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

Steps for Enrolling in JazzCares

STEP 1: Prescriber completes the Enrollment Form (Sections 1-6) 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, 6000 Park Lane, Pittsburgh, PA 15275 **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 (asparaginase erwinia chrysanthemi (recombinant)-rywn) injection, for intramuscular use, from a prescriber licensed in the United States. RYLAZE is indicated as a component of a multi-agent chemotherapeutic regimen 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. Patient will provide proof of income 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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*Indicates required field.

Section 1: Patient Information

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

Social Security # (SSN) *(If patient does 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

Total Number of People Living in Patient's Household

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

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

*Does Patient Have Private Medical Insurance? ☐ Yes ☐ No

*Does Patient Have Government Medical Insurance? ☐ Yes ☐ No

(includes Medicare B/D, Medicaid, Veterans Administration, State, or another government-sponsored program)

Section 2: 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

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Section 3: 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

*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

Section 4: Diagnosis and Clinical Information

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

ICD-10 Description

*Has the Patient Been Diagnosed With Acute Lymphoblastic Leukemia or Lymphoblastic Lymphoma and Developed Hypersensitivity to *E. coli*-derived Asparaginase? ☐ Yes ☐ No

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

Section 5: Treatment Information

Product Requested **RYLAZE** *Dose *Treatment Date(s)

Other Drug(s) Prescribed With RYLAZE

CPT Code(s)

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Section 6: Shipping Information

Check if same as in Section 3 ☐

*Practice Name

Department

*Shipping Address

Corresponding DEA Number

*City

*State

*Zip

*Phone

Fax

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

Jazz Pharmaceuticals

US-ASN-2100013 Rev0721

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