TAVALISSE Enrollment and Patient Assistance Program Form

Please complete all sections and fax form to:
1-833-FXrigel (833-397-4435) or 650-449-8682.
For more information call 1-833-rigelOC (833-744-3562) or 650-449-8646
Monday-Friday from 8 am to 8 pm EST or visit www.TAVALISSE.com.

RIGEL ONECARE PROGRAMS*

Nurse Advocate
- Will identify the applicable support resources for patients taking TAVALISSE
- Will provide patients taking TAVALISE with adherence and product education calls that are personalized to their desired frequency
- Will assist with access needs for TAVALISSE such as benefit investigations, prior authorizations, and appeal processes, if needed
- Exclusively works on TAVALISSE

Patient Assistance Program (PAP)
- ≤ 500% of Federal Poverty Level
- On-label indications only
- Any patient, 18 years of age or older, is eligible if criteria is met

Copay or Co-Insurance Assistance
- Copay as little as $15 per month
- No patient income requirement
- Annual benefit of $25,000
- Must have commercial insurance (No Medicaid, Medicare, or other government programs)

Free Drug Supply
- For insurance coverage delays longer than 5 business days
- Up to 60 days supply and/or insurance coverage is determined
- On-label indications only
- Any patient, 18 years or older, is eligible if criteria is met

All RIGEL ONECARE programs are subject to eligibility requirements and changes. Criteria above does not represent all criteria for each program. Must be US resident or US territory resident. Restrictions Apply.

Instructions for HCPs:
1. Complete sections 1-4
2. Obtain appropriate patient signature in section 7
3. Complete sections 8 and 9, if needed

What to expect next:
1. Upon receipt of this application RIGEL ONECARE will work directly with your patient to obtain the other necessary information and documentation to see if your patient qualifies for our programs.
2. RIGEL ONECARE will notify you/your patient directly of their eligibility as quickly as possible.
3. RIGEL ONECARE will coordinate delivery for the patient if/when the patient is approved.

1. PATIENT INFORMATION

First Name ____________ Last Name ____________ DOB ____________
Gender: Male ☐ Female ☐ Other ☐
Street Address ____________ City ____________ State ______ Zip ______
Home Phone# ____________ Mobile Phone# ____________ Email Address ____________
Primary Insurance Name ____________ Insurance Phone# ____________
ID# ____________ Group# ____________ Policy Holder Relationship ____________
Secondary Insurance Name ____________ Insurance Phone# ____________
ID# ____________ Group# ____________ Policy Holder Relationship ____________
Pharmacy Benefit Carrier Name ____________ BIN# ____________ PCN# ____________
Patient's preferred language ____________

2. CLINICAL INFORMATION

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 ____________
Please select previous therapies that the patient has undergone for chronic immune thrombocytopenia:

☐ Corticosteroid
☐ Intravenous immune globulin (IVIG)
☐ Rho(D) immune globulin
☐ Splenectomy
☐ Doptelet (avatrombopag)
☐ Promacta (eltrombopag)
☐ Nplate (romiplostim)
☐ Rituxan (rituximab)
☐ Danazol
☐ Cellcept
☐ Other

Please list known patient allergies: ____________

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PATIENT INFORMATION

First Name ______________ Last Name ______________ DOB ______________

3. PRESCRIBER INFORMATION

First Name ______________ Last Name ______________
NPI# ______________ State License# ______________ DEA# ______________
Practice/Institutional Name ______________
Office Address ______________ City ______________ State ______ Zip ______
Office Phone# ______________ Office Fax# ______________
Office Contact Name ______________ Office Contact Email ______________
Office Contact Direct Line ______________

Select your preferred method of contact: ❒ Phone ❒ Fax ❒ Email

Preferred pharmacy: Preferred pharmacy will be utilized when allowed by the payer.

❒ Biologics, Inc. ❒ Optum Specialty Pharmacy ❒ US Bioservices
❒ Hem/Onc (Pharmacy): Name______________ Phone# ______________ Fax# ______________

4. PRESCRIPTION & PRESCRIBER AUTHORIZATION

By signing below, I, as the treating healthcare practitioner, 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. I authorize Specialty Pharmacy to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

See full Prescribing Information, at www.TAVALISSE.com, for detailed product and dosage information.

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

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

OR

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

5. NEXT STEPS

What should be expected after submitting the enrollment form?
Upon submission of the enrollment form to RIGEL ONECARE, a Nurse Advocate will confirm receipt with your office to initiate the services you requested on behalf of your patient(s).

ACCESS. SUPPORT. CARE.

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6. RIGEL'S PRIVACY NOTICE AND PATIENT AUTHORIZATION

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

PERSONAL INFORMATION FOR PATIENT SUPPORT 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 in the RIGEL ONECARE program ("Personal Information") to Rigel Pharmaceuticals, Inc., its affiliated companies, contractors, and vendors (together "Rigel") 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, (vi) call, email, text message, and mail materials from Rigel at the telephone number(s) and addresses (physical & e-mail) provided on the enrollment form, and (vii) share such information with pharmacies, my insurer(s), healthcare provider (including my doctor(s) and their staff) and other third parties for the purposes described above. 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. 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.

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 authorize my pharmacy to receive payment from Rigel for disclosing my Personal Information in exchange for providing the services associated with the program or for marketing purposes.

TIMEFRAME, COPY, AND REVOCATION I understand that this Authorization will remain valid for (5) years from this date, 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.

7. PATIENT RELEASE

My signature below certifies that I have received, read, understood, and agree to the Privacy Notice and Patient Authorization to release and use my personal health information. I also attest that I (the patient) is 18 years of age or older.

Patient Printed Name ______________________________

Patient Signature ______________________________ Date ______________

Personal Representative Printed Name ______________________________ Relationship to Patient ______________

Personal Representative Signature* ______________________________ Date ______________

*If not signed by the patient.

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8. PATIENT ASSISTANCE

Total number of people in your home (including yourself): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ +6

Are you a Veteran? ☐ Yes ☐ No

US Resident: ☐ Yes ☐ No

Disabled: ☐ Yes ☐ No

Total Gross Monthly Household Income $_________________ SS# __________–_____–__________

Do you have Medicare? ☐ Yes ☐ No

Do you have Medicaid? ☐ Yes ☐ No

I hereby certify that I am not insured for (or am rendered uninsured through the payer denial of) TAVALISSE. In order to qualify for free product, I must meet the program criteria. I understand that my income will be validated through Experian(R) based on the information I provided. I understand that RIGEL ONECARE could ask me for a copy of my IRS 1040 form or other proof of income for the purpose of an audit. I agree to provide my financial documentation in a timely manner, if so requested. RIGEL ONECARE reserves the right to make an independent determination of my financial and medical need.

RIGEL ONECARE reserves the right at any time, and without notice, to modify or discontinue this program and any assistance provided to me. I represent and certify that I am a legal resident of the United States (and U.S. territories) and verify that the information provided in this enrollment form is current, complete, and accurate. I agree that I, my healthcare provider, my healthcare provider's institution, or any other person, must not seek payment or accept reimbursement from any third party payer, including any federal healthcare program such as Medicare or Medicaid, or any private or other insurance plan, or from any other person or entity for any free supply of TAVALISSE tablets supplied under this program, regardless of whether a payer subsequently determines that it will cover the product. I agree to be responsible for notifying RIGEL ONECARE if (i) I obtain coverage through another source state, or private program), (ii) I no longer meet the income criteria for the program, or (iii) I find any errors in my application.

Any changes in insurance coverage and/or financial circumstances while enrolled in the program may affect your ability to continue to receive free product via the PAP program. You must re-apply for program eligibility at the end of each calendar year. RIGEL ONECARE will reach out to you and your healthcare provider at this time to help with the reenrollment process.

9. PATIENT ASSISTANCE PROGRAM RELEASE

My signature below certifies that I have received, read, understood, and agree to the Patient Assistance Program.

Patient Printed Name ______________________________

Patient Signature ______________________________ Date ______________

Personal Representative Printed Name ______________________________ Relationship to Patient ______________

Personal Representative Signature* ______________________________ Date ______________

*If not signed by the patient.

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

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