



# Prescription Information, and ZytigaOne™ Support Enrollment Form

Please complete and fax this form to 1-(855) 998-4422 or mail to 105 Mall Boulevard, Monroeville, PA 15146-2230.

## Patient Information (Complete caregiver information only if you authorize or prefer that caregiver(s) be contacted in place of you—see Patient Authorization section below)

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

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ E-MAIL \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ BEST TIME TO CONTACT \_\_\_\_\_

CAREGIVER/CONTACT #1 \_\_\_\_\_ PHONE (home) \_\_\_\_\_ (cell) \_\_\_\_\_ BEST TIME TO CONTACT \_\_\_\_\_

CAREGIVER/CONTACT #2 \_\_\_\_\_ PHONE (home) \_\_\_\_\_ (cell) \_\_\_\_\_ BEST TIME TO CONTACT \_\_\_\_\_

(A caregiver/contact is someone who can be contacted in place of the patient)

## Insurance Information (Complete this section or provide a copy of insurance card)

PRIMARY INSURANCE _____	SECONDARY INSURANCE _____
CARDHOLDER _____	CARDHOLDER _____
RELATIONSHIP TO CARDHOLDER _____	RELATIONSHIP TO CARDHOLDER _____
EMPLOYER _____ INS. CO. PHONE _____	EMPLOYER _____ INS. CO. PHONE _____
POLICY# _____	POLICY# _____
GROUP# _____	GROUP# _____

PRESCRIPTION DRUG INSURER \_\_\_\_\_ CARD/BIN# \_\_\_\_\_ PHONE \_\_\_\_\_

(Please include alpha prefix and suffix with policy and group# when applicable)

## Patient Authorization for ZytigaOne™ Support Services (To be completed only when there is not a valid Business Associate Agreement with the Covered Entity. Patient should read the Patient Authorization on the Patient Copy and sign below)

My signature below certifies that I have read, understand, and agree to the Patient Authorization to release my protected health information to Janssen Biotech, Inc. and companies working on their behalf, including vendors, other affiliates, specialty pharmacies, and other service providers supporting ZytigaOne™ Support as defined on the Patient Copy (collectively, "Janssen Biotech").

I would be interested in receiving additional information about enrolling in ZytigaOne™ Support Extended Services. **Yes No**

I authorize ZytigaOne™ Support to leave a message, including the prescription name ZYTIGA®, if I am unavailable when they call. **Yes No**

If I cannot be reached, I authorize ZytigaOne™ Support to contact my caregiver(s). I prefer and authorize ZytigaOne™ Support to contact my caregiver(s) in place of me.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ PATIENT NAME \_\_\_\_\_

If patient cannot sign, patient's legally authorized representative must sign below.

PATIENT NAME \_\_\_\_\_ BY \_\_\_\_\_

Signature of person legally authorized to sign for patient

NAME OF PERSON LEGALLY AUTHORIZED TO SIGN \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

## Prescriber Information

PRESCRIBER NAME (First, Last) \_\_\_\_\_ SPECIALTY \_\_\_\_\_

PRACTICE NAME \_\_\_\_\_ OFFICE CONTACT \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

E-MAIL \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_

MEDICAID/MEDICARE PROVIDER# \_\_\_\_\_ TAX ID# \_\_\_\_\_

STATE LICENSE# \_\_\_\_\_ UPIN/NPI# \_\_\_\_\_

## Clinical Information

DIAGNOSIS 185.00 Malignant neoplasm of prostate COMMENT/OTHER \_\_\_\_\_ DATE OF DIAGNOSIS OR YEARS WITH DISEASE \_\_\_\_\_

## Prior Authorization—If you would like ZytigaOne™ Support to provide support for the prior authorization process, please check the appropriate box(es):

**Prior Authorization Form Preparation**

By checking this box, I request that ZytigaOne™ Support assist my office in addressing the requirements of this patient's health plan related to prior authorization for treatment with ZYTIGA®. I understand that assistance includes obtaining the health plan-specific prior authorization form, and completing it based upon the patient-specific information provided on this form. I understand that the partially completed prior authorization form will be provided to my office by ZytigaOne™ Support for possible submission to the health plan.

**Prior Authorization Status Monitoring**

By checking this box, I request that ZytigaOne™ Support actively monitor the status of the prior authorization submission. I request that ZytigaOne™ Support provide status updates to my office with respect to this patient's prior authorization for treatment with ZYTIGA®.

## Prescription Information (If requesting benefits investigation only, do not complete this section)

**Initial Dosing\***

Rx **ZYTIGA® (abiraterone acetate) 250-mg tablets**

**DIRECTIONS:** Take 1,000 mg PO QD on an empty stomach. **QUANTITY:** \_\_\_\_\_ **REFILLS #** \_\_\_\_\_

\*For patients with baseline moderate hepatic impairment (Child-Pugh Class B), reduce the ZYTIGA® starting dose to 250 mg once daily. Avoid ZYTIGA® in women who are or may become pregnant and patients with baseline severe hepatic impairment (Child-Pugh Class C). Refer to the ZYTIGA® (abiraterone acetate) full PRESCRIBING INFORMATION, including the following sections: INDICATIONS AND USAGE, CONTRAINDICATIONS, DOSAGE AND ADMINISTRATION, WARNINGS AND PRECAUTIONS, ADVERSE REACTIONS, DRUG INTERACTIONS, and USE IN SPECIFIC POPULATIONS prior to initiating treatment.

NAME (if different than above) \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

**PRESCRIBER SIGNATURE REQUIRED. I certify that therapy with ZYTIGA® (abiraterone acetate) is medically necessary for this patient. I will be supervising the patient's treatment accordingly and I have reviewed the current ZYTIGA® Prescribing Information.**

PRESCRIBER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SUPERVISING PHYSICIAN NAME (if applicable) \_\_\_\_\_

For assistance or additional information, call 1-855-ZYTIGA-1 (998-4421), Monday–Friday, 8:00AM–8:00PM ET

Patient insurance benefit investigation is provided as a service by the support services administrator under contract for Janssen Biotech. In this regard, the support services administrator assists healthcare professionals in the determination of 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 Janssen Biotech 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 Janssen Biotech make no representations or warranties, expressed or implied, as to the accuracy of the information. In no event shall the support services administrator, or Janssen Biotech 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.

Janssen Biotech assumes no responsibility for, and does not guarantee, the quality, scope, or availability of the services including but not limited to reimbursement support services, patient education, and other support services. Each provider, not Janssen Biotech, 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 ZYTIGA® (abiraterone acetate), please see full Prescribing Information available at [www.zytiga.com](http://www.zytiga.com).**

## Patient Copy

### **Provider Instructions**

- 1. Have the patient read this form and sign the acknowledgement on the front of the Prescription Information, and ZytigaOne™ Support Enrollment Form relating to the Patient Authorization and ZytigaOne™ Support Extended Services Enrollment Information.**
- 2. Provide the patient with this sheet and a copy of the front of the Prescription Information, and ZytigaOne™ Support Enrollment Form which they have signed.**

## **PATIENT AUTHORIZATION (PA)**

My signature on the front of the Prescription Information, and ZytigaOne™ Support Enrollment Form confirms that I authorize each of my physicians, pharmacists, including any specialty pharmacy which receives my prescription for ZYTIGA® (abiraterone acetate) and other healthcare providers (together “Healthcare Providers”) and each of my health insurers (together, “Insurers”) to disclose my protected health information, including but not limited to medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and/or group numbers (together, “Protected Health Information”) to Janssen Biotech, Inc. its affiliated companies, agents and representatives, including providers of alternate sources of funding for prescription drug costs, and other service providers supporting access programs for Healthcare Providers and patients (ZytigaOne™ Support) (together “Janssen Biotech”) for the purposes described below.

Specifically, I authorize Janssen Biotech to receive, use, and disclose my Protected Health Information in order to (i) enroll me in, and contact me and/or the personal legally authorized to sign on my behalf, or the caregiver(s) I have authorized to be contacted on my behalf by checking the box(es) in the Patient Authorization section on the front of this form about ZytigaOne™ Support programs; (ii) provide me and/or the person legally authorized to sign on my behalf, or the caregiver(s) I have authorized on my behalf by checking the box(es) in the Patient Authorization section on the front of this form with educational materials, information, and services related to ZYTIGA®; (iii) verify, investigate, assist with, and coordinate my coverage for ZYTIGA® with my Insurers; (iv) coordinate prescription fulfillment; and (v) assist with analyses related to the quality, efficacy, and safety of ZYTIGA®. Furthermore, I understand that my Protected Health Information will not be used or disclosed by Janssen Biotech for any other purpose unless permitted by law or unless information that specifically identifies me is removed. I understand that Janssen Biotech will make every effort to keep my information private. If my information is accidentally shared, federal privacy laws do not require that the person/party receiving it not disclose the information further. Information disclosed under these circumstances and provided to a third party may no longer be protected by federal privacy laws. I understand that I am not required to sign the front of the Prescription Information, and ZytigaOne™ Support Enrollment Form. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me. If I refuse to sign the front of the Prescription Information, and ZytigaOne™ Support Enrollment Form, or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from ZytigaOne™ Support.

I understand that I may cancel (revoke) this Authorization at any time by mailing a letter to ZytigaOne™ Support, c/o TheraCom, LLC, 105 Mall Boulevard, Monroeville, PA, 15146-2230. I can also revoke my authorization by informing my Healthcare Providers and Insurers in writing that I do not want them to share any information with Janssen Biotech, but this will not affect Janssen Biotech’s ability to use and disclose Protected Health Information that it has received prior to its receipt of notification that I wish to discontinue my participation in the program. My authorization will also end if ZytigaOne™ Support is discontinued. Furthermore, I understand that I have the right to see or copy the Protected Health Information my Healthcare Providers or Insurers have given to Janssen Biotech.

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## **ZytigaOne™ Support EXTENDED SERVICES ENROLLMENT INFORMATION**

By checking the appropriate box and signing the front of the Prescription Information, and ZytigaOne™ Support Enrollment Form, I agree to allow ZytigaOne™ Support to provide me or the caregiver(s) I have authorized on my behalf with information about ZytigaOne™ Support Extended Services enrollment. ZytigaOne™ Support can provide the extended services that I may choose related to my use of ZYTIGA®.

To support the extended services that you may select to receive if you enroll, your name, address, and other information that you give us will be used by Janssen Biotech, Inc. the marketer of ZYTIGA®, and companies that work with Janssen Biotech, including vendors and other affiliates, to support the Program. We will also use the information you give us to learn more about the patients who use ZYTIGA® and to improve the information we provide to patients who are being treated with ZYTIGA®. Janssen Biotech will not share your information with anyone else except as stated above and as required by law. If you want to stop receiving this information from Janssen Biotech, you may ask us to remove you from our contact list by calling 1-855-ZYTIGA-1 (998-4421).

**Please read the accompanying Important Product Information for ZYTIGA® and discuss any questions you have with your doctor.**

**Janssen Biotech, Inc.**