YOU&i™ Support Program

imbruvica® (ibrutinib)
560, 420, 280, 140 mg tablets | 140, 70 mg capsules

Getting Started With the YOU&i™ Support Program

When you sign up for support, a YOU&i™ Support Program team member will:

- Call you to help you understand your insurance coverage
- Help you find affordability support options
- Connect you with educational resources about your disease you can receive over time

Follow these steps to enroll in the YOU&i™ Support Program and access its ongoing educational resources and affordability support options. This form has sections for both the patient and prescriber to complete. Both sections must be complete for the patient to enroll in the YOU&i™ Support Program.

Patient Instructions

Select support options

Choose to enroll in access and affordability support, nurse call support, or both options*

Sign to give consent

Read the consent form and legal information on page 4 to release your personal information and receive

- Benefits investigation and appeals support
- Prior authorization support
- Information about affordability support options, including the Instant Savings Program if appropriate

Provide personal and insurance information

- Include your preferred method of contact
- Give all insurance and prescription cards to your prescriber

*You may opt out of the YOU&i™ Support Program at any time by contacting 877-877-3536.

Prescriber Instructions

Discuss the YOU&i™ Support Program with your patient

Describe access and affordability support options and nurse call support

Fill out personal and practice information

Include state license and NPI numbers

Indicate prescription information and optional specialty pharmacy triage

- Indicate ICD-10 diagnosis code and select the dose
- Select your preferred distribution method

Sign to indicate medical necessity

Review IMBRUVICA® prescribing information and sign to authorize prescription

Fax completed form to the YOU&i™ Support Program: 800-752-5896

Be sure to send patient page, prescriber page, copies of patient's insurance and prescription cards, and dose selection. Prescription is only valid if received by fax.

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YOU&i™ Patient Enrollment Form

Toll-free line: 877-877-3536 (Option 1 on menu), Monday-Friday, 8:00 am-8:00 pm & Saturday, 8:00 am-5:00 pm ET | **Fax:** 800-752-5896
Address: 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067 | www.youandisupport.com

About this form: Use this form to enroll in the YOU&i™ Support Program. Once completed and signed, your prescriber will fax the form to 800-752-5896. You may need to provide additional information depending on the type of support you request.

Patient Section: To be completed by the patient.

Select Your Support: Check the boxes below to select your support options.

☐ **Access and Affordability Support Options** include benefits investigations, prior authorization support, appeals support, Instant Savings Program (commercial insurance only), and other options as applicable.

☐ **YOU&i™ Nurse Support and Educational Communications** include a call center staffed by nurses who can provide educational information about your disease and treatment with IMBRUVICA® (ibrutinib). This option also offers additional communications, including occasional emails with helpful information and resources.

Patient Consent: Read the consent form on page 4 and sign below.

SIGN HERE Patient Signature: _____ Date: _____

SIGN HERE Guardian Signature (if applicable): _____ Date: _____

Patient Information: Fill out your information and choose your preferred contact method.

First, Middle, Last Name: _____

Gender: ☐ Female ☐ Male DOB (MM/DD/YYYY): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: ( ) _____ ☐ Home ☐ Work ☐ Mobile

Secondary Phone: ( ) _____ ☐ Home ☐ Work ☐ Mobile

Preferred Method of Contact: ☐ Home ☐ Work ☐ Mobile ☐ Text ☐ Email

Best Time to Contact: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ AM ☐ PM

Preferred Language: _____

Email Address: _____

Caregiver's Name (First and Last): _____

Caregiver's Relationship to Patient: _____ Caregiver Phone: ( ) _____

Insurance Information: Provide your PRESCRIPTION and MEDICAL cards to your prescriber so they can fax copies with your form.

REMEMBER

☐ I do not have health insurance, or I do not have prescription coverage

Prescription Card Information

Prescription Card Name: _____ Prescription Card Phone: _____

Primary Cardholder Name: _____ Primary Cardholder DOB (MM/DD/YYYY): _____

Relationship to Patient (write "self" if you are the cardholder): _____

Member ID: _____ RxBIN#: _____ RxPCN#: _____ RxGRP#: _____

Primary Insurance Information

Insurance Name: _____ Insurance Phone: _____

Primary Cardholder Name: _____ Primary Cardholder DOB (MM/DD/YYYY): _____

Relationship to Patient (write "self" if you are the cardholder): _____

Cardholder Employer Name: _____ Member ID: _____ Group ID: _____

Secondary Insurance Information

Insurance Name: _____ Insurance Phone: _____

Primary Cardholder Name: _____ Primary Cardholder DOB (MM/DD/YYYY): _____

Relationship to Patient (write "self" if you are the cardholder): _____

Cardholder Employer Name: _____ Member ID: _____ Group ID: _____

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About this form: Discuss the YOU&i™ Support Program with your patient. Use this form to enroll your patient in the YOU&i™ Support Program. Once completed and signed, fax the form to 800-752-5896.

Rx Prescriber Section: To be completed by the prescriber.

Prescriber Information: Fill out your information, including your state license and NPI numbers.

First and Last Name: _____
Practice/Facility Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Office Phone: ( ) _____ Fax: ( ) _____
Office Email: _____
Office Contact Name/Title: _____
Office Contact Phone: ( ) _____
State License #: _____ NPI #: _____

The prescriber is to comply with state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

☐ Prescriber's office has made copies of the front and back of the patient's **primary, secondary, and supplemental medical and prescription cards and will fax them with this enrollment form.**

Prescription Information: Indicate the ICD-10 diagnosis code and select the dose. Select your preferred distribution method.

☐ Specialty Pharmacy Triage (if using IODP, do not check): I agree that this form, including my prescription decision and SP preference, can be sent to the SP indicated below.

Patient Name _____ Patient DOB (MM/DD/YYYY): _____

ICD-10 Diagnosis Code: _____

☐ IMBRUVICA® (ibrutinib) 560-mg tablet	☐ IMBRUVICA® (ibrutinib) 280-mg tablet	☐ IMBRUVICA® (ibrutinib) 140-mg capsule
☐ IMBRUVICA® (ibrutinib) 420-mg tablet	☐ IMBRUVICA® (ibrutinib) 140-mg tablet	☐ IMBRUVICA® (ibrutinib) 70-mg capsule

Directions: _____ | **Quantity:** _____ | **Refills:** _____

☐ On-site dispensing pharmacy _____
☐ Avella Specialty Pharmacy ☐ Biologics ☐ Diplomat Specialty Pharmacy ☐ Onco360 ☐ No Preference

As the treating physician, I have discussed preference for a Specialty Pharmacy (SP) with this patient. This patient prefers use of the SP indicated. I authorize Pharmacyclics LLC and Janssen Biotech, Inc., and its representatives to fax this prescription to:

1. The SP designated as checked above.
2. If designated SP is not plan-approved, the completed prescription will be sent to a plan-approved SP.

If you have questions about the in-network SP(s) for your patients, please contact the YOU&i™ Support Program at 877-877-3536.

Prescriber Signature: Sign below. Remember, the prescription is only valid if received by fax.

I certify that IMBRUVICA® therapy is medically necessary for this patient. I have reviewed the current IMBRUVICA® prescribing information.

SIGN HERE
Prescriber Signature: _____ Date: _____

(Dispense as Written)

Supervising Physician's Name (if applicable): _____ Date: _____

Special Note: Prescribers in all states must follow applicable law for a valid prescription. For prescribers in states with official prescription form requirements, such as NY state, please submit your prescription on an official state prescription, along with this form.

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Healthcare Provider Consent

By providing your information and information about your patient on the front of the YOU&i™ Support Program Enrollment Form, you are requesting the services described on this form. The information you provide will only be used by Pharmacyclics LLC and Janssen Biotech, Inc., our affiliates, and our service providers involved in delivering these services. You may withdraw your request for these services by calling 877-877-3536. Our Privacy Policy, available at www.pharmacyclics.com/privacy-policy, governs the use of the information you provide. By providing the information and submitting this form, you indicate you read, understand, and agree to these terms.

Patient insurance benefit investigation is provided as a service by the support services administrator under contract for Pharmacyclics LLC and Janssen Biotech, Inc. In this regard, the support services administrator assists healthcare professionals and patients with determining whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer and patient information provided by the healthcare provider under appropriate authorization following the provider's exclusive determination of medical necessity.

Importantly, insurance verification is the ultimate responsibility of the provider. Third-party reimbursement is affected by many factors. Therefore, the support services administrator and Pharmacyclics LLC and Janssen Biotech, Inc. make no representation or guarantee that full or partial insurance reimbursement or any other payment will be available. This information is provided as an information service only. While the support services administrator tries to provide correct information, it and Pharmacyclics LLC and Janssen Biotech, Inc. make no representations or warranties, expressed or implied, as to the accuracy of the information. In no event shall the support services administrator, or Pharmacyclics LLC and Janssen Biotech, Inc. or its employees or agents be liable for any damages resulting from or relating to the services. All providers and other users of this information agree that they accept responsibility for the use of this service.

Pharmacyclics LLC and Janssen Biotech, Inc. assume no responsibility for, and do not guarantee, the quality, scope, or availability of the services including, but not limited to, information related to access and affordability support options and the nurse call support program. Each provider, not Pharmacyclics LLC and Janssen Biotech, Inc., is responsible for the services they provide. These support services have no independent value to providers apart from the product and are included within the cost of the product.

Before prescribing IMBRUVICA® (ibrutinib), please see full Prescribing Information available at www.imbruvica.com.

Patient Copy: Patients, keep this page for your records.

PATIENT AUTHORIZATION for the YOU&i™ Support Program brought to you by Pharmacyclics LLC and Janssen Biotech, Inc.

By signing the YOU&i™ Support Program Enrollment Form, I authorize each of my providers, pharmacies, and insurers (together, "Healthcare Companies") to disclose my protected health information ("Health Information").

Health Information includes, but is not limited to

- My medical records and treatment
- My health insurance coverage, insurance plan, and/or group numbers
- My name, address, and telephone number

I authorize disclosure of my Health Information to Pharmacyclics LLC and Janssen Biotech, Inc. and its affiliates and agents (together, "Pharmacyclics LLC and Janssen Biotech, Inc.") for the following purposes:

Specifically, I authorize Pharmacyclics LLC and Janssen Biotech, Inc. to receive, use, and disclose my Health Information for the following purposes:

- To enroll me in the YOU&i™ Support Program and contact me (and/or other parties I have authorized)
- To provide me (and/or other parties I have authorized) with educational materials, nursing educational calls (if selected), surveys about my treatment experience with IMBRUVICA® (ibrutinib), and other support related to IMBRUVICA®
- To verify, investigate, assist with, and coordinate my coverage for IMBRUVICA® with my insurers
- To coordinate prescription fulfillment (as requested)
- To assist with analyses related to the quality, efficacy, and safety of IMBRUVICA®

If selected, I give my permission to use my personal information to receive B-cell malignancy disease state information and information about a product approved to treat B-cell malignancies and its support offerings from Pharmacyclics LLC, Janssen Biotech, Inc., and its affiliates, service providers, and co-promotion partners.

I understand that pharmacies may receive direct or indirect compensation from Pharmacyclics LLC and Janssen Biotech, Inc. for the use or disclosure of my personal information to the YOU&i™ Support Program for the purposes stated above.

I understand that once my Health Information has been disclosed to Pharmacyclics LLC and Janssen Biotech, Inc., it will no longer be protected by HIPPA or other privacy laws. However, Pharmacyclics LLC and Janssen Biotech, Inc. agree to protect my Health Information by using and disclosing it only for the purposes described in this authorization or as permitted by law. My choice about whether to sign will not change the way I am treated by my Healthcare Companies.

I understand that if I do not sign this Enrollment Form, or cancel my authorization later, I will not be able to participate or receive assistance from the YOU&i™ Support Program. This authorization expires 3 years from the date indicated on the Patient Authorization section, unless I cancel it sooner by calling 1-877-877-3536, going to www.imbruvica.com/unsubscribe, or mailing a request to 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067.

I understand that cancelling this authorization will end further uses and disclosures of my information but will not affect any use of my information that occurred before my request was processed. I am entitled to receive a copy of this authorization.

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