JazzCares®
Making a difference in Patients' lives, one Patient at a time

RYLAZE®
asparaginase erwinia chrysanthemi (recombinant)-rywn for injection 10mg/0.5mL per vial

JazzCares® Enrollment Form

*Indicates required field.

Steps for Enrolling in JazzCares

STEP 1: Prescriber completes the Enrollment Form (Sections 1-7) and signs the Prescriber Certification.

STEP 2: Patient provides a copy of the front and back of insurance card.

STEP 3: **Confirm that all sections are complete!**

STEP 4: Prescriber can fax the signed forms, with copies of the cards mentioned above, to 1-855-593-3955 OR mail to JazzCares Program, PO Box 5490, Louisville, KY 40255 **OR** **complete the enrollment electronically through jazzcares.com/hcp/rylaze**.

STEP 5: Patient reads Patient Authorization Form. Patient may sign and date the Patient Authorization Form (see last page) or may complete the authorization electronically through **jazzcares.com/rylaze**.

Is Your Patient Eligible for the JazzCares Patient Assistance Program?[a]

PRESCRIPTION	Patient has a valid prescription for RYLAZE, from a prescriber licensed in the United States. The prescription is for the treatment of acute lymphoblastic leukemia (ALL) and lymphoblastic lymphoma (LBL) in adult and pediatric patients 1 month or older who have developed hypersensitivity to *E. coli*-derived asparaginase.
RESIDENCY	Patient is a legal US resident (includes Puerto Rico and the US Virgin Islands).
INSURANCE	Patient has either (a) no insurance coverage or (b) while insured, he/she is deemed uninsured due to lack of coverage for RYLAZE.
INCOME	Patient's total household gross income is less than 400% of the Federal Poverty Level as defined by the US Department of Health and Human Services Proof of income required from one or more of the sources listed below: • Copy of patient's most current Federal Income Tax Form(s) for all earners in patient's household • W2 statements for all earners in patient's household • Yearly benefits statement (SSA, 1099) • One month of pay stubs • Three months of bank statements showing income deposited and source • Unemployment letter or worker's compensation statements • Veteran's benefits, alimony/child support, or rental income • Employer letter on company letterhead • If your patient has zero income, they can provide a letter from patient's family, person they are living with, or clergy, explaining how they are supported with no income. Patient can also submit a letter on facility letterhead from a social worker or prescriber explaining their situation

There is no guarantee of approval. Jazz Pharmaceuticals reserves the right to terminate or modify this program at any time with or without notice. Other terms and conditions apply.

[a]Provides Jazz products at no cost to patients who meet the eligibility requirements and are uninsured or deemed uninsured due to lack of coverage.

Visit jazzcares.com/hcp/rylaze to enroll your patient online.

Call JazzCares toll free at 1-833-533-5299, Monday-Friday, 8 AM to 8 PM ET.

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Section 1: Patient Information

*First Name | MI *(if applicable)* | *Last Name

Social Security # (SSN)
(If you do not have an SSN, please provide another form of ID [ie, Green Card or work visa number].)

*Date of Birth

*Gender: ☐ Male ☐ Female ☐ Prefer Not to Say

*Address | Apartment/Suite #

*City | *State | *ZIP

Email | *Home Phone | *Cell Phone

Language: ☐ English ☐ Spanish ☐ Other

*Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

Section 2: Financial Information *(Required to determine patient assistance program eligibility)*

*Total Annual Household Income of All Earners in Your Household $
(including SSI, pension income, etc.)

*Total Number of People Living in Your Household

*Are You a Legal Resident of the United States? ☐ Yes ☐ No
(includes Puerto Rico and US Virgin Islands)

*Do You Have Private Medical Insurance? ☐ Yes ☐ No

*Do You Have Government Medical Insurance? ☐ Yes ☐ No
(includes Medicare B/D, Medicaid, Veterans Administration, State, or another government-sponsored program)

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*Indicates required field.

Section 3: Insurance Information

Please include copy of front and back of patient's insurance card(s).

PRIMARY INSURER

*Insurer Name | Insurer Phone Number | *Policy ID Number

Group Number | Subscriber's Name *(if not self)* | Employer

SECONDARY INSURER

Insurer Name | Insurer Phone Number | Policy ID Number

Group Number | Subscriber's Name *(if not self)* | Employer

Section 4: Prescriber Information

To be completed by the prescriber.

*Prescriber Name | Specialty

Practice Name | Office Contact Name

*NPI Number | State Medical License Number | Tax ID Number | PTAN *(required for Medicare patients)*

*Address | Apartment/Suite #

*City | *State | *ZIP

Email | *Phone | *Fax

Setting of Care: ☐ Prescriber's Office ☐ Outpatient Hospital ☐ Other *(explain)*

Are You Contracted With the Patient's Insurance? ☐ Yes ☐ No

Billing Contact Name | Billing Contact Phone Number

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*Indicates required field.

Section 5: Diagnosis and Clinical Information

*Diagnosis *(please indicate ICD-10 Code)*

ICD-10 Description

*Has the Patient Been Diagnosed With ALL or LBL and Developed Hypersensitivity to *E. coli*-derived Asparaginase?
☐ Yes ☐ No

Is the Patient Currently Taking RYLAZE? ☐ Yes ☐ No If Yes, Start Date

Section 6: Treatment Information

Product Requested **RYLAZE** *Dose

*Treatment Date(s)

Other Drug(s) Prescribed With RYLAZE

CPT Code(s)

Section 7: Shipping Information

Check if same as in Section 4 ☐

*Practice Name

Department

*Shipping Address

Corresponding DEA Number

*City

*State

*ZIP

*Phone

Fax

ALL=acute lymphoblastic leukemia; LBL=lymphoblastic lymphoma.

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Prescriber Certification

By signing below, I certify that (a) the above-prescribed therapy is medically necessary and, (b) I have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for the above-prescribed therapy(ies), to Jazz Pharmaceuticals and its affiliates or vendors for the purpose of seeking information related to coverage for the therapy(ies) and/or assisting in initiating or continuing therapy.

*Prescriber's Signature *(no stamps please)*

Date

US-JPC-2400034 Rev1224

Jazz Pharmaceuticals

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Patient Authorization Form

Patient Authorization and Request for Transmission of Personal Information to Jazz Pharmaceuticals, Inc.

Signature is required for participation in Jazz-sponsored patient support programs and activities

*Indicates required field.

*Prescriber Name

Patient/Patient Representative Information

*Patient/Patient Representative Name

*Date of Birth

*Phone Number

Email

I hereby authorize and direct my prescriber(s) and their staff, my health insurer(s) and the specialty pharmacy that will fill my prescription (the "Pharmacy"), to disclose the following information ("Personal Information") to Jazz Pharmaceuticals (including its affiliates and vendors who help provide the services) (together "Jazz Pharmaceuticals" or "Jazz") for any Jazz-sponsored patient support programs and activities, including the JazzCares program:

- Information concerning my treatment with Jazz Pharmaceuticals' products, including relevant diagnoses and prescriptions; and
- Information about my health insurance benefits, including deductibles and out-of-pocket costs.

I understand and authorize Jazz Pharmaceuticals to use and further disclose the Personal Information it receives as a result of this Form for the following purposes:

(i) operating, administering, enrolling me in, and/or continuing my participation in the JazzCares program or any other Jazz-affiliated patient support services and activities related to my condition or treatment;

(ii) verifying, investigating, coordinating, and resolving insurance coverage or reimbursement inquiries and payment for Jazz Pharmaceuticals' products;

(iii) coordinating my receipt of and payment for Jazz Pharmaceuticals' products;

(iv) contacting me about any Jazz-sponsored patient support programs and activities, including the JazzCares program (this may include supplemental educational materials, information, offers and services related to my therapy or my medical condition, or opportunities to participate in focus groups, surveys or interviews);

(v) contacting and providing my Personal Information to patient advocacy organizations, patient assistance programs, co-pay assistance or similar programs to determine eligibility for coverage and enrollment;

(vi) de-identifying my Personal Information by aggregating it for research purposes;

(vii) managing Jazz-sponsored patient support programs and activities, including the JazzCares program, and administrative purposes that support these services and programs.

I understand and authorize Jazz Pharmaceuticals to contact me using the contact information provided to Jazz to enroll me in, operate, and administer any Jazz-sponsored patient support services, including the JazzCares program, through a variety of means including email, postal mail, phone, fax, or SMS/text (which I can separately opt in below) unless I opt out of these communications by contacting Jazz Pharmaceuticals using the contact information below. I understand that the operation and administration of certain of these services and/or programs may require that Jazz contact me by telephone or SMS/text.

I understand Jazz Pharmaceuticals may report back to my prescriber(s) and their staff, my health insurer(s) or the Pharmacy, any Personal Information about me that Jazz Pharmaceuticals may create or receive. I understand that my health insurer(s), Pharmacy, and third party vendor(s) may receive remuneration (payment) in exchange for disclosing my Personal Information to Jazz Pharmaceuticals (including JazzCares, its affiliates, and vendors who help provide the services) and/or for providing me with support services for the purposes described above.

I understand that after my Personal Information is transmitted to Jazz Pharmaceuticals, it may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA). However, Jazz Pharmaceuticals will not disclose my Personal Information to a third party that is not related to the patient support programs (such as a family member or friend) unless I specifically authorize Jazz to do so. If I request that a person or an entity other than Jazz Pharmaceuticals receives my Personal Information, I understand the receiver may not be subject to HIPAA or other privacy laws and the Personal Information might be re-disclosed by the recipient.

I understand that I may refuse to sign this Form and my refusal will not affect the treatment I receive from my prescriber(s) and their staff, my health insurer(s) and the Pharmacy, nor will it affect my enrollment or eligibility for health insurance benefits to which I am otherwise entitled. I also understand that I can revoke this Form at any time in the future, but if I do so, I may no longer be eligible to participate in Jazz-sponsored patient support programs and activities, including the JazzCares program.

I understand that should I revoke this Form, the revocation will not impact uses and disclosures of my Personal Information that have already occurred in reliance on this Form.

This Form will remain valid until termination of enrollment in Jazz-sponsored patient support programs and activities, including the JazzCares program, unless a shorter time is required by state law. I can also revoke it earlier by calling 1-833-533-5299 or sending my request to: Jazz Pharmaceuticals, PO Box 5490, Louisville, KY 40255.

I understand the Program may be changed or ended at any time without prior notification. I understand I may request a copy of this Form that is on file with Jazz.

Further information concerning Jazz Pharmaceuticals' privacy practices can be found at https://www.jazzpharma.com/privacy-statement/. If you are a resident of California, a description of the personal information collected by Jazz Pharmaceuticals and your rights under the California Consumer Privacy Act can also be found on this website: https://www.jazzpharma.com/privacy-statement/supplemental-notice-for-california-consumers/.

I verify the information provided is true and correct. If I am the caregiver for the patient, I confirm I am authorized to sign on behalf of the patient.

Income Validation Consent

I understand and authorize Jazz Pharmaceuticals and its affiliates and vendors to use a third-party financial services company to run an income validation to determine eligibility for patient assistance programs. If discrepancies are found during this validation, JazzCares may request additional supporting income documentation.

☐ If you prefer not to consent to an income validation, please check the box. By opting out of the income validation, you will need to provide proof of income documentation to determine your eligibility for the patient assistance program.

***Patient/Patient Representative Signature** ***Date**

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Jazz Pharmaceuticals

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