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Astellas Pharma Support Solutions

ASTELLAS PATIENT ASSISTANCE PROGRAM
APPLICATION FORM FOR MYRBETRIQ® (mirabegron extended-release tablets)

Website: www.astellaspharmasupportsolutions.com
Phone: 1-800-477-6472 **Fax:** 1-866-317-6235
Address: P.O. Box 501847, San Diego, CA 92150
Hours: Monday–Friday from 9 AM–8 PM ET

PATIENT AND SHIPMENT INFORMATION

The application MUST be submitted together with a signed Patient Authorization Form (PAF) in order for Astellas Pharma Support Solutions℠ (APSS) to evaluate a patient's eligibility under the Astellas Patient Assistance Program. The patient's signature on the PAF allows APSS to use the patient's personally identifiable information to determine eligibility for enrollment in the program. Upon patients' enrollment in the Astellas Patient Assistance Program, the patient's prescription for Myrbetriq will be shipped to the address below unless indicated otherwise in the Alternate Shipping Information section.

Patient Name: _____ **Sex:** Male Female

Daytime Phone: _____ **Evening/Cell Phone:** _____

Home Address: _____

City: _____ **State:** _____ **ZIP:** _____

ALTERNATE SHIPPING INFORMATION (MYRBETRIQ CANNOT BE SHIPPED TO P.O. BOX)

☐ **DO NOT** ship Myrbetriq directly to the address identified in the Patient and Shipment Information section. Ship the Myrbetriq supply to the address below.

Site Name (if applicable): _____

Contact Person Name: _____ **Telephone:** _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

ASSESSMENT FOR PATIENT ASSISTANCE PROGRAM

Evaluate the patient for the Astellas Patient Assistance Program?

☐ Yes ☐ No

If APSS needs additional information to determine the patient's income eligibility under the program, APSS may request such information from the HCP or patient.

CURRENT INSURANCE INFORMATION

Insurance Status:

Patient is insured **Patient is uninsured** **Patient is pending insurance with:** _____ (type or name of insurance)

Patient Insurance Policy 1:

Medicare Part B **Medicaid** **Private/Commercial*** *Includes Medicare Advantage

Policy Name: _____
Subscriber Name: _____
Subscriber ID #: _____
Telephone: _____
Effective Date: _____

Patient Insurance Policy 2:

Medicare Part B **Medicaid** **Private/Commercial*** *Includes Medicare Advantage

Policy Name: _____
Subscriber Name: _____
Subscriber ID #: _____
Telephone: _____
Effective Date: _____

Patient Prescription Insurance:

Medicare Part D **Private/Commercial***

Insurer/PBM Name: _____
Telephone: _____

Subscriber ID #: _____
Subscriber Name: _____

FOR FULL PRESCRIBING INFORMATION SEE WWW.US.ASTELLAS.COM/THERAPEUTIC/PRODUCT/
OR CONTACT ASTELLAS MEDICAL INFORMATION AT 1-800-727-7003.

ASTELLAS PATIENT ASSISTANCE PROGRAM APPLICATION FORM (CONTINUED)

PRESCRIBER AND PRACTICE INFORMATION

Prescriber Name: _____

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

Facility/Practice Name: _____

Facility/Practice Address: _____

Contact Person Name (other than Prescriber): _____

Telephone: _____ Fax: _____

PRESCRIPTION FOR Myrbetriq® (mirabegron extended-release tablets)

Complete the prescription information below in its entirety to request a **90-day supply.**

Patient Name: _____ Date of Birth: _____

Diagnosis Code: _____

Known Allergies: _____

Myrbetriq Strength and Frequency:

25 mg (Bottle of 90, NDC 0469-2601-90) once daily

50 mg (Bottle of 90, NDC 0469-2602-90) once daily

Total Daily Quantity: 90

Total Refills: ☐ 0 ☐ 3

Prescriber's original signature (stamps not accepted) _____ **Date:** _____

CERTIFICATION AND CONSENT FOR THE ASTELLAS PATIENT ASSISTANCE PROGRAM

I hereby attest that I am the prescribing healthcare provider and that the Astellas medicine I prescribed to this patient is medically appropriate and I have explained such to my patient. I certify that I have received the necessary authorization to release the protected health information (as defined by the Health Insurance Portability and Accountability Act [HIPAA] of 1996) referenced in the application submitted to Astellas Pharma Support Solutions℠ (APSS) for the purpose of APSS evaluating the patient's eligibility for the Astellas Patient Assistance Program. Additionally, I authorize APSS, as designated agent and on behalf of my patient, to forward a prescription for the Astellas medicine, by fax or other mode of delivery, to a pharmacy.

I certify that this prescription complies with all applicable state and local laws. I also certify that the information regarding the patient, including prescription insurance status, is accurate to the best of my knowledge.

If my patient obtains the Astellas medicine via the Astellas Patient Assistance Program, I understand that (a) no third party or patient can be charged for the medicine provided under the program and (b) that no free product should be sold, traded, or distributed for sale. I also understand that provision of free drug as part of the Astellas Patient Assistance Program is not contingent upon future purchase or prescribing of any Astellas medicine.

I acknowledge I may be contacted by email, postal mail, or fax using the information I've provided, and I understand my personal information will be used and disclosed by Astellas in accordance with Astellas' privacy policy, available at www.astellas.com/us/privacy-policy.

***My signature below certifies that I have read, understand and agree to the prescriber certification statement above.**

Prescriber's original signature* (stamps not accepted) _____ **Date:** _____

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Myrbetriq (mirabegron extended-release tablets) 25 mg, 50 mg SUPPORT SOLUTIONS

PATIENT AUTHORIZATION FORM

My signature authorizes my doctor(s), my healthcare providers, my health plan or payer, and my pharmacy to disclose to Astellas ("Company") and its third-party suppliers, vendors, and other service providers supporting MYRBETRIQ Support Solutions (collectively, the "Service Providers") information about me (for example, my name, Social Security number, address, insurance policy number, and income) and my medical condition (for example, my diagnosis or medications) (together, "Personally Identifiable Information"). This information can include spoken or written facts about my health and insurance benefits. It can include copies of records from my healthcare providers or health plans about my health or healthcare. I understand that my healthcare providers and my pharmacy may receive remuneration, or payment, for disclosing my information pursuant to this authorization.

I understand that MYRBETRIQ Support Solutions is a component of Astellas Pharma Support Solutions℠ and that the Service Providers may be compensated by Astellas. The Service Providers will use and give out my information to:

(i) Assist in my enrollment in MYRBETRIQ Support Solutions and to contact me and/or the person legally authorized to sign on my behalf;

(ii) Provide me and/or the person legally authorized to sign on my behalf with educational and other materials, information, and support related to MYRBETRIQ Support Solutions;

(iii) Verify, investigate, assist with, and coordinate my coverage for MYRBETRIQ® (mirabegron extended-release tablets) with my payer;

(iv) Coordinate prescription fulfillment;

(v) Assess my eligibility for patient assistance and/or benefits, if necessary;

(vi) Make referrals to other independent programs or alternate sources that may be available to provide assistance to me as allowed under the law, if necessary; and

(vii) Assist with analyses of the efficiencies and performance of Services provided by Service Providers.

In some instances, the Service Providers may de-identify my information and use or disclose the de-identified information (in individual or aggregated form) for any legitimate business purposes.

I understand that the Service Providers will make reasonable efforts to keep my

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information private; however, I understand that once my information has been disclosed to the Service Providers, how the Service Providers further disclose my information may no longer be protected under federal and state privacy laws.

This authorization will last for three (3) years from the date below or until I am no longer receiving MYRBETRIQ® (mirabegron extended-release tablets) or enrolled in MYRBETRIQ Support Solutions, whichever is later. I do not have to provide this authorization, but if I do not, I will not be able to have my insurance coverage verified, have alternate sources of assistance researched, or access other support provided by or on behalf of MYRBETRIQ Support Solutions. My choice as to whether to provide this authorization will not change the way my doctors, healthcare providers, or payers treat me. If I no longer wish to participate in MYRBETRIQ Support Solutions, I shall inform my healthcare providers and/or the administrators of MYRBETRIQ Support Solutions in writing that I do not want them to share any more information with the Service Providers, but it will not change any actions that took place before I told them. I have the right to revoke or cancel this authorization, in writing, at any time by providing written notice to my healthcare providers and/or the administrators of MYRBETRIQ Support Solutions. Cancellation of this authorization will be valid when received by the administrators of MYRBETRIQ Support Solutions. I understand that a cancellation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I know I have a right to see or copy the information my healthcare providers or payers have given to the Service Providers.

If an application is submitted to determine my eligibility for assistance from the Astellas Patient Assistance Program (PAP), I agree to allow Company and Service Providers to use my demographic information, including, but not limited to, Social Security number, date of birth, name, and/or address, as needed to access my credit information and information derived from public and other sources, including information from a consumer reporting agency (credit bureau), to estimate my income in conjunction with the eligibility determination process performed to determine my eligibility under the PAP. Company and Service Providers reserve the right to ask for additional documents and information at any time. I agree to notify my healthcare providers and MYRBETRIQ Support Solutions if I become aware of changes that would affect my eligibility, including, but not limited to, changes in health insurance status or coverage, financial status, and United States residency.

If your application is approved, MYRBETRIQ Support Solutions can send you text

messages about the Program throughout your enrollment period. These text messages are optional. You can participate in the Program without signing up for text messages. When you sign up for the text messages (by providing your cell phone number), you must agree to the following conditions:

- Program will send an autodialed, pre-recorded text message (standard text message and data rates apply).
- You can opt out at any time by calling 1-800-477-6472 or replying "STOP" to the text messages.
- Program is not responsible if a communication is not delivered due to technical difficulties like server issues, phone carrier outages, or discontinued service.
- Be aware that anyone who can open or have access to your phone might see your text messages.
- If your mobile operator is not participating in text messaging services, you will not receive text messages.
- These text messages are NOT reminders to take your medication. You are responsible to take your medication as prescribed.
- Do NOT report product complaints or adverse events (like side effects) by text message. To report these, please call MYRBETRIQ Support Solutions at 1-800-477-6472.
- To receive text messages, you must provide your cell phone number.

Astellas is committed to the safety and effectiveness of our products. In the event you experience an adverse drug event or side effect, Astellas requests your consent to be able to contact you, your family member, and/or your healthcare provider. This contact may be via phone, email, or any commonly used electronic form or medium. The purpose of this follow up is to help us at Astellas to better understand the event you experienced in relation to our product.

For additional information regarding how Astellas handles personal information, please visit our Privacy Policy link at: https://www.astellas.com/us/privacy-policy.

This Authorization Statement is governed by and interpreted in accordance with the laws of the state of Illinois, excluding Illinois conflict of law rules, and applicable federal law.

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Patient Signature

By signing below, I provide my agreement to this written consent and authorization, which certifies that I have read and understand the above Patient Authorization Form.

Patient Name (please print): _____

Patient Signature: _____Date:_____

Representative Signature

If this Patient Authorization Form is being signed by a representative, please describe the representative's authority to act on behalf of the patient:

_____

☐ I am acting for another person and I hereby affirm that I have the legal right to do so, that I am the parent or legal guardian of the patient, or that I otherwise have a valid power of attorney to act on behalf of the patient.

Representative Name (please print): _____

Representative Signature: _____Date:_____

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