NEW Jakafi™ ruxolitinib (tablets)

How to Prescribe Jakafi™

Jakafi is available through a limited network of Specialty Pharmacies. The IncyteCARES program was created to facilitate patient access to Jakafi and is available toll-free for all healthcare providers, patients and their caregivers at 1-855-4-Jakafi (855-452-5234).

Please follow these steps to successfully prescribe Jakafi for your patients:

Step 1: Complete the Program Enrollment Form

Both you and the patient complete and sign, then FAX the one-page Jakafi Enrollment Form to IncyteCARES at 1-855-525-7207. This form will serve as the patient's initial prescription for Jakafi. Be sure to have the patient check the enrollment boxes for both the Access and Reimbursement Services and the Education and Support Services, if they would like to participate in these services.

Step 2: Insurance Verification

The IncyteCARES program will confirm your patient's insurance coverage. Once verified, your patient's prescription will be sent to a Specialty Pharmacy. Through IncyteCARES a comprehensive co-payment assistance and free-drug program is available for eligible patients.*

Step 3: Medication sent from a Specialty Pharmacy

Your patient will be assigned to a Specialty Pharmacy that provides the lowest patient out-of-pocket cost for Jakafi. The Specialty Pharmacy will collect co-payments, provide refill reminders, and ship Jakafi directly to your patient.

*Co-pay assistance program not available in all states or for patients who are receiving prescription reimbursement under any federal, state, or government-funded programs. Enrollment necessary.

IncyteCARES Program

Connecting to Access, Reimbursement, Education and Support

P.O. Box 221798 • Charlotte, NC 28222-1798 • Phone: **1-855-4-Jakafi (855-452-5234)** • Fax: **1-855-525-7207**

IncyteCARES offers two services: 1.) Access and Reimbursement services assist patients starting on Jakafi™ (ruxolitinib) 2.) Education and Support services encourage patients to stay on Jakafi

1 Physician Information

Physician Name: _____

Site/Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Office Contact: _____ Telephone: _____

Fax: _____ Best Time to Call: _____

Office Contact E-mail: _____

State License #: _____ **Payer Specific ID#:** _____

Tax ID #: _____ **NPI #:** _____

2 Patient Clinical Information (Please complete A - D)

A) Patient Diagnosis / ICD-9 Code:

☐ 238.76 Myelofibrosis with myeloid metaplasia ☐ 289.83 Myelofibrosis

☐ Other diagnosis: _____

B) Does the patient have intermediate or high-risk myelofibrosis?

☐ Yes ☐ No

C) Previous or Current Myelofibrosis Therapies:

Does this patient have or has had any previous MF therapies?

☐ Yes: _____ ☐ No

D) Contact for IncyteCARES to call to discuss this patient's therapy?

Name _____ at (____) _____ – _____

Title (eg, MD, RN, BSN, MSN, PA, NP)

3 Prescription

Upon confirmation of insurance coverage (or the patient's approval for assistance through the Program), medication should be shipped via a specialty pharmacy provider to the patient's home address (listed above, right) unless otherwise indicated by practitioner:

Patient Name: _____ Date: _____

Product Name: Jakafi™ (ruxolitinib)

Dosage: ☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 25 mg

Sig: Twice a day Quantity: _____

Refill(s): _____ DEA #: _____

Ship to: ☐ Patient's home ☐ Doctor's office

Is there a preferred Specialty Pharmacy? _____

4 Physician Declaration

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Jakafi based on my professional judgment of medical necessity.

I represent and warrant that I have my patient's authorization on file to disclose their health information and to transfer such authorization to Incyte and its agents to use and disclose such information as necessary to provide reimbursement services and to forward this prescription to a dispensing pharmacy on behalf of my patient.

I appoint IncyteCARES solely to convey on my behalf to the pharmacy chosen by or for the above-named patient, the prescription described herein.

I authorize IncyteCARES to perform a preliminary assessment of insurance verification for the above-named patient, and I further authorize and request that the Program provide to me any and all information necessary for completing a Letter of Medical Necessity as may be required as a result of such insurance verification assessment.

Physician Signature: _____

Date: ____ / ____ / _____

Please fax to 855-525-7207

 RUX-1111 01/12

A Patient Information

Patient Name: _____

Shipping Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ SSN: _____

Phone Number: _____ Best Time to Call: _____

Alternate Phone Number: _____

Primary Language: _____

E-mail Address: _____

Alternate Contact and Phone Number: _____

B Patient Insurance Information

Primary Rx Insurer: _____

Telephone: _____

Policy ID Number: _____ Group Number: _____

Subscriber Name/Date of Birth: _____

Secondary Rx Insurer: _____

Telephone: _____

Policy ID Number: _____ Group Number: _____

Subscriber Name/Date of Birth: _____

Please include a photocopy of the patient's insurance card(s), if possible.

C Patient Financial Information*

Current annual household income: $ _____

Number of household members dependent on income stated above (include applicant): _____

If you would like to be considered for co-pay or product support please provide income information for potential eligibility determination. If approved for support, documentation (latest tax return or W2 or one month of pay stubs) will be required within 90 days.

D Patient Authorization for the IncyteCARES Program

Access and Reimbursement Services

I understand my physician has authorized IncyteCARES to request a benefits verification to determine if my prescription for Jakafi is covered under my health insurance. I have requested that IncyteCARES determine my eligibility for co-pay assistance or free drug. If IncyteCARES needs to verify my financial or insurance information, I authorize my healthcare providers or my insurance company to disclose information about me.

I understand that any co-pay assistance or free drug provided to me through IncyteCARES is contingent upon meeting certain eligibility criteria and that Incyte has the right at any time, and without notice, to modify or discontinue IncyteCARES or any assistance provided to me.

I understand that I can cancel this authorization at any time by writing to IncyteCARES at the address above. If I cancel this authorization, then my healthcare providers and my insurance company will not provide any further information about me, and IncyteCARES will no longer provide me with assistance.

I understand that once IncyteCARES receives information about me, federal privacy laws may no longer apply. I also understand that IncyteCARES will only use or disclose information about me to operate the Program and provide services to me or to assist me in finding alternative sources of funding or coverage for my treatment.

I understand that I do not have to sign this authorization to obtain treatment or seek payment for treatment on my own; however, in order to be eligible for the services provided by IncyteCARES I must sign the authorization.

Education and Support Services

I authorize Incyte and affiliated companies to use and release information about me to its agents working on its behalf for the purposes of providing education and ongoing support services to me for Jakafi. I authorize Incyte to use and give out my information, send me materials related to Jakafi or other information in which I might be interested, and to contact me by e-mail, mail, or phone on occasion regarding these services or for feedback about Jakafi, or as required or permitted by law.

I acknowledge that I am a resident of the United States and verify that the information provided in this enrollment form is current, complete, and accurate.

This authorization expires in ten (10) years.

I WISH TO BE ENROLLED AS FOLLOWS BY CHECKING THE APPROPRIATE BOX(ES)

☐ ACCESS AND REIMBURSEMENT SERVICES ☐ EDUCATION AND SUPPORT SERVICES

By signing below I authorize IncyteCARES to contact me and notify me regarding my benefits

Patient Signature: _____ Date: ____/____/____

Legal Guardian or Representative Signature: _____ Date: ____/____/_____

Relationship to Patient: _____

IncyteCARES
Connecting to Access, Reimbursement, Education and Support

IncyteCARES Program Enrollment Instructions For Providers

The left-hand side of the form contains physician information needed for enrollment and physician must sign.

1 Physician Information

Physician Name: Lisa Smith, MD
Site/Facility Name: Community Practice Providers, Inc
Street Address: 3720 River Road, Suite 500
City: Springfield State: IL Zip: 62701
Office Contact: Christy Jones Telephone: (555) 111-2222
Fax: (555) 111-3333 Best Time to Call: Before 2 PM
Office Contact E-mail: cjones@cpp.com
State License #: 12345 **Payer Specific ID#:** 09876
Tax ID #: 45678 **NPI #:** 0101010

2 Patient Clinical Information (Please complete A - D)

A) Patient Diagnosis / ICD-9 Code:
☐ 238.76 Myelofibrosis with myeloid metaplasia ☒ 289.83 Myelofibrosis
☐ Other diagnosis: _____

B) Does the patient have intermediate or high-risk myelofibrosis?
☒ Yes ☐ No

C) Previous or Current Myelofibrosis Therapies:
Does this patient have or has had any previous MF therapies?
☐ Yes: _____ ☒ No

D) Contact for IncyteCARES to call to discuss this patient's therapy?
Name Lisa Smith at (555) 111 – 2222
Title (eg, (MD), RN, BSN, MSN, PA, NP)

3 Prescription

Upon confirmation of insurance coverage (or the patient's approval for assistance through the Program), medication should be shipped via a specialty pharmacy provider to the patient's home address (listed above, right) unless otherwise indicated by practitioner:

Patient Name: Richard Simons Date: 01/01/12
Product Name: Jakafi™(ruxolitinib)
Dosage: ☐ 5 mg ☐ 10 mg ☐ 15 mg ☒ 20 mg ☐ 25 mg
Sig: Twice a day Quantity: 60
Refill(s): 12 DEA #: 999333000
Ship to: ☒ Patient's home ☐ Doctor's office
Is there a preferred Specialty Pharmacy? No

4 Physician Declaration

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Jakafi based on my professional judgment of medical necessity.

I represent and warrant that I have my patient's authorization on file to disclose their health information and to transfer such authorization to Incyte and its agents to use and disclose such information as necessary to provide reimbursement services and to forward this prescription to a dispensing pharmacy on behalf of my patient.

I appoint IncyteCARES solely to convey on my behalf to the pharmacy chosen by or for the above-named patient, the prescription described herein.

I authorize IncyteCARES to perform a preliminary assessment of insurance verification for the above-named patient, and I further authorize and request that the Program provide to me any and all information necessary for completing a Letter of Medical Necessity as may be required as a result of such insurance verification assessment.

Physician Signature: Lisa Smith
Date: 01 / 01 / 2012

Please fax to 855-525-7207

Step 1

Physician Information

Include practice contact information, office staff contact and any payer-specific provider ID number relevant for the patient's insurance to facilitate quick and effective contact with the payer and your office. Please write legibly or type information, if possible.

Step 2

Patient Clinical Information

This section is required and could delay the verification process if not completed.

This information will help with enrollment into co-pay assistance and/or prior authorization assistance.

Please complete A - D:

- A) Patient's diagnosis
- B) Indicate if the patient has intermediate or high-risk myelofibrosis according to the IWG criteria
- C) Previous or current myelofibrosis therapy (this may be substituted with last chart note)
- D) If a program oncology nurse needs to discuss patient clinical information with the office, please include whom they should speak with and their contact information.

Step 3

Prescription

Include patient name, dosage, quantity, refills, DEA # and date to complete the prescription. A separate prescription is not needed.

Please check the box to indicate if Jakafi should be shipped to the patient's home or the doctor's office. Also, if there is a preferred in-network specialty pharmacy, please list this here.

Step 4

Physician Declaration

A physician signature is required in order for IncyteCARES to perform a benefit verification.

Completed forms can be faxed to 1-855-525-7207 or mailed to IncyteCARES program P.O. Box 221798 Charlotte, NC, 28222-1798

IncyteCARES Program Enrollment Instructions For Patients/Caregivers

The right-hand side of the form contains patient information needed for enrollment and the patient must sign.

Patient Contact Information

Step 1

Include patient and alternate contact name and relationship, with alternate phone numbers and best time to call, so the program can call to discuss benefits and the specialty pharmacy can call to schedule delivery.

Patient Rx Insurance Information

Step 2

Include patient's Rx insurance information: Rx plan name, ID, group # and phone # to facilitate contact with the patient's Rx insurance company to verify benefits. Please include a photocopy of the Rx insurance card(s), if possible.

Financial Information

Step 3

Include current annual household income and the number of dependents (including patient) if the patient would like to be considered for copay or free drug assistance.

Patients will be temporarily approved if they meet the eligibility requirements but must provide income documentation (latest tax return, W2, or one month of pay stubs) within 90 days to remain eligible for assistance.

Patient Authorization for the Program

Step 4

Include patient or guardian signature and date. Signature is required in order for IncyteCARES to contact the patient with the results of the benefits verification.

Check the applicable boxes to be considered for co-pay and free drug assistance and to enroll in the patient education and support services.

A Patient Information

Patient Name: Richard Simons
Shipping Address: 1234 Green Tree Road
City: Small Town **State:** IL **Zip:** 62700
Date of Birth: 08/24/67 SSN: 100-00-0001
Phone Number: (555) 100-5000 Best Time to Call: Early Evening
Alternate Phone Number: (555) 200-6000
Primary Language: English
E-mail Address: Richard@email.com
Alternate Contact and Phone Number: Betty Simons (wife), (555) 100-5001

B Patient Insurance Information

Primary Rx Insurer: Rx Insurance Co.
Telephone: (630) 444-0000
Policy ID Number: 65432 Group Number: 77777
Subscriber Name/Date of Birth: Richard Simons, 08/24/67

Secondary Rx Insurer: Secondary Rx Insurance Co.
Telephone: (630) 555-1111
Policy ID Number: 99999 Group Number: 55555
Subscriber Name/Date of Birth: Betty Simons, 04/22/71

Please include a photocopy of the patient's insurance card(s), if possible.

C Patient Financial Information*

Current annual household income: $ 78,000
Number of household members dependent on income stated above (include applicant): 3

If you would like to be considered for co-pay or product support please provide income information for potential eligibility determination. If approved for support, documentation (latest tax return or W2 or one month of pay stubs) will be required within 90 days.

D Patient Authorization for the IncyteCARES Program

Access and Reimbursement Services
I understand my physician has authorized IncyteCARES to request a benefits verification to determine if my prescription for Jakafi is covered under my health insurance. I have requested that IncyteCARES determine my eligibility for co-pay assistance or free drug. If IncyteCARES needs to verify my financial or insurance information, I authorize my healthcare providers or my insurance company to disclose information about me.

I understand that any co-pay assistance or free drug provided to me through IncyteCARES is contingent upon meeting certain eligibility criteria and that Incyte has the right at any time, and without notice, to modify or discontinue IncyteCARES or any assistance provided to me.

I understand that I can cancel this authorization at any time by writing to IncyteCARES at the address above. If I cancel this authorization, then my healthcare providers and my insurance company will not provide any further information about me, and IncyteCARES will no longer provide me with assistance.

I understand that once IncyteCARES receives information about me, federal privacy laws may no longer apply. I also understand that IncyteCARES will only use or disclose information about me to operate the Program and provide services to me or to assist me in finding alternative sources of funding or coverage for my treatment.

I understand that I do not have to sign this authorization to obtain treatment or seek payment for treatment on my own; however, in order to be eligible for the services provided by IncyteCARES I must sign the authorization.

Education and Support Services
I authorize Incyte and affiliated companies to use and release information about me to its agents working on its behalf for the purposes of providing education and ongoing support services to me for Jakafi. I authorize Incyte to use and give out my information, send me materials related to Jakafi or other information in which I might be interested, and to contact me by e-mail, mail, or phone on occasion regarding these services or for feedback about Jakafi, or as required or permitted by law.

I acknowledge that I am a resident of the United States and verify that the information provided in this enrollment form is current, complete, and accurate.

This authorization expires in ten (10) years.

I WISH TO BE ENROLLED AS FOLLOWS BY CHECKING THE APPROPRIATE BOX(ES)

☒ ACCESS AND REIMBURSEMENT SERVICES ☒ EDUCATION AND SUPPORT SERVICES

By signing below I authorize IncyteCARES to contact me and notify me regarding my benefits

Patient Signature: Richard Simons Date: 01 / 01 / 2012

Legal Guardian or Representative Signature: N/A Date: ____/____/____

Relationship to Patient: N/A

Completed forms can be faxed to 1-855-525-7207 or mailed to IncyteCARES program P.O. Box 221798 Charlotte, NC, 28222-1798