YOU&i™ Dose Exchange

Prescription and Enrollment Form for IMBRUVICA® (ibrutinib)

Please complete, sign, and fax this form to 1-800-752-5896

Healthcare Provider

There may be times when you need to reduce your patient's dose because they have experienced an adverse reaction or are taking certain concomitant medications. The YOU&i™ Dose Exchange Program is available to facilitate this dose reduction if you decide to adjust your patient's dose before they have finished their current pack of IMBRUVICA®.Your patient may qualify for the YOU&i™ Dose Exchange Program if your patient meets each of the requirements in the Program Eligibility section below. Please complete this form, sign it, and fax it back to the YOU&i™ Dose Exchange Program.

Please note that the YOU&i™ Dose Exchange Program is facilitated by the YOU&i™ Dose Exchange Program pharmacy and not by the specialty or in-office dispensing pharmacy to which the patient's previous prescription was submitted.

For ongoing refills, a new prescription will need to be submitted to the patient's existing specialty or in-office dispensing pharmacy.

Patient Prescription Information

NAME (First, MI, Last)_____ DOB (MM/DD/YYYY)_____

PHONE_____ ADDRESS_____

Dose Exchange Prescription (Current Strength)

Rx:
- ☐ **IMBRUVICA® (ibrutinib) 560 mg tablet**
- ☐ **IMBRUVICA® (ibrutinib) 420 mg tablet**
- ☐ **IMBRUVICA® (ibrutinib) 280 mg tablet**
- ☐ **IMBRUVICA® (ibrutinib) 140 mg tablet**

New Strength

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

DIRECTIONS: 1 pill taken PO once daily

QTY: _____ pills remaining to be exchanged (not to exceed 28 pills)

DIAGNOSIS CODE: _____

Prescriber's Signature X _____ DATE _____

Prescriber Information

PRESCRIBER'S NAME (First, Last)_____ SPECIALTY_____

PRACTICE NAME_____ OFFICE CONTACT_____

STREET ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONE_____ FAX _____ NPI#_____

Program Eligibility

To be eligible for participation in the YOU&i™ Dose Exchange Program, patients

1. Must have remaining pills from a current prescription for an FDA-approved indication for IMBRUVICA®.
2. Must return their remaining pills. Instructions for return will be provided with a pre-addressed envelope for the patient to return the unused quantity of previous strength.

Below are Required Terms and Conditions for the Program

- YOU&i™ Dose Exchange Program is available to a given patient for up to two (2) separate dose reductions. The quantity to be exchanged should not exceed 28 pills per exchange.
- Neither Prescriber, Prescriber's institution, Pharmacy, Pharmacist, or any other person, including the patient, may seek payment or accept reimbursement from any patient, any third-party payer, including any state or federal entity or any private or other insurance plan, or from any other person or entity, for IMBRUVICA® supplied under this Program, regardless of whether the payer subsequently determines it will cover the product.
- With respect to product provided to Medicare Part D patients pursuant to the Program, Pharmacy must notify such patients' Part D plans that product is being provided to these patients outside the Part D benefit, and that no part of the costs of the drug provided as part of the Program shall be counted towards any Part D patient's out-of-pocket costs, and no claim will be filed with a Part D plan or by a Part D patient for such drug. As a condition of this Program, the applicable pharmacist will provide an appropriate notification to the patient's Part D plan. Notification will be provided as a payment-related use and disclosure pursuant to the Health Insurance Portability and Accountability Act and state privacy laws.
- Product provided pursuant to this Program may not be sold, traded or distributed for sale.
- In my medical judgment, the new strength of IMBRUVICA® is clinically appropriate for the patient named above and its use is consistent with the FDA-approved indication. This supply of IMBRUVICA® is specifically for the patient named above. Patient must be a resident of the United States or Puerto Rico.
- I have explained to my patient that he or she must return the unused drug according to the instructions provided by the YOU&i™ Dose Exchange Program.

Prescriber: I certify that I understand and agree to comply with all of my obligations as they relate to the above referenced Program Eligibility and Terms and Conditions.

Prescriber's Signature X _____ DATE_____

Pharmacist: I certify that I understand and agree to comply with all of my obligations as they relate to the above referenced Program Eligibility and Terms and Conditions stated herein. In addition, I certify that I have read the required Program Eligibility and Terms and Conditions of this Program to the patient and received confirmation from the patient that he/she understands and will comply with the Terms and Conditions.

YOU&i™ Pharmacist's Signature X _____ DATE_____

For assistance or additional information, call 1-877-877-3536, Monday-Friday, 8:00AM-8:00PM ET.

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