Healthcare Providers: Please fax this completed and signed form to XOSPATA Support Solutions℠ or to a Specialty Pharmacy in the authorized XOSPATA Network. **Remember to complete the prescription drug information and obtain healthcare provider and patient signatures.**

Please note – All fields denoted with an asterisk (*) are required fields.

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

XOSPATA® gilteritinib 40mg tablets SUPPORT SOLUTIONS℠

1. PATIENT INFORMATION

Name*: _____ Date of Birth*: _____
Sex: ☐ Male ☐ Female Phone*: _____ Phone Type: ☐ Home ☐ Work ☐ Mobile
Email: _____
Address*: _____
City*: _____ State*: _____ ZIP*: _____
Permission to contact patient? ☐ Yes ☐ No Best time to contact: _____

2. CURRENT INSURANCE INFORMATION*

☐ Patient has no insurance
Patient Insurance Plan: _____
☐ Medicare Part D ☐ Medicaid ☐ Private/Commercial ☐ Medicare Advantage
Insurer Name: _____
Insurer Phone: _____
Subscriber Name: _____ Policy ID: _____ Group No.: _____
Prescription Insurer Name: _____
PBM Subscriber ID: _____ PBM Phone No.: _____
PBM BIN No.: _____ PBM Group No.: _____

3. ASSESSMENT FOR ASTELLAS PATIENT ASSISTANCE PROGRAM*

The patient's Social Security number is required to assess income eligibility for the Astellas Patient Assistance Program.

Patient's Social Security Number: ☐☐☐-☐☐-☐☐☐☐

4. PATIENT AUTHORIZATION FOR XOSPATA SUPPORT SOLUTIONS*

My signature below certifies that I have read, understand, and agree to the Patient Authorization Statement on pages 3 and 4.

Patient Name (please print): _____

Patient Signature X: _____ **Date:** _____

If signed by a representative, please describe the representative's authority to act on behalf of the patient (Note: Office personnel cannot sign on behalf of the patient): _____

I am acting for another person and I hereby affirm that I have the legal right to do so, that I am the parent or legal guardian of the patient or otherwise have a valid power of attorney to act on behalf of the patient.

Representative Signature X: _____ **Date:** _____

5. PRESCRIBER INFORMATION

Prescriber Name* (First, Last): _____
Specialty: _____ Practice Name*: _____
Office Contact: _____
Office Contact Phone*: _____ Fax*: _____
Address*: _____
City*: _____ State*: _____ ZIP*: _____
Medicaid/Medicare Provider No.*: _____ Tax ID No.*: _____
State License No.*: _____ UPIN/NPI*: _____
Self-Dispensing Practice: ☐ **Preferred Specialty Pharmacy:** _____

6. PRESCRIPTION FOR XOSPATA® (gilteritinib) tablets*

In order for us to send medication to your patient, the prescription information must be complete and accurate.

Patient Name: _____ **Date of Birth:** _____
Diagnosis Code: _____
Product Name: XOSPATA® (gilteritinib) 40 mg tablets
Instructions: Take _____ 40 mg tablets per _____ for _____ days
Dispense: _____ -day supply Refills: _____

Doctor/Prescriber Signature X _____ **Date:** _____

Dispense as Written – Stamped signatures cannot be accepted

Prescriber Certification
My signature below certifies that I have read, understand, and agree to the Prescriber Certification Statement on page 4.

Prescriber Signature X_____ **Date:** _____

(This form cannot be processed without an original signature)

7. (OPTIONAL) PRESCRIPTION FOR XOSPATA QUICK START+® PROGRAM

Complete this additional (optional) prescription for a XOSPATA QUICK START+ Program, which can provide a one-time, 7-day supply of XOSPATA, at no cost, to eligible patients who experience a delay in insurance coverage. The shipment will be made to the address designated in Section 1.

Patient Name: _____ Date of Birth: _____
Product Name: XOSPATA® (gilteritinib) 40 mg tablets
Instructions: Take _____ 40 mg tablets per _____ for _____ days
Dispense: 7-day supply Refills: 0

Prescriber Signature X _____ Date: _____

PLEASE CLICK HERE FOR FULL PRESCRIBING INFORMATION, INCLUDING BOXED WARNING.

XOSPATA® gilteritinib 40mg tablets SUPPORT SOLUTIONS℠

SUPPORT

Astellas ("Company") has developed an integrated approach of customized access and reimbursement support to help patients minimize potential barriers to accessing XOSPATA (hereinafter referred to as "XOSPATA Support Solutions" or "Support"). This Support is designed to help healthcare providers and patients evaluate a patient's coverage and reimbursement options for XOSPATA. The patient and prescriber signatures in Sections 4 and 6 authorize the Service Providers (defined in the Patient Authorization Statement) to perform any or all of the following, if necessary, to assist with patient access to XOSPATA:

- Perform benefits verification/prior authorization (PA), if PA is required by payor
- Assist with benefits appeal
- Make referral to Specialty Pharmacy
- Make referral to other independent programs or alternate sources that may be available to provide patient with assistance as allowed under the law
- Determine eligibility for the free drug program through the Astellas Patient Assistance Program
- Provide additional support

Perform benefits verification/prior authorization (PA), if PA is required by payor – A benefits verification allows a Service Provider to call a patient's insurance plan to investigate specific coverage for XOSPATA. During the call, a Service Provider may inquire about patient eligibility for benefits, coverage restrictions, deductible, copayment or coinsurance, benefit maximum amounts, and any other payor requirements. A Service Provider may provide the healthcare provider with a summary of the benefits verification research.

If a PA is required, a Service Provider will use reasonable efforts to provide the healthcare provider information on what to submit to the payor, the submission process, and an estimation of how long it will take the payor to make a determination.

Assist with Benefits Appeal – If a payor denies coverage for XOSPATA, Service Providers may assist the healthcare provider with appealing the payor decision. This means that a Service Provider may use reasonable efforts to provide the healthcare provider and/or the pharmacy provider information on what to submit to the payor, the submission process, and an estimation of how long it will take the payor to make a determination.

Make referral to Specialty Pharmacy – This service allows Service Providers to call a patient's insurance plan to confirm in-network specialty pharmacy options and forward the prescription directly to the appropriate pharmacy. If applicable, Service Providers will provide the healthcare provider a summary of the prescription referral to such Specialty Pharmacy or third party.

Make referral – A Service Provider may refer patients to other independent programs or alternate sources that may be available to provide patient with assistance as allowed under the law.

Determine eligibility for the free drug program through the Astellas Patient Assistance Program – The Astellas Patient Assistance Program was established to provide certain Astellas medications, at no cost, to eligible uninsured patients. A Service Provider may obtain information from patients, such as insurance status and income in order to determine eligibility. If a patient is approved, a Service Provider will notify both the healthcare provider and patient and ship the XOSPATA prescription to the patient.

Provide additional support – The Service Providers and the Company may provide educational and other information on XOSPATA via mail, email, phone, or other methods of communication. This may include helping to connect patients to third-party organizations that may be able to provide additional support.

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PATIENT AUTHORIZATION STATEMENT

My signature on the front of this form authorizes my doctor(s), my healthcare providers, my health plan or payor, and my pharmacy to disclose to Astellas ("Company") and its third-party suppliers, vendors, and other service providers supporting XOSPATA Support Solutions (collectively, the "Service Providers") information about me (for example, my name, Social Security number, address, insurance policy number and income) and my medical condition (for example, my diagnosis or medications) (together, "Personally Identifiable Information"). This 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 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 Astellas. The Service Providers will use and give out my 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 with my payor; (iv) coordinate prescription fulfillment; (v) assess my eligibility for patient assistance and/or benefits, if necessary; (vi) make referrals to other independent programs, or alternate sources that may be available to provide assistance to me as allowed under the law, if necessary; and (vii) assist with analyses of the efficiencies and performance of Services provided by Service Providers. In some instances the Service Providers may de-identify my information and use or disclose the de-identified information (in individual or aggregated form) for any legitimate business purposes. I understand that the Service Providers will make reasonable efforts to keep my information private; however, I understand that once my information has been disclosed to the Service Providers, how the Service Providers further disclose my information may no longer be protected under federal and state privacy laws.

This authorization will last for three (3) years from the date on page 1 or until I am no longer receiving XOSPATA or enrolled in XOSPATA Support Solutions, whichever is later. I do not have to sign this authorization, but if I do not, 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. My choice as to whether to sign this form will not change the way my doctors, healthcare providers, or payors treat me. If I no longer wish to participate in XOSPATA Support Solutions, I shall inform my healthcare providers and/or the administrators of XOSPATA Support Solutions in writing that I do not want them to share any more information with the Service Providers, but it will not change any actions that took place before I told them. I have the right to revoke or cancel

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PATIENT AUTHORIZATION STATEMENT (cont.)

this authorization, in writing, at any time by providing written notice to my healthcare providers and/or the administrators of XOSPATA Support Solutions. 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 know I have a right to see or copy the information my healthcare providers or payors have given to the Service Providers.

If an application is submitted to determine my eligibility for assistance from the Astellas Patient Assistance Program (PAP), I agree to allow Company and Service Providers to use my demographic information, including but not limited to 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 PAP. Company and Service Providers reserve the right to ask for additional documents and information at any time. 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.

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.

PRESCRIBER CERTIFICATION STATEMENT

By signing on page 1, 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) tablets is medically appropriate and I have explained such to my patient. 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 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 his or her 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. 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.

If my patient obtains XOSPATA via the Astellas Patient Assistance Program I understand that (a) no third party or patient can be charged for XOSPATA provided under such program and (b) that no free product should be sold, traded, or distributed for sale. I also understand that provision of free drug as part of the Astellas Patient Assistance Program is not contingent upon future purchase or prescribing of XOSPATA.

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

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