BIZENGRI® (zenocutuzumab-zbco) 20 mg/mL Injection for IV Use

Patient Enrollment Form

SUPPORT REQUESTED (check all that apply)

☐ Insurance Verification ☐ Patient Assistance ☐ Claims Support
☐ Prior Authorization/Appeals ☐ Copay Assistance

For assistance, call (877) 353-8546, Monday-Friday, 9:00 am to 5:00 pm Eastern Time.

Page 1 is to be completed by the patient. Page 2 is to be completed by the healthcare provider.

1 PATIENT INFORMATION

First Name: _____ **Last Name:** _____
Address: _____
Date of Birth: _____ **Phone:** _____
Sex: ☐ Male ☐ Female **US Resident:** ☐ Yes ☐ No
SSN (last 4 digits) _____ **Email:** _____
Patient Representative Name: _____ **Patient Representative Phone:** _____

2 FINANCIAL INFORMATION (Only Required for Patient Assistance request)

Total Number of Household Members (including enrollee): _____ ***Total Annual Gross Household Income:** _____

*Please submit **Proof of Income with the Enrollment Form** which includes, but not limited to 1040 form, W2, Social Security Awards Letter, SSA 1099. If you have questions about income documentation, please contact PTx Assist.

3 AUTHORIZATION TO USE AND DISCLOSE MY INFORMATION

Please read the following, and if you agree, sign below. By signing, I am enrolling in PTx Assist, the program which provides services for Partner Therapeutics. Such services include medication education and other support services, such as co-pay assistance and other forms of patient assistance (no-cost medication), offered now or in the future. I attest that the information in this form is true, correct, and complete, and I understand that PTx Assist ("the Program") assistance will terminate if the Program becomes aware of any fraud or if Bizengri ® (zenocutuzumab-zbco) is no longer prescribed to me. I understand that in order for the Program to provide me with assistance, it will need to obtain, review, use, and disclose information related to my personal health, including information related to my medical records and history, medications, medical conditions and treatment, health insurance coverage and the personal information on this enrollment form including my name, address, telephone number, social security number, insurance plan and/or group numbers (together, "Protected Health Information"). I agree to update the Program should any of the information on this application form change, including if I become eligible for any benefit through a federal, state, or private program, which may reimburse for Bizengri®. I understand that changes in my health insurance coverage may impact my eligibility for the Program.

By signing this form, I authorize my treating doctor, my employer, and my health insurer to give people who work for and with Partner Therapeutics, including its business partners and agents ("Partner Therapeutics"), my Protected Health Information. I also authorize Partner Therapeutics (Partner Therapeutics, Inc.) to receive, use and disclose my Protected Health Information for the following purposes: (i) to enroll me in, and contact me and/or the Patient Representative I identify below ("Patient Representative"), about PTx Assist programs, including potential enrollment in the copay assistance program or Patient Assistance Program if I am eligible; (ii) to help verify, investigate, assist with or coordinate insurance coverage for Bizengri or to obtain payment or other support for Bizengri; (iii) to coordinate my prescription fulfillment; (iv) to provide me and/or my Patient Representative with educational materials, information and services related to Bizengri; and (v) to assist with analyses related to the quality, efficacy and safety of Bizengri, including patient access and treatment compliance. In carrying out these activities, Partner Therapeutics may share information about me with my doctor, my employer, my health insurer, my pharmacy and/or pharmacists, and independent third-party patient assistance foundations. Third parties may receive payment from Partner Therapeutics to provide the services associated with the Program. I understand that my Protected Health Information will not be used or disclosed by Partner Therapeutics for any other purpose than described in this form unless permitted by law or unless information that specifically identifies me is removed and therefore is "de-identified." I also understand that Partner Therapeutics will make every effort to keep my information private, but that information used or disclosed under this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

This Authorization is valid for two (2) years from the date of my signature or until I am no longer participating in the Program, whichever is sooner. I understand that Partner Therapeutics has the right to change or end the Program at any time without prior notification to me. I understand that I may refuse to sign this form and that doing so will not affect my doctor's treatment of me or my eligibility for insurance benefits. I further understand that I may revoke this Authorization at any time by contacting the Program at 1-877-353-8546. The revocation will not apply to any information already used or disclosed pursuant to this Authorization. If I do not sign this form, or cancel (revoke) my Authorization later, I understand that this means that I will not be able to participate or receive assistance from PTx Assist.

†By providing my phone number, I authorize PTx Assist to use autodialers or prerecorded and artificial voice messages to contact me. I understand that these calls/texts may mention the name of Partner Therapeutics products or services and include details about my insurance coverage and doctor's name. I understand that I am not required to consent to being contacted by phone or text message as a condition of any purchase of Partner Therapeutics products or enrollment. Message and data rates may apply. I understand that I may opt out of receiving these communications at any time by calling Partner Therapeutics at (877) 353-8546.

I permit Partner Therapeutics to speak with my Patient Representative about the information on this form and the status of my request. I understand that I have the right to see or copy the Protected Health Information my healthcare providers or insurers have given to Partner Therapeutics.

Printed Name of Patient: _____ **Date:** _____
Signature: _____
Printed Name if Signed by a Patient Representative: _____

4 INSURANCE INFORMATION – PLEASE CHECK HERE IF THE PATIENT IS UNINSURED ☐

Primary Medical Insurance: _____
Payer Phone: _____ **Group#** _____ **Policy ID:** _____
Policyholder Name: _____ **Policyholder Date of Birth:** _____ **Policyholder's Relationship to Patient:** _____
Secondary Medical Insurance: _____
Payer Phone: _____ **Group#** _____ **Policy ID:** _____
Policyholder Name: _____ **Policyholder Date of Birth:** _____ **Policyholder's Relationship to Patient:** _____
Patient First Name: _____ **Patient Last Name:** _____

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5 PRESCRIBER INFORMATION

Prescriber Name: _____

Prescriber Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Tax ID: _____ **NPI #** _____ **State License #** _____

Treating Facility Name: _____ **Facility Tax ID:** _____ **Facility NPI #** _____

Treating Facility Address: _____

Treating Setting of Care: ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Physician's Office ☐ Home Infusion
☐ Other – Please Specify: _____

Office Contact: _____ **Phone:** _____

Email: _____ **Fax:** _____

Preferred Method of Contact: ☐ Phone ☐ Email ☐ Fax (If unspecified, then all communications will be sent via fax.)

For **Copay Assistance Only:** Payment will be in the form of Virtual Debit Card (VDC) so please confirm email address:

_____

For **Patient Assistance Program Only:** Bizengri will be shipped to the **Treating Facility Address** above unless otherwise specified.

_____

6 CLINICAL INFORMATION

Primary Diagnosis (ICD-10): _____ **Other Diagnosis Code(s):** _____

Has the Patient Tested NRG1 Positive? ☐ Yes ☐ No

Prior Therapies Received: _____

7 BIZENGRI PRESCRIPTION INFORMATION

BIZENGRI® (zenocutuzumab-zbco) 20 mg/mL Injection for IV Use:

Dose: _____ mg **Frequency:** every _____ weeks

Dispense Quantity: _____ vials **Refill:** _____

Additional Directions: _____

Patient Allergies: _____

Concurrent Medication: _____

Patient will be pre-medicated prior to initial Bizengri infusion (not supplied by PTx Assist) with the following: _____

_____

†Prescriber Certification and Authorization: By signing below, I am certifying that the information contained in this form is complete and accurate to the best of my knowledge. My signature certifies that I am a licensed practitioner eligible under state law to prescribe, receive, and administer the requested medication(s) listed on this enrollment form. I understand that Partner Therapeutics, Inc. reserves the right to modify or terminate PTx Assist at any time and without notice. I understand that Partner Therapeutics is not responsible for filing claims and that the information provided by PTx Assist is for general reference and informational purposes only and is based on my patient's health plan and payer guidelines. I also understand that verification of insurance coverage is ultimately my responsibility as the healthcare provider and that reimbursement by payers is subject to many factors. Partner Therapeutics, through PTx Assist, does not represent or guarantee that payer reimbursement or any other payment or reimbursement of any kind will be made. I understand that Partner Therapeutics does not reimburse for claims denied by payers. If my patient participates in the Patient Assistance Program, I certify that I will not charge the patient or submit a claim to any third party for services related to my patient's Bizengri therapy. I understand that any product provided under the Patient Assistance Program must only be used for the approved patient and may not be sold, traded, or returned for credit.

All final decisions on diagnosis, the need for treatment, and the appropriateness of Bizengri for a particular patient rest with me as the patient's healthcare provider. I understand that I am under no obligation to prescribe any Partner Therapeutics drug and I have not received and will not receive any benefit from Partner Therapeutics for prescribing a Partner Therapeutics drug. I further verify that I have the required authorizations, including a valid and completed HIPAA Authorization form, from my patient to release the referenced medical and/or other patient information relating to my patient's treatment to PTx Assist. By completing and signing this form, I agree to be contacted by Partner Therapeutics and companies working with them, by mail, fax, e-mail, or telephone for the purposes of managing and delivering services through the PTx Assist program. I may withdraw my request for PTx Assist services at any time by calling (877) 353-8546.

Printed Name of Prescriber: _____ **NPI #** _____

Signature
(no stamped signature) _____ **Date:** _____

For general information about the PTx Assist Support Program, including financial criteria, please call (877) 353-8546, Monday through Friday, 9:00 am to 5:00 pm Eastern Time. Please fax the completed form to (855) 881-6864.

Please see full Prescribing Information, including BOXED WARNING,
for BIZENGRI (zenocutuzumab-zbco) 20 mg/mL Injection for IV Use at www.bizengri.com.