UroGen Support™ Patient Enrollment Form for JELMYTO

For an overview of key steps, please visit **www.JELMYTO.com/hcp/support**

UroGen Support Program Offerings

Once completed, this enrollment form allows UroGen Support to provide access and reimbursement information and support to eligible JELMYTO patients. The program offerings include benefits investigation, informational support and assistance with prior authorization and coverage appeal process, billing and coding support, patient affordability programs, and logistical assistance around product acquisition, preparation, and delivery.

Jelmyto® (mitomycin) for pyelocalyceal solution | UroGen Support™

If you have questions regarding patient enrollment or require assistance, please call 855-JELMYTO (855-535-6986). Once completed, please fax this form to UroGen Support at 833-664-7216, email to escalations@urogensupport.com, or log into the portal at UroGenSupport.com to upload form.

ALL INFORMATION IS REQUIRED unless otherwise noted.

Patient Information

☐ Check here if a copy of the Patient's Face Sheet is included. If the Patient's Face Sheet is not included, please complete this section.

First name		Last name	
DOB	Gender	US Resident ☐ Yes ☐ No	Last 4 digits of SSN
Address		City/State	Zip
Email Address		Mobile Phone ☐ Preferred Phone	Home Phone ☐ Preferred Phone
Is it appropriate to leave a detailed message via voice mail? ☐ Yes ☐ No	Alternate contact name		Alternate contact number
Relationship to patient		Patient allergies	

Patient Insurance Information

☐ Check here if copies of patient's primary and secondary insurance cards are attached. ☐ Check here if patient does not have insurance.

Primary medical insurance provider	
Insurance provider phone number	Primary insurance holder (if not patient)
Primary insurance holder DOB	Primary insurance holder last 4 digits of SSN
Policy number	Group number
Secondary medical insurance provider	
Insurance provider phone number	Primary insurance holder (if not patient)
Primary insurance holder DOB	Primary insurance holder last 4 digits of SSN
Policy number	Group number

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Patient Assistance Program

☐ Check here if you would like to enroll patient in the UroGen Support Patient Assistance Program.

Total gross yearly income	Entire household income
How many people live in the household (include patient)	Visit **JELMYTO.com/hcp/support** for eligibility criteria.

Commercial Copay Program

☐ Check here if you would like to enroll the patient in the UroGen Support Commercial Copay Program.

Visit **JELMYTO.com/hcp/support** for eligibility criteria.

Patient Authorization

Health Insurance Portability and Accountability Act authorization

I authorize my healthcare providers (including those pharmacies that may receive my prescription for JELMYTO) and my health insurers to disclose personal health information (PHI) about me, including health information relating to my medical condition, treatment, prescription, financial, including results from a soft credit check, insurance coverage, as well as identifying information about me (e.g., name, address, and date of birth) to UroGen Pharma, Ltd., its affiliates, employees, representatives and its agents (collectively "UroGen" or "UroGen Support") that have been hired to administer the UroGen Support program on its behalf in order for UroGen Support to (1) enroll me in UroGen Support; (2) determine my benefit eligibility and potential out-of-pocket costs for JELMYTO; (3) communicate with my healthcare providers and health plans about my treatment plan; (4) provide support offerings including patient education and access to financial assistance for JELMYTO; (5) help get JELMYTO prepared and delivered to my healthcare providers; (6) facilitate my participation in JELMYTO patient programs that I have elected to receive information about as indicated below; and (7) provide education and instruction to my healthcare providers during the JELMYTO instillation procedures. I agree that, using the contact information I provide, UroGen Support may contact me for reasons related to the UroGen Support program and support offerings and may leave messages for me that may disclose that I am on JELMYTO therapy. I consent to being contacted by a UroGen Support program representative in order for the program to obtain further information or clarification regarding any adverse event I may experience. UroGen may also use PHI about me for quality assurance purposes and to evaluate the operations and services of UroGen Support.

I understand that once my PHI has been disclosed to UroGen Support, it is no longer protected by federal privacy laws and UroGen Support may re-disclose it; however, UroGen Support has agreed to protect my PHI by using and disclosing it only for the purposes described above or as required by law.

I can withdraw this authorization by calling UroGen Support at 855-535-6986 or mailing a letter requesting such revocation to UroGen Support, 601 S Lake Destiny Road, Suite 300, Maitland, FL 32751, but it will not change any actions taken before I withdraw authorization. Withdrawal of authorization will end further uses and disclosures of PHI by the parties identified in this form except to the extent those uses and disclosures have been made in reliance upon my authorization. I understand that I may refuse to sign this form and, if I do so, I will not be able to participate in the UroGen Support program, but it will not affect my eligibility to obtain medical treatment or my ability to seek payment for this treatment or affect my insurance enrollment or eligibility for insurance coverage. Once this form is signed, my prescriber is authorized to send my enrollment to UroGen Support via email, fax, or text message and communicate information via phone in order to facilitate the sharing of marketing materials. This authorization expires three (3) years after the date I sign below, or the maximum period allowed under applicable law if less than three years. I understand that I will receive a copy of the signed authorization.

Patient Education and Support Materials Consent

I authorize UroGen Support to send me relevant educational and support materials that pertain to low-grade UTUC and/or JELMYTO ***via email or direct mail.*** This may include materials from UroGen Pharma or a third party working on UroGen Pharma's behalf.

☐ Check this box if you do not want to receive patient education and support.

UroGen Support Patient Assistance Program and Commercial Copay Program authorization

☐ By checking this box, I understand that UroGen Support will determine my eligibility for and enroll me in the Patient Assistance Program (PAP) if I am eligible. Generally, patients are eligible for PAP if they have been prescribed JELMYTO, do not have insurance coverage for JELMYTO, and have a household adjusted gross income level less than or equal to 400% of the federal poverty level based on their household size.

☐ By checking this box, I understand that UroGen Support will determine my eligibility and enroll me in the Commercial Copay Program if I am commercially insured with a valid prescription for JELMYTO. Enrolled patients are eligible to receive an annual benefit maximum of up to $14,000. Patient is responsible for $50 per dose, and any remaining costs after any maximum monthly and/or annual benefit is reached. I also certify that information submitted for any affordability program is accurate, that expenses requested for payment are eligible, actually incurred, and that they were not and will not be paid by my insurance, Flexible Spending Account (FSA), Health Savings Account (HSA), Health Reimbursement Account (HRA), or any other payer or discount/copay program. I certify that submitted rebate claims will not be paid by Medicare, Medicaid, Tricare, CHAMPUS, VA, or any other government (state or federally funded) program, and that I am not covered under any of these programs. I understand that I am liable for any misrepresentations herein to the full extent of applicable law. Offer good only in the United States and its territories.

PRIVACY NOTICE: For more information on what data we collect about you and how we use it, as well as information about the rights you may have under the California Consumer Privacy Act, please see our Privacy Policy available at **www.urogen.com/privacy-policy/**.

Patient signature (REQUIRED): By signing this document, I authorize the release of my information as set forth above.

Patient signature	Printed name	
Date	DOB	Phone number
If applicable: authorized representative name	Relationship to patient	Phone number

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Patient Name _____ DOB _____

ALL INFORMATION IS REQUIRED unless otherwise noted.

Practice Information		Prescriber Information	
Practice name		Prescriber name	
Practice address		Prescriber address	
City/State	ZIP code	City/State	ZIP code
NPI number	Tax ID number	NPI number	
DEA number	Expiration date	Medicaid number	
Office contact name		State license number	
Phone number	Fax number	Phone number	Fax number
Email		Email	
Preferred method of contact ☐ Phone ☐ Fax ☐ Email		Preferred method of contact ☐ Phone ☐ Fax ☐ Email	

Diagnosis Information

Please select diagnosis code. Failure to do so will delay processing of the Patient Enrollment Form.

☐ C65.1 malignant neoplasm of right renal pelvis	☐ C66.1 malignant neoplasm of right ureter
☐ C65.2 malignant neoplasm of left renal pelvis	☐ C66.2 malignant neoplasm of left ureter
☐ C65.9 malignant neoplasm of unspecified renal pelvis	☐ C66.9 malignant neoplasm of unspecified ureter

Prescription Information

Instructions to Pharmacy (select all that apply)

☐ Initial Course	Prepare **one kit** of JELMYTO 80 mg weekly according to JELMYTO instructions for Pharmacy for instillation via ureteral catheter or nephrostomy tube for 6 completed instillations. **Refills: 8** (may dispense PRN for incomplete instillations).
☐ Maintenance Course	Prepare **one kit** of JELMYTO 80 mg monthly according to JELMYTO instructions for Pharmacy for instillation via ureteral catheter or nephrostomy tube. **Refills: 12**
☐ Initial Course Second Kidney/Bilateral Disease	Prepare **one kit** of JELMYTO 80 mg weekly according to JELMYTO instructions for Pharmacy for instillation via ureteral catheter or nephrostomy tube for 6 completed instillations. **Refills: 8** (may dispense PRN for incomplete instillations).
☐ Maintenance Course Second Kidney/Bilateral Disease	Prepare **one kit** of JELMYTO 80 mg monthly according to JELMYTO instructions for Pharmacy for instillation via ureteral catheter or nephrostomy tube for 6 completed instillations. **Refills: 12**

By signing below, I certify that (1) the above therapy is medically necessary and in the best interest of the patient listed above; (2) I authorize UroGen Pharma, Inc. and its contractors and business partners ("Contractors") to (i) supply any information to the insurer of the above named patient, (ii) forward the above prescription by fax or other means of delivery to a licensed pharmacy, and (iii) verify benefits and coordinate the dispense of JELMYTO where appropriate (BIR is for low-grade UTUC only); and (3) I represent to that I have obtained all necessary Federal and state authorizations and consents from my patient to allow me to release health information to UroGen Support and its contracted third parties; and (4) I agree to the Business Associate Agreement with Copilot Provider Support Services as presented at **https://baa.urogensupport.com/**.

Prescribing Physician signature (Signature required. Stamp not acceptable)	
Printed name	Date

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Patient Name _____ DOB _____

Product Delivery Information

If using a mixing partner, address where product will be delivered for instillation/treatment (if known).
If self-mixing, delivery address must match address on file with Cardinal Health SPD.

Location name	Contact name	
Address 1	City/State	Zip code
Address 2	City/State	Zip code
Phone number	Fax number	
Email	Preferred method of contact ☐ Phone ☐ Fax ☐ Email	

Site of Care Information (if different from Prescriber Information)

☐ Check here if site of care information is the same as the Prescriber Information.
☐ Check here if site of care information is the same as Practice Information.
☐ Check here if site of care is the same as the Product Delivery Information.

Note: this is where the patient will be instilled with JELMYTO. If known, all information is required.

Site of care type ☐ Physician Office ☐ Ambulatory Surgical Center ☐ Hospital Outpatient		Other
Site of care name	Site of care contact name	
Address 1	City/State	Zip code
Address 2	City/State	Zip code
Phone number	Fax number	Email
NPI number	Medicaid number	Tax ID number
Site of care scheduler contact name (if different from site of care contact)		Phone number
Site of care benefits contact name (where patient insurance coverage results will be sent)		Phone number
Preferred method of contact ☐ Phone ☐ Fax ☐ Email		

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