPATA Support Solutions can send you text messages about the Program throughout your enrollment period. These text messages are optional. You can participate in the Program without signing up for text messages. When you sign up for the text messages (by providing your cell phone number), you must agree to the following conditions:

- Program will send an autodialed, pre-recorded text message (standard text message and data rates apply).
- You can opt out at any time by calling 1-844-632-9272 or replying "STOP" to the text messages.
- Program is not responsible if a communication is not delivered due to technical difficulties like server issues, phone carrier outages, or discontinued service.
- Be aware that anyone who can open or have access to your phone might see your text messages.
- If your mobile operator is not participating in text messaging services, you will not receive text messages.
- These text messages are NOT reminders to take your medication. You are responsible to take your medication as prescribed.
- Do NOT report product complaints or adverse events (like side effects) by text message. To report these, please call XOSPATA Support Solutions at 1-844-632-9272.
- To receive text messages, you must provide your cell phone number.

PATIENT INFORMATION		
First Name*:	Last Name*:	Date of Birth (MM/DD/YYYY)*:

Patient Authorization Statement (Continued)

Astellas is committed to the safety and effectiveness of our products. In the event you experience an adverse drug event or side effect, Astellas requests your consent to be able to contact you, your family member, and/or your healthcare provider. This contact may be via phone, email, or any commonly used electronic form or medium. The purpose of this follow up is to help us at Astellas to better understand the event you experienced in relation to our product.

For additional information regarding how Astellas handles personal information, please visit our Privacy Policy link at: **www.astellas.com/us/privacy-policy**

This Authorization Statement is governed by and interpreted in accordance with the laws of the state of Illinois, excluding Illinois conflict of law rules, and applicable federal law.

INCOME AND ASSESSMENT FOR PATIENT ASSISTANCE PROGRAM (Complete this section to be evaluated for PAP)	
Annual Income:	Household/Family Size:

My signature below certifies that I have read, understand, and agree to the Patient Authorization Statement on pages 4-6.

If this Patient Authorization Form is being signed by a representative, please describe the representative's authority to act on behalf of the patient: _____

_____

Patient Name (please print): _____

Patient/Authorized Representative Signature: X _____ Date: _____

☐ I am signing on behalf of the patient and I hereby affirm that I have the legal right to do so, I am the parent or legal guardian of the patient, or I otherwise have a valid power of attorney to act on behalf of the patient.
(Note: Office personnel cannot sign on behalf of the patient.)

Authorized Representative Name (if applicable): _____ Relationship to Patient: _____

If you have questions or need assistance accessing XOSPATA® (gilteritinib), go to XOSPATASupportSolutions.com or call XOSPATA Support Solutions® at 1-844-632-9272, Monday–Friday, 8:30 AM–8:00 PM ET.

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