Yonsa®
(abiraterone acetate)
125 mg tablets

# YONSA SUPPORT®

## Patient Assistance Program (PAP) Application

YONSA SUPPORT® will initiate a benefits investigation (BI) of your patient's insurance coverage for YONSA®. If applicable, YONSA SUPPORT® will research eligibility for the YONSA SUPPORT® PAP for non-insured, functionally uninsured, and underinsured patients. If eligible, YONSA SUPPORT® will help with this PAP application.

To get your patients started, prescribers are required to complete this form in its entirety with their patient, as well as sign and fax the form and any supporting documents to the YONSA SUPPORT® PAP at 1-877-872-6575 or mail to PO Box 29051, Phoenix, AZ 85038-9051.

Please see eligibility guidelines inside.

**Please see accompanying Full Prescribing Information.**

# HOW TO APPLY

**1. Complete** this form in its entirety with your patient.

**2. Sign & Date** the form.

*IMPORTANT: Wet signatures are required from both the patient and the prescriber. Once you've completed the form, please be sure to add wet signatures in both patient and prescriber sections.*

**3. Fax** the completed, signed form with the appropriate supporting information to 1-877-872-6575 (or mail to PO Box 29051, Phoenix, AZ 85038-9051), based on the following patient insurer status:

**NO INSURANCE:** Fax the completed, signed form and proof of income.

**FINANCIAL HARDSHIPS:** Fax the completed, signed form, proof of income, and supporting documentation explaining changes in circumstances (eg, loss of employment, change in marital status).

*IMPORTANT: Proof of income should be in the form of 1) the previous year's federal income tax returns for the patient, spouse, and dependents; 2) all income statements from the patient's employer (W2 or 1099); or 3) the patient's Social Security Income Yearly Benefits Statement.*

**PREVIOUS APPROVAL OR DENIAL:** If there is already a prior authorization (PA) or insurance appeals approval or denial, please include in the fax. If a PA is required for the Sun Pharma product requested, you will need to provide the PA number and date of approval or attach a copy of the denial letter. If this is a renewal, you will need to process and submit a new PA. If this information is not received with the healthcare provider section of this application, there may be a delay in processing for your patient.

# WHAT TO EXPECT AFTER APPLYING

Once the application is received, a YONSA SUPPORT® customer service representative will conduct a BI to help better understand your patient's coverage and the costs associated with YONSA® treatment. Providing complete and accurate information will ensure a timely response to your request.

Once the BI is completed, YONSA SUPPORT® will:

- Follow up with the provider and payer to make sure that the PA is submitted and approved
  NOTE: If the PA is denied, the customer service representative will send the appeal requirements to the provider and follow up at a later time
- Process the outcome of the BI and evaluate your patient's eligibility
- Research eligibility for the YONSA SUPPORT® PAP, if applicable, for non-insured, functionally uninsured, and underinsured patients. If eligible, YONSA SUPPORT® will help with this PAP application

**Please see accompanying Full Prescribing Information.**

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# ELIGIBILITY GUIDELINES

Eligibility is subject to each patient's current status. Eligibility reverification will be completed on a case-by-case basis, based on each patient's insurance. For patients with government insurance, eligibility reverification occurs at the start of the calendar year (January 1). Uninsured patients and commercially insured patients must have eligibility reverified 12 months after the original date of the application. Eligibility guidelines are subject to change. Sun Pharma reserves the right to change, rescind, or revoke its Patient Assistance Program at any time.

## Patients may qualify for the YONSA SUPPORT® PAP if the following guidelines are met:

### Non-insured patients

- Residency in the United States, Puerto Rico, Guam, or Virgin Islands
- Insurance coverage is terminated (commercial, Medicare, or Medicaid), or the patient has no insurance
- Income at or below 400% of the federal poverty level (FPL), or a hardship exception (between 400% and 425%) and cost of drug that is greater than 10% of the patient's annual household income
- Diagnosis is an on-label ICD-10-CM code
- At least 18 years of age

### Functionally uninsured patients

- Residency in the United States, Puerto Rico, Guam, or Virgin Islands
- Commercial insurance does not cover YONSA®, no prescription coverage, emergency only, discount card only, exceeded yearly cap, generic coverage only, product not on formulary (no non-formulary exception available or non-formulary exception not approved)
- Patients who are enrolled in a government insurance program (such as Medicare or Medicaid) are not eligible for PAP if that program provides any coverage for YONSA®
- Income at or below 400% of the FPL, or a hardship exception (between 400% and 425%) and cost of drug that is greater than 10% of the patient's annual household income
- Diagnosis is an on-label ICD-10-CM code
- At least 18 years of age

### Underinsured patients

- Residency in the United States, Puerto Rico, Guam, or Virgin Islands
- Insurance coverage identified, but the patient cannot afford out-of-pocket costs
- Income at or below 400% of the FPL, or a hardship exception (between 400% and 425%) and cost of drug that is greater than 10% of the patient's annual household income
- Diagnosis is an on-label ICD-10-CM code
- At least 18 years of age

**Please see accompanying Full Prescribing Information.**

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VERSION 2, APRIL 2021

# YONSA SUPPORT® Patient Assistance Program

Please complete this form in its entirety. Once completed, please print, sign, and fax to the YONSA SUPPORT® Patient Assistance Program at 1-877-872-6575 or mail to PO Box 29051, Phoenix, AZ 85038-9051. If you have any questions about this application, please call 1-855-44YONSA (1-855-449-6672) Monday - Friday, 8 AM – 8 PM EST.

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## PATIENT INFORMATION

○ NEW PATIENT APPLICATION ○ PATIENT REAPPLICATION

First name | Middle initial | Last name | Date of birth (MM/DD/YYYY)

Address | City/State | ZIP code

Phone number

**GENDER:** ○ Male ○ Female ○ Prefer not to say

Previous treatment history, if any

## INCOME

**NOTE:** You (the patient) will need to provide proof of household income. Please be sure to fax proof of income with this form.

Number of people in the household (yourself, your spouse, and any dependents)

Total combined **monthly** household income (yourself, your spouse, and any dependents)

Total combined **annual** household income (yourself, your spouse, and any dependents)

## INSURANCE INFORMATION

**PLEASE CHECK ONE:**

○ No insurance coverage

○ **PREFERRED:** Copy of the policyholder's insurance card(s) (front and back) is attached (include all insurance cards: commercial, Medicare, and/or secondary insurance and prescription card)

○ Complete the insurance information below (if you cannot copy the policyholder's insurance card[s])

Primary insurance | Policy holder

Insurance phone # | Policy ID

Group # | Rx BIN | PCN

## PATIENT ATTESTATION AND HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

By signing this form below, I give permission for my healthcare providers (HCPs), my pharmacies, and my health insurer(s) to disclose my personal information, including information about my health insurance and payment/benefits, prescriptions, medical condition and treatment, and my demographic and contact information ("Personal Information") to Sun Pharmaceutical Industries, Inc., its affiliates, business partners, service providers, third-party contractors, and agents (together, "Sun Pharma") for the purposes described below.

I understand the purpose of this Authorization is to (1) apply for the YONSA SUPPORT® Patient Assistance Program (the "Program"), including to help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with YONSA®, coordinate my receipt of and payment for YONSA®, facilitate my access to YONSA®, and assist in an appeal, grievance, and/or independent review request of a denial of insurance benefits and/or coverage; (2) manage the Program, which may include conducting quality assurance and other internal business activities in connection with the Program; (3) provide me with adherence reminders and treatment support; (4) for marketing purposes which includes, but is not limited to, providing me with educational and promotional materials, information, special offers, and services related to my therapy or my medical condition, which may be funded or sent by a Program affiliate; and (5) for market research purposes, which includes contacting me to participate in focus groups, surveys, or interviews. Please complete this form in its entirety. Once completed, please print, sign, and fax to the YONSA SUPPORT® Patient Assistance Program at 1-877-872-6575 or mail to PO Box 29051, Phoenix, AZ 85038-9051. If you have any questions on the application, please call 1-855-44YONSA (1-855-449-6672) Monday - Friday, 8 AM – 8 PM EST.

I understand that my Personal Information may be summarized for statistical or other purposes and provided to Sun Pharma.

While the Program will safeguard my Personal Information and only use it for intended purposes, I understand that once my Personal Information is disclosed to Sun Pharma it may no longer be protected by federal privacy law. I understand that I may refuse to sign this Authorization. I also may revoke (withdraw) this Authorization at any time in the future by sending a written notice to PO Box 29051, Phoenix, AZ 85038-9051, or by calling 1-855-44YONSA (1-855-449-6672), but I understand that this revocation will only apply to my HCPs, pharmacies, and health insurer(s) once they receive notification of my revocation and only to the extent they have not already taken action based on it. My refusal to sign this Authorization or future revocation will not affect the commencement or continuation of my treatment, payment for treatment, insurance enrollment, or eligibility for benefits; however, if I refuse to sign this Authorization or if I revoke this Authorization, I may no longer be eligible to participate in the Program. I understand that this Authorization will remain valid for five (5) years after the date of my signature, unless a shorter period is mandated by state law or I revoke it before then. I understand that I have the right to receive a copy of this Authorization.

Patient signature | Printed name | Date (MM/DD/YYYY) | Personal rep signature | Printed name | Date (MM/DD/YYYY)

**I ACKNOWLEDGE THAT I HAVE READ AND AGREE TO THE PATIENT HIPAA AUTHORIZATION ABOVE.**

Patient signature | Printed name | Date (MM/DD/YYYY) | Personal rep signature | Printed name | Date (MM/DD/YYYY)

VERSION 2, APRIL 2021

# YONSA SUPPORT® Patient Assistance Program

Please complete this form in its entirety. Once completed, please print, sign, and fax to the YONSA SUPPORT® Patient Assistance Program at 1-877-872-6575 or mail to PO Box 29051, Phoenix, AZ 85038-9051. If you have any questions about this application, please call 1-855-44YONSA (1-855-449-6672) Monday - Friday, 8 AM – 8 PM EST.

Yonsa® (abiraterone acetate) 125 mg tablets

## PRESCRIBER INFORMATION

Prescriber's name | NPI #

Phone | Fax

Address

City | State | ZIP code

## YONSA® PRESCRIPTION INFORMATION

**PRESCRIBER: PLEASE ATTACH A SEPARATE PRESCRIPTION IF THIS SECTION DOES NOT COMPLY WITH YOUR STATE'S PRESCRIPTION LAW.**

Patient name | Date of birth (MM/DD/YYYY)

**ICD-10-CM DIAGNOSIS CODE:** ◯ C61 - malignant neoplasm of the prostate ◯ Other

**SECONDARY DIAGNOSIS/ICD-10-CM:**

◉ YONSA® (abiraterone acetate) 125 mg

Directions | Refills

Quantity | Days' supply

Has the patient previously been treated with Zytiga® or Xtandi®: ◯ Yes ◯ No

Prescriber signature (wet signature required) | Print prescriber name | Date (MM/DD/YYYY)

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◯ **DISPENSE AS WRITTEN**

## METHYLPREDNISOLONE PRESCRIPTION INFORMATION

**PRESCRIBER: PLEASE ATTACH A SEPARATE PRESCRIPTION IF THIS SECTION DOES NOT COMPLY WITH YOUR STATE'S PRESCRIPTION LAW.**

This section is mandatory as methylprednisolone is required to be taken with YONSA®.

◉ Methylprednisolone 4-mg tablet

Directions | Refills

Quantity | Days' supply

Is the patient non-compliant with any food restrictions? ◯ Yes ◯ No

Prescriber signature (wet signature required) | Print prescriber name | Date (MM/DD/YYYY)

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## PRESCRIBER ATTESTATION AND SIGNATURE

Methylprednisolone is required to be taken with YONSA®. NOTE: YONSA SUPPORT® will not investigate benefits for methylprednisolone. Please refer to the Full Prescribing Information before initiating treatment. Sun Pharmaceutical Industries, Inc., and its contractors and agents (together "Sun Pharma"), will use the information you provide to administer and improve YONSA SUPPORT® Patient Assistance Program (the "Program") as well as authorize Sun Pharma to communicate via telephone, fax, or email to carry out the services described in the application. By signing below, I (the prescriber) understand and agree that:

- I certify that the patient and physician information obtained in this application is complete and accurate to the best of my knowledge
- I have prescribed YONSA® based on my professional judgment of medical necessity
- Any medications supplied by Sun Pharma as a result of this form are for use by the named patient only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third-party payer (private or government) for reimbursement
- Sun Pharma may modify or terminate the Program at any time without notice
- I have received the necessary legal authorization from the patient to transmit the patient's personal health information, for the purposes provided on this form, to Sun Pharma
- I authorize the Program to transmit prescribing information to a third party(ies) to dispense the drug above to this patient
- My patient has provided a signed HIPAA Authorization that allows me to share protected health information with Sun Pharma for purposes of this program
- The YONSA SUPPORT® Patient Assistance Program may contact me for additional information relating to the Program, including but not limited to via email, fax, telephone, and text

Prescriber signature (wet signature required) | Print prescriber name | Date (MM/DD/YYYY)

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SUN PHARMA

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# Questions?

## Contact your Sun Representative

Please contact your Sun Representative (Field Reimbursement Manager or Regional Business Director) with any questions about the application process or call YONSA SUPPORT® at **1-855-44YONSA (1-855-449-6672)** Monday - Friday, 8 AM – 8 PM EST.

To start the application process for your patient, please complete, sign, and fax pages 4 and 5 of this form to **1-877-872-6575** or mail to **PO Box 29051, Phoenix, AZ 85038-9051**.

**Please see accompanying Full Prescribing Information.**