rigel onecare™
ACCESS. SUPPORT. CARE.

# TAVALISSE Enrollment Form

Please complete all five (5) sections and fax both sides of the completed form to:
1-833-FXrigel (833-397-4435) or 650-449-8682.
For more information call us at 1-833-rigelOC (833-744-3562) or 650-449-8646
Monday-Friday from 8 AM to 8 PM EST or visit us at www.TAVALISSE.com.

Tavalisse™ (fostamatinib disodium hexahydrate) tablets

## 1. Patient Information

First Name ______ Last Name ______ DOB ______ Gender (F/M) ______

Street Address ______ City ______ State ______ Zip ______

Home Phone# ______ Mobile Phone# ______ Email Address ______

Primary Insurance Name ______ Insurance Phone# ______ Secondary Insurance Name ______ Insurance Phone# ______

ID# ______ Group# ______ Policy Holder Relationship ______ ID# ______ Group# ______ Policy Holder Relationship ______

Pharmacy Benefit Carrier Name ______ BIN# ______ PCN# ______

## 2. Clinical Info

Platelet Count: ______ / ______ Most Recent Treatment: ______
Value (K/µL) Date (mm/dd/yyyy)

Primary Diagnosis Code: ☐ ICD10-D69.3 (ITP) ☐ ICD 9-287.31 (ITP) ☐ Other ______

## 3. Patient Release

My signature below certifies that I have received, read, understood, and agree to the Privacy Notice and Patient Authorization (included as page two of this form) to release and use my personal health information.

______ / ______ ______ / ______
Patient Signature Date (mm/dd/yyyy) Personal Representative Signature* Relationship to Patient
***If not signed by the patient above.**

## 4. Prescriber Information

First Name ______ Last Name ______ NPI# ______

State License# ______ DEA# ______ Practice/Institutional Name ______

Street Address ______ City ______ State ______ Zip ______

Office Contact Name ______ Office Email ______

Office Phone# ______ Office Fax# ______

**Select your preferred method of contact:** ☐ Phone ☐ Fax ☐ Email

Preferred Pharmacy:
**Preferred pharmacy will be utilized when allowed by the payer.** ☐ Biologics, Inc. ☐ Diplomat Pharmacy, Inc. ☐ US Bioservices

☐ Hem/Onc (Pharmacy): Name ______ Phone# ______ Fax# ______

## 5. Prescription & Prescriber Authorization

**By signing below, I, as the treating physician, state:** (i) This prescription is medically appropriate for this patient and I will be supervising this patient's treatment; (ii) all information supplied to Rigel or its agents ("Rigel") relating to this enrollment form is accurate, and has been obtained pursuant to a separate, valid patient authorization that allows Rigel to contact this patient to provide services relating to (1) treatment and (2) benefit verification and/or preauthorization. **Further, I understand that:** (a) any free product provided is for the use of this patient only and shall not be sold or transferred to anyone else, or returned for credit; (b) free product may not be counted toward Medicare Part D out-of-pocket costs, nor claimed for reimbursement from any third-party payer (private or government); (c) I am under no obligation to prescribe any Rigel drug and I have not received and will not receive any benefit from Rigel for prescribing a Rigel drug; and (d) Rigel may revise, change, or terminate programs at any time without notice.

☐ **Commercial Prescription (Box must be checked and prescription completed)**
TAVALISSE
Sig: Take 1 (one) tablet (100mg) by mouth twice daily. Qty ______ Refills ______
Sig: Take 1 (one) tablet (150mg) by mouth twice daily. Qty ______ Refills ______

☐ **Free Drug Supply Program* (Box must be checked and prescription completed)**
TAVALISSE
Sig: Take 1 (one) tablet (100mg) by mouth twice daily. Qty ______ Refills ______
Sig: Take 1 (one) tablet (150mg) by mouth twice daily. Qty ______ Refills ______
***If necessary, allows FREE supply of product to eligible patients while appropriate insurance authorizations are secured.**

**If this section does not comply with your state's prescription laws, please provide us with a compliant prescription**

______ / ______ **OR** ______ / ______
Prescriber's Signature (no stamp) Date (mm/dd/yyyy)
**Dispense as Written (DAW)**

Prescriber's Signature (no stamp) Date (mm/dd/yyyy)
**Substitution Allowed**

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Tavalisse™ (fostamatinib disodium hexahydrate) tablets

6. Rigel's Privacy Notice and Patient Authorization

**Rigel has programs available to support patients and providers, and we will use the information provided to see which program, based on its criteria, patients qualify for. Please read the following carefully, then sign and date on the previous page.**

**Personal Information.** I authorize my healthcare providers (including my doctor(s) and their staff), my pharmacies, my employer and my health insurer(s) to disclose my personal information, which may include any information related to healthcare insurance, benefits, coverage limits, appeals and health records related to my treatment or other relevant information which Rigel deems necessary for use in the RIGEL ONECARE program ("Personal Information"), to Rigel, its affiliated companies, business partners, and vendors (together "Rigel") so that Rigel can (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with TAVALISSE, (ii) coordinate my receipt of TAVALISSE, (iii) provide me with information about TAVALISSE, (iv) contact me throughout therapy to discuss my therapy and provide clinical support, (v) conduct market research, surveys, quality assurance, and other internal business activities in connection with the RIGEL ONECARE program.

**Personal Communication.** I authorize Rigel to disclose my Personal Information to any pharmacies, my insurer(s), healthcare provider (including my doctor(s) and their staff) and other third parties for the purposes described above. By providing my signature on the enrollment form, I agree to receive telephone calls, emails, text messages, and mailed materials from Rigel at the telephone number(s) and addresses (physical & e-mail) provided on the enrollment form. I understand that my cell phone carrier's standard rates may apply for calls and texts to my cell phone. I understand and agree that Personal Information transmitted by email and cell phone cannot be secured against unauthorized access.

**Use.** While Rigel will only use my Personal Information for the intended purposes described above, I understand that once my Personal Information is disclosed it may be re-disclosed by recipients and will no longer be protected by federal privacy law. I understand my Personal Information may be used by pharmacies to process my prescription. I understand that I may refuse to provide my authorization or in the future opt out of specific components or services of RIGEL ONECARE, and that my refusal will not affect my ability to receive treatment from my healthcare providers. I understand that some pharmacies may receive payment for disclosing my Personal Information in exchange for providing the services associated with the program.

**Patient Support.** If I qualify for the Rigel Patient Support Program I understand that any assistance provided under this program is contingent upon my ability to meet the eligibility criteria for the program as determined by Rigel. I acknowledge that the assistance provided through this program is temporary. I also understand that any medicines I may receive from this program is only for me and I agree that I will not give them to anyone else and if I am a Medicare Prescription Drug Plan or Medicare Advantage Prescription Drug Plan beneficiary, that I may not submit a claim for payment to Medicare or any third-party payer, and no part of the payment for the product provided hereunder will be claimed as part of my true out-of-pocket expense (TrOOP).

**Timeframe, Copy, and Revocation.** I understand that this Authorization will remain valid while the RIGEL ONECARE program is available, unless I revoke it earlier. I also understand that the RIGEL ONECARE program may change or end at any time without prior notification. I also understand that I can obtain a copy of my signed Authorization upon request and that I can revoke this Authorization at any time by calling Rigel at 1-833-rigelOC (833-744-3562) or 650-449-8646 or by writing to RIGEL ONECARE, 4060 Wedgeway Ct, Earth City, MO 63045. I also understand any revocation will only apply to my healthcare provider(s), pharmacies, and health insurer(s) once they receive notification of my revocation.

Please visit **www.TAVALISSE.com** for Important Safety Information and full Prescribing Information.

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