IncyteCARES
Connecting to Access, Reimbursement, Education and Support

Jakafi®
ruxolitinib (tablets)

IncyteCARES Program Enrollment Form

Please legibly complete all fields not marked optional, for timely processing. **Fax completed form to 1-855-525-7207**.

We will contact you within 2 business days. For questions, call **1-855-452-5234.**

*For details about all program services your patient can receive upon enrollment, see **IncyteCARES.com**.*

☐ **Check here to request only a Benefits Investigation for your patient.**

PATIENT INFORMATION

Full Name _____ Date of Birth ____ /____ /____

Home Address _____

City _____ State _____ ZIP _____

Medicare ID *(Optional)* _____ Email *(Optional)* _____

Phone Number _____ Alternate Phone Number *(Optional)* _____

Best Time to Call *(Optional)* ☐ Morning ☐ Afternoon ☐ Evening

Primary Language *(Optional)* ☐ English ☐ Spanish ☐ Other _____

Is patient a resident of the United States or Puerto Rico? ☐ Yes ☐ No

ALTERNATE CONTACT *(Optional)*

Full Name _____ Relationship _____ Phone Number _____

FINANCIAL INFORMATION *(Optional)*—Required only to apply for the Patient Assistance Program.
See **IncyteCARES.com** for details.

Current Annual Household Income _____ Number of People in Household _____

INSURANCE INFORMATION

Primary Prescription Insurer _____ Phone _____

Policy ID Number _____ Group Number _____

If patient is the policy subscriber, check here and skip fields below. ☐

Subscriber Name _____ Subscriber Date of Birth ____ /____ /____

Secondary Prescription Insurer *(Optional)* _____ Phone _____

Policy ID Number _____ Group Number _____

*If patient is **not** the policy subscriber, check here and complete fields below.* ☐

Subscriber Name _____ Subscriber Date of Birth ____ /____ /____

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For complete program details, visit **IncyteCARES.com**. ***Please see Full Prescribing Information at Jakafi.com.***

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PRESCRIBER DECLARATION

I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Jakafi based on my professional judgment of medical necessity.

I represent and warrant that I have my patient's authorization on file to (i) disclose his/her health information and to transfer such information to Incyte and its agents to use and disclose as necessary to provide reimbursement services and (ii) to forward this prescription to a dispensing pharmacy on behalf of my patient.

I appoint IncyteCARES solely to convey on my behalf, to the pharmacy chosen by or for the patient, the prescription described herein.

I authorize IncyteCARES to perform a preliminary assessment of insurance verification for the patient, and I further authorize and request that the program provide to me any and all information necessary for completing a Letter of Medical Necessity as may be required as a result of such insurance verification assessment.

☐ **I have read and agree to the declaration above.**

Prescriber Name _____ Date ____ /____ /____

PRESCRIPTION FOR JAKAFI

Use this section to write your patient's prescription.
A separate prescription form is not needed, unless required by state law. Date ____ /____ /____

Patient Name _____ Date of Birth ____ /____ /____

Medication Name: Jakafi® (ruxolitinib) Dosage: ☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 25 mg

Directions _____

Concurrent Medications *(Optional)* _____

Allergies *(Optional)* _____

Days Supply: ____ Refill(s) ____ DEA Number *(Optional)* _____

Ship medication to: ☐ Patient's Home ☐ Doctor's Office

Preferred Specialty Pharmacy *(Optional)* _____

Prescriber Signature _____ Date ____ /____ /____

PRESCRIBER INFORMATION

Prescriber Full Name _____

State License Number _____ Payer-Specific ID Number _____

Tax ID Number _____ NPI Number _____

Site/Facility Name _____

Street Address _____ City _____ State ____ ZIP _____

Office Contact Name _____ Email *(Optional)* _____

Phone Number _____ Fax Number _____

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CLINICAL INFORMATION

Indication for which you are prescribing Jakafi® (ruxolitinib) for this patient:

☐ Intermediate or high-risk myelofibrosis (MF), including primary MF, post–polycythemia vera MF, and post–essential thrombocythemia MF in adults

☐ Polycythemia vera (PV) in adults who have had an inadequate response to or are intolerant of hydroxyurea

☐ Steroid-refractory acute graft-versus-host disease (GVHD) in adult and pediatric patients 12 years and older

☐ Other (include description and diagnosis code) _____

Treatment status: ☐ New to Jakafi ☐ Currently on Jakafi ☐ Restarting Jakafi

Please see Important Safety Information for Jakafi on page 4.

PATIENT AUTHORIZATION

All fields are required unless noted.

I authorize my healthcare providers (eg, physicians, pharmacies) and my insurance company to disclose personal health information about me, including information related to my medical condition and treatment, my health insurance coverage, and my address, email address, and telephone number (collectively, my "PHI") to Incyte, its agents, and the IncyteCARES Program (collectively, "Incyte") so that Incyte may use the information for purposes of: (i) assisting in my enrollment in IncyteCARES; (ii) assessing my eligibility for copay assistance or free drug or referring me to other programs or sources of funding and financial support; (iii) coordinating delivery of Jakafi® (ruxolitinib) to me or my healthcare provider; (iv) providing education, information on Incyte products and services, and ongoing support services to me related to Jakafi; (v) gathering feedback on my therapy and/or disease state; (vi) contacting me by mail, email, phone, or fax for any of the above purposes; and (vii) creating information that does not identify me personally for use for other legitimate purposes. I understand that my pharmacy providers may receive remuneration for making such disclosures. I also authorize my healthcare providers and my insurance company to use my PHI to communicate with me about Incyte products and services and I understand that they may receive remuneration for making such communications. I understand that, once disclosed pursuant to this authorization, my PHI may no longer be protected under federal or state law and could be disclosed by Incyte to others, but I understand that Incyte will make reasonable efforts to keep it private and to disclose it only for the purposes set forth in this authorization.

I understand that I do not have to sign this authorization to obtain healthcare treatment or benefits; however, in order to receive the services and communications described above, I must sign the authorization. I understand that I may cancel my authorization at any time by contacting IncyteCARES at 1-855-452-5234 or by mail at PO Box 221798, Charlotte, NC 28222-1798. My cancellation of this authorization will be effective when my healthcare providers and insurance companies are notified of its receipt by Incyte, but will not apply to PHI already used or disclosed in reliance upon this authorization.

I understand that I have a right to receive a copy of this authorization. This authorization expires one year after the date below unless I cancel it before then.

☐ **For patients eligible for IncyteCARES education and support program (which includes occasional emails and outbound calls):** I agree to be contacted by Incyte, its agents, and the IncyteCARES program representatives about information on Incyte products and services at the email address and phone number(s) provided in my enrollment form. To review Incyte's Privacy Policy, please visit **https://incyte.com/privacy-policy**.

Patient's Full Name _____

Signature _____ Date ____ /____ /____

Patient's Legal Representative *(Optional)* _____

Signature _____ Date ____ /____ /____ Relationship with patient _____

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IMPORTANT SAFETY INFORMATION

- Treatment with Jakafi® (ruxolitinib) can cause thrombocytopenia, anemia and neutropenia, which are each dose-related effects. Perform a pre-treatment complete blood count (CBC) and monitor CBCs every 2 to 4 weeks until doses are stabilized, and then as clinically indicated
- Manage thrombocytopenia by reducing the dose or temporarily interrupting Jakafi. Platelet transfusions may be necessary
- Patients developing anemia may require blood transfusions and/or dose modifications of Jakafi
- Severe neutropenia (ANC <0.5 × 10^9/L) was generally reversible by withholding Jakafi until recovery
- Serious bacterial, mycobacterial, fungal and viral infections have occurred. Delay starting Jakafi until active serious infections have resolved. Observe patients receiving Jakafi for signs and symptoms of infection and manage promptly. Use active surveillance and prophylactic antibiotics according to clinical guidelines
- Tuberculosis (TB) infection has been reported. Observe patients taking Jakafi for signs and symptoms of active TB and manage promptly. Prior to initiating Jakafi, evaluate patients for TB risk factors and test those at higher risk for latent infection. Consult a physician with expertise in the treatment of TB before starting Jakafi in patients with evidence of active or latent TB. Continuation of Jakafi during treatment of active TB should be based on the overall risk-benefit determination
- Progressive multifocal leukoencephalopathy (PML) has occurred with Jakafi treatment. If PML is suspected, stop Jakafi and evaluate
- Advise patients about early signs and symptoms of herpes zoster and to seek early treatment
- Increases in hepatitis B viral load with or without associated elevations in alanine aminotransferase and aspartate aminotransferase have been reported in patients with chronic hepatitis B virus (HBV) infections. Monitor and treat patients with chronic HBV infection according to clinical guidelines
- When discontinuing Jakafi, myeloproliferative neoplasm-related symptoms may return within one week. After discontinuation, some patients with myelofibrosis have experienced fever, respiratory distress, hypotension, DIC, or multi-organ failure. If any of these occur after discontinuation or while tapering Jakafi, evaluate and treat any intercurrent illness and consider restarting or increasing the dose of Jakafi. Instruct patients not to interrupt or discontinue Jakafi without consulting their physician. When discontinuing or interrupting Jakafi for reasons other than thrombocytopenia or neutropenia, consider gradual tapering rather than abrupt discontinuation
- Non-melanoma skin cancers including basal cell, squamous cell, and Merkel cell carcinoma have occurred. Perform periodic skin examinations
- Treatment with Jakafi has been associated with increases in total cholesterol, low-density lipoprotein cholesterol, and triglycerides. Assess lipid parameters 8-12 weeks after initiating Jakafi. Monitor and treat according to clinical guidelines for the management of hyperlipidemia
- In myelofibrosis and polycythemia vera, the most common nonhematologic adverse reactions (incidence ≥15%) were bruising, dizziness, headache, and diarrhea. In acute graft-versus-host disease, the most common nonhematologic adverse reactions (incidence >50%) were infections and edema
- Dose modifications may be required when administering Jakafi with strong CYP3A4 inhibitors or fluconazole or in patients with renal or hepatic impairment. Patients should be closely monitored and the dose titrated based on safety and efficacy
- Use of Jakafi during pregnancy is not recommended and should only be used if the potential benefit justifies the potential risk to the fetus. Women taking Jakafi should not breastfeed during treatment and for 2 weeks after the final dose

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