**For a faster and more efficient enrollment process, visit XTANDIaccess.com to enroll online now.**

**Website:** XTANDISupportSolutions.com
**Phone:** 1-855-898-2634
**Fax:** 1-855-982-6341

# XTANDI Support Solutions Enrollment Form

Please complete this form and fax it to XTANDI Support Solutions or to a specialty pharmacy in the authorized XTANDI® (enzalutamide) network.
**Remember to complete the prescription drug information and obtain healthcare provider and patient signatures.**

**Please note: All fields denoted with an asterisk (*) are required fields.**

## PATIENT INFORMATION

| First Name*: | Last Name*: | Date of Birth (MM/DD/YYYY)*: | Sex*: ☐ Male ☐ Female |
|---|---|---|---|
| Home Address*: | | City*: State*: | ZIP*: |
| Primary Phone*: | Alternative Phone: | Email: | |
| Primary Phone Type*: ☐ Cell ☐ Home ☐ Work | Alternative Phone Type: ☐ Cell ☐ Home ☐ Work | Opt-in for: ☐ Educational Materials ☐ Patient Connect Information ☐ Text Updates (See the Patient Authorization for Terms & Conditions) | |
| Permission to contact patient? ☐ Yes ☐ No Best time to contact: Permission to leave detailed voicemail ☐ Yes ☐ No Language (Optional): | | Preferred Language: ☐ English ☐ Spanish ☐ Other: | |

## PATIENT PHARMACY INSURANCE (Optional)

| Policyholder First and Last Name: | | Policyholder Date of Birth (MM/DD/YYYY): | Policyholder Relationship to Patient: |
|---|---|---|---|
| Pharmacy Insurer Name: | Pharmacy Insurer Phone Number: | Pharmacy Insurance Card ID: | |

## ASSESSMENT FOR ASTELLAS PATIENT ASSISTANCE PROGRAM*

Evaluate the patient for the Astellas Patient Assistance Program? ☐ Yes ☐ No

Was the prescription previously sent to a specialty pharmacy? ☐ Yes ☐ No Specialty Pharmacy:

## PATIENT AUTHORIZATION FOR XTANDI SUPPORT SOLUTIONS*

**My signature below certifies that I have read, understand, and agree to the Patient Authorization Statement on page 2.**

Patient Name (please print): ______________________________

Patient/Legal Representative Signature X ______________________________ Date ________

☐ I am signing on behalf of the patient, and I hereby affirm that I have the legal right to do so, that I am the parent or legal guardian of the patient, or that I otherwise have a valid power of attorney to act on behalf of the patient.

Please describe your relationship to the patient: ______________________________

Legal Representative Name: ______________________________

Xtandi (enzalutamide) 40 mg tablets | 80 mg tablets

SUPPORT SOLUTIONS

## PRESCRIBER AND PRACTICE INFORMATION

| Prescriber Name (First and Last*): | Practice Specialty: | Practice Name: |
|---|---|---|
| **Office Contact Name*:** | **Office Contact Phone*:** | **Fax*:** |
| Address*: | City: | |
| State*: | ZIP*: | Prescriber UPIN/NPI*: |

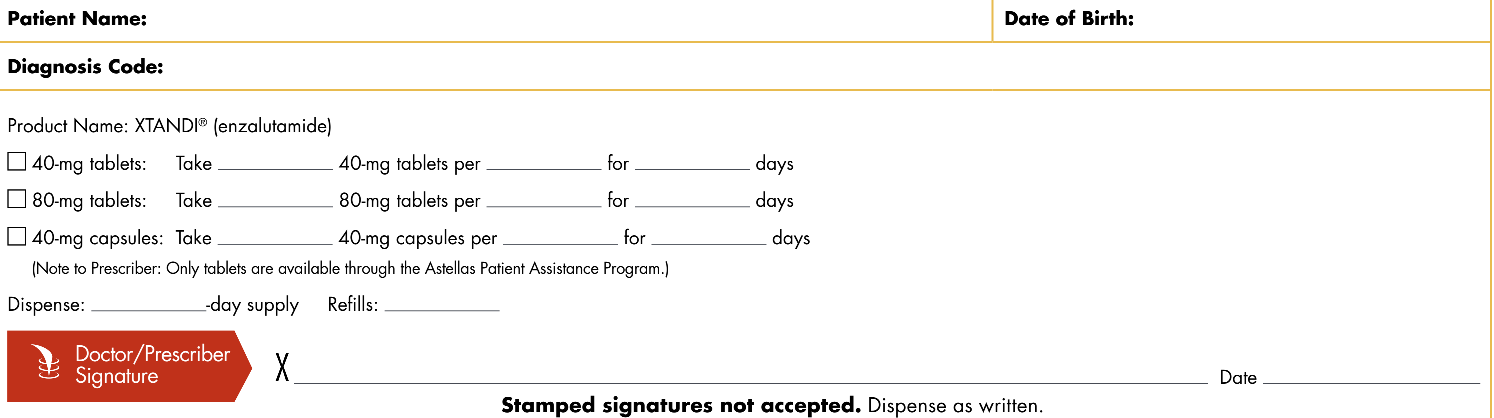
Preferred Specialty Pharmacy: ______________________________

☐ Self-Dispensing Pharmacy (Please check this box if you are a self-dispensing pharmacy)

## PRESCRIPTION FOR XTANDI® (enzalutamide)*

**In order for us to send medication to your patient, the prescription information must be complete and accurate.**

Send the electronic prescription (eRx) to: ARX Patient Solutions Pharmacy, 4500 W. 107th Street, Overland Park, KS 66207 NCPDP: 1720677



| **Patient Name:** | **Date of Birth:** |
|---|---|
| **Diagnosis Code:** | |

Product Name: XTANDI® (enzalutamide)

☐ 40-mg tablets: Take ________ 40-mg tablets per ________ for ________ days

☐ 80-mg tablets: Take ________ 80-mg tablets per ________ for ________ days

☐ 40-mg capsules: Take ________ 40-mg capsules per ________ for ________ days

(Note to Prescriber: Only tablets are available through the Astellas Patient Assistance Program.)

Dispense: ________-day supply Refills: ________

Doctor/Prescriber Signature X ______________________________ Date ____________

**Stamped signatures not accepted.** Dispense as written.

**Prescriber Certification**

**My signature below certifies that I have read, understand, and agree to the Prescriber Certification Statement on page 5.**

Prescriber Signature X ______________________________ Date ____________

**Stamped signatures not accepted.** This form cannot be processed without an original signature.

## PATIENT AUTHORIZATION STATEMENT

My signature on the front of this form authorizes my doctor(s), my healthcare providers, my health plan or payer, and my pharmacy to disclose to Astellas ("Company") and its third-party suppliers, vendors, and other service providers supporting XTANDI Support Solutions (collectively, the "Service Providers") information about me (for example, my name, Social Security number, address, insurance policy number, and income) and my medical condition (for example, my diagnosis or medications) (together, "Personally Identifiable Information"). This information can include spoken or written facts about my health and insurance benefits. It can include copies of records from my healthcare providers or health plans about my health or healthcare. I understand that my healthcare providers and my pharmacy may receive remuneration, or payment, for disclosing my information pursuant to this Authorization.

I understand that XTANDI Support Solutions is a component of Astellas Pharma Support Solutions℠ and that the Service Providers may be compensated by Astellas. The Service Providers will use and give out my information to (i) assist in my enrollment in XTANDI Support Solutions and to contact me and/or the person legally authorized to sign on my behalf; (ii) provide me and/or the person legally authorized to sign on my behalf with educational and other materials, information, and support related to XTANDI Support Solutions; (iii) verify, investigate, assist with, and coordinate my coverage for XTANDI® (enzalutamide) with my payer; (iv) coordinate prescription fulfillment; (v) assess my eligibility for patient assistance and/or benefits, if necessary; (vi) make referrals to other independent programs or alternate sources that may be available to provide assistance to me as allowed under the law, if necessary; and (vii) assist with analyses of the efficiencies and performance of Services provided by Service Providers. In some instances the Service Providers may de-identify my information and use or disclose the de-identified information (in individual or aggregated form) for any legitimate business purposes. I understand that the Service Providers will make reasonable efforts to keep my information private; however, I understand that once my information has been disclosed to the Service Providers, how the Service Providers further disclose my information may no longer be protected under federal and state privacy laws.

This authorization will last for three (3) years from the date on page 1 or until I am no longer receiving XTANDI or enrolled in XTANDI Support Solutions, whichever is later. I do not have to sign this authorization, but if I do not, I will not be able to have my insurance coverage verified, have alternate sources of assistance researched, or access other support provided by or on behalf of XTANDI Support Solutions. My choice as to whether to sign this form will not change the way my doctors, healthcare providers, or payers treat me. If I no longer wish to participate in XTANDI Support Solutions, I shall inform my healthcare providers and/or the administrators of XTANDI Support Solutions in writing that I do not want them to share any more information with the Service Providers, but it will not change any actions that took place before I told them. I have the right to revoke or cancel this authorization, in writing, at any time by providing written notice to my healthcare providers and/or the administrators of XTANDI Support Solutions. Cancellation of this authorization will be valid when received by the administrators of XTANDI Support Solutions. I understand that a cancellation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I know I have a right to see or copy the information my healthcare providers or payers have given to the Service Providers.

If an application is submitted to determine my eligibility for assistance from the Astellas Patient Assistance Program (PAP), I agree to allow Company and Service Providers to use my demographic information, including, but not limited to, Social Security number, date of birth, name, and/or address as needed to access my credit information and information derived from public and other sources, including information from a consumer reporting agency (credit bureau), to estimate my income in conjunction with the eligibility determination process performed to determine my eligibility under the PAP. Company and Service Providers reserve the right to ask for additional documents and information at any time. I agree to notify my healthcare providers and XTANDI Support Solutions if I become aware of changes that would affect my eligibility, including, but not limited to, changes in health insurance status or coverage, financial status, and United States residency.

If your application is approved, XTANDI Support Solutions can send you text messages about the Program throughout your enrollment period. These text messages are optional. You can participate in the Program without signing up for text messages. When you sign up for the text messages (by providing your cell phone number above), you must agree to the following conditions:

- Program will send an autodialed, pre-recorded text message (Standard text message and data rates apply).
- You can opt out at any time by calling 1-855-898-2634 or replying “STOP” to the text messages.
- Program is not responsible if a communication is not delivered due to technical difficulties like server issues, phone carrier outages, or discontinued service.
- Be aware that anyone who can open or have access to your phone might see your text messages.
- If your mobile operator is not participating in text messaging services, you will not receive text messages.
- These text messages are NOT reminders to take your medication. You are responsible to take your medication as prescribed.

- Do NOT report product complaints or adverse events (like side effects) by text message. To report these, please call XTANDI Support Solutions at 1-855-898-2634. To receive text messages, you must provide your cell phone number.

Astellas is committed to the safety and effectiveness of our products, in the event you experience an adverse drug event or side effect, Astellas requests your consent to be able to contact you, your family member and/or your healthcare provider. This contact may be via phone, email, or any commonly used electronic form or medium. The purpose of this follow up is to help us at Astellas to better understand the event you experienced in relation to our product.

For additional information regarding how Astellas handles personal information, please visit our Privacy Policy link at: https://www.astellas.com/us/privacy-policy.

This Authorization Statement is governed by and interpreted in accordance with the laws of the state of Illinois, excluding Illinois conflict of law rules, and applicable federal law.

## PRESCRIBER CERTIFICATION STATEMENT

By signing on page 2, I hereby attest that I am the prescribing healthcare provider and I agree to submit requests to XTANDI Support Solutions because I have determined that XTANDI® (enzalutamide) is medically appropriate and I have explained such to my patient. I certify that I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act [HIPAA] of 1996) to the Service Providers for the purpose of providing access and reimbursement support, assisting in initiating or continuing therapy, and/or the evaluation of the patient's eligibility for support. I authorize Service Providers, as my designated agent and on behalf of my patients, to forward a prescription for XTANDI, by fax or other mode of delivery, to a pharmacy within the XTANDI Support Solutions network.

I also certify that this prescription complies with all applicable state and local laws. I agree to notify the Service Providers if I become aware of changes in my patient's circumstances that would affect their eligibility, including, but not limited to, changes in health insurance status or coverage, financial status, United States residency status, or the indication for which XTANDI has been prescribed for this patient.

I understand that Astellas reserves the right to change or terminate the Astellas Patient Assistance Program at any time, or to refuse to provide XTANDI® (enzalutamide) under the Astellas Patient Assistance Program to any patient.

If my patient obtains XTANDI via the Astellas Patient Assistance Program, I understand that (a) no third party or patient can be charged for XTANDI provided under such program and (b) that no free product should be sold, traded, or distributed for sale. I also understand that provision of free drug as part of the Astellas Patient Assistance Program is not contingent upon future purchase or prescribing of XTANDI.

I acknowledge I may be contacted by email, postal mail, or fax using the information I've provided, and I understand my personal information will be used and disclosed by Astellas in accordance with Astellas' privacy policy, available at www.astellas.com/us/privacy-policy.

I certify that a copy of the Patient Authorization Statement has been given to the patient named on page 1 and their representative and that I have provided my patient with a description of XTANDI Support Solutions.

I certify that I have reviewed the additional terms available at hcpverify.com/terms, which are specifically incorporated herein by reference, and acknowledge and consent to their application and enforceability in regard to this certification.

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