UNLOXCYT SUPPORT™ Patient Services Enrollment Form

Fax completed form and copies of both sides of insurance and pharmacy benefit cards to **UNLOXCYT SUPPORT**.
Fax: 1-855-786-7458

Please complete all required fields (marked with an asterisk [*]) to prevent delays. For more information or assistance, please call UNLOXCYT SUPPORT at 1-855-865-9994 or visit www.unloxcytpro.com/support.

1 Patient Information (*REQUIRED)

***Patient Name:** _____
***Address:** _____
***Mobile Phone:** _____ Alternate Phone: _____
Caregiver Name: _____

***Date of Birth:** ____ / ____ / ____ ☐ Male ☐ Female ☐ Other
***City/State/ZIP:** _____
Email: _____
Caregiver Phone: _____ Caregiver Email: _____

Messaging Consent (OPTIONAL):

☐ Opt in to receive recurring automated text messages from UNLOXCYT SUPPORT, including refill reminders and a digital savings card, at the mobile phone number provided. Consent to receiving text messages is not a condition of purchase of goods or services. Message and data rates may apply. Message frequency varies. Text HELP for help. Text STOP to opt out. Please visit SUN PHARMACEUTICAL INDUSTRIES, INC.'s privacy policy at https://sunpharma.com/usa/privacy-policy/ and the mobile terms and conditions at www.unloxcytpro.com/support. Checkpoint Therapeutics Inc. is a subsidiary of Sun Pharmaceutical Industries, Inc.

☐ By checking this box, I am requesting Patient Access Liaison service for my patient. I understand that Patient Access Liaisons do not work under the direction of an HCP, nor do they offer medical advice. By requesting this service, I understand that a Patient Access Liaison may reach out to my patient on a regular basis to offer support throughout the UNLOXCYT™ treatment journey.

2 Insurance

Patient is: ☐ a US resident ☐ Uninsured ☐ Card(s) attached (if checked, proceed to step 3)

	Primary Insurer	Secondary Insurer
Insurer Name		
Insurer Phone		
Policyholder Name		
Policy #		
Group #		
Medicare Beneficiary ID #		
Policyholder's Relationship to Patient		

3 Prescriber (*REQUIRED, where applicable)

***Prescriber Name:** _____
***NPI #:** _____ ***State License #:** _____
PTAN #: _____ DEA #: _____ Tax ID #: _____
Collaborating Physician Name (If Applicable): _____
NPI #: _____

Administration Site of Care (if different than Practice/Facility Name):
Name of facility: _____
Address: _____
City/State/ZIP: _____
☐ Physician Office ☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Ambulatory Surgical Center

***Practice/Facility Name:** _____
***GRP NPI #:** _____
***Address:** _____
***City/State/ZIP:** _____
Office Contact: _____
Phone: _____ Fax: _____
Email: _____
Preferred Method of Contact: ☐ Phone ☐ Fax ☐ Email

4 Prescription and Authorization (*REQUIRED)

Please check the appropriate box:

☐ **Patient is a new start: Expected start date:** ____ / ____ / ____

☐ **Patient is an existing patient: # of infusions:** _____
Last infusion date: ____ / ____ / ____

***Primary Diagnostic Code:** _____

Description: UNLOXCYT™ (cosibelimab-ipdl) ☐ Dispense: 4 (four) 300-mg vials. Administer via intravenous infusion every 3 weeks. Refill: _____ times

***Allergies:** ☐ No known allergies ☐ Yes (please list) _____

By signing below and submitting this form, I certify that: (a) the person named on this form is my patient (the "Patient"); the information provided, to the best of my knowledge, is complete and accurate; and therapy with UNLOXCYT is medically necessary for the Patient; (b) my office received the Patient's authorization to release the information above and other of the Patient's protected health information (as defined under the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to SUN PHARMACEUTICAL INDUSTRIES, INC., UNLOXCYT SUPPORT Patient Services, the contracted dispensing pharmacy, and other contractors of SUN PHARMACEUTICAL INDUSTRIES, INC. for the purpose of (i) requesting reimbursement support services such as benefits investigation, prior authorization, appeals, and co-pay support; (ii) seeking enrollment of the Patient in the Patient Assistance Program; and (iii) assisting in the Patient obtaining or continuing therapy; (c) product provided at no cost through UNLOXCYT SUPPORT Patient Services (if applicable) shall only be used for the Patient, and I will not attempt to resell, barter, transfer, trade, or return the product for credit, nor will I or my office seek reimbursement for free product provided to the Patient from any third-party payer (private or government, including but not limited to Medicare and Medicaid); (d) my office will maintain any free product separately from commercial inventory and administer the free product only to the Patient; (e) if the Patient is no longer on therapy or otherwise cannot use the free product, I will promptly contact UNLOXCYT SUPPORT Patient Services to arrange for product return or disposal; (f) I authorize UNLOXCYT SUPPORT Patient Services to transmit the above prescription to the appropriate specialty pharmacy for my patient; (g) I understand that I am under no obligation to prescribe any SUN PHARMACEUTICAL INDUSTRIES, INC. product and that I have not received nor will I receive any benefit from SUN PHARMACEUTICAL INDUSTRIES, INC. for doing so. Special Note: CA, MA, NC, and PR: Interchange is mandated unless prescriber writes the words "No Substitution." ATTN: New York and Iowa prescribers, please submit electronic prescription. The prescriber is to comply with the prescriber's state-specific prescription requirements.

_____
***Original Signature** (Dispense as Written) Today's Date

Fax: 1-855-786-7458 | **Phone:** 1-855-865-9994 | Please see full Prescribing Information at www.unloxcytpro.com and full Terms and Conditions for the participation in UNLOXCYT SUPPORT Patient Services Programs at www.unloxcytpro.com/support. See Privacy Policy at **https://sunpharma.com/privacy-policy-new/**

UNLOXCYT™ (cosibelimab-ipdl) Injection 300mg

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The information that you provide will be used by Sun Pharmaceutical Industries, Inc., our affiliates, and our service providers for your patient's enrollment and participation in UNLOXCYT SUPPORT Patient Services. Our Privacy Policy governs the use of the information that you provide. By submitting this form, you indicate that you read, understand, and agree to these terms.

5 HIPAA Authorization and Patient Consent (*Required)

*By signing below, I, _____
Print Patient First Name | Print Patient Last Name | Date of Birth

authorize my healthcare providers ("Providers") and health insurers ("Insurers") to disclose my personal health information, including my medical condition(s), medical history, medical treatments including prescription drugs, and financial information such as my insurance coverage (together, my "PHI") to SUN PHARMACEUTICAL INDUSTRIES, INC., its agents and contractors (together, "Sun Pharma") for purposes of my obtaining services from UNLOXCYT SUPPORT. I authorize Sun Pharma to share my PHI with my Providers, Insurers, and Dispensing Pharmacies, to verify, assist with, and coordinate my coverage for UNLOXCYT™ and my eligibility for support program enrollment. I also authorize Sun Pharma to use my PHI to: (i) provide me with educational materials, information, and services related to UNLOXCYT and other Sun Pharma medications; (ii) contact me, using my contact information provided on this form, with treatment-related communications and to inform me about opportunities to participate in focus groups, surveys, or interviews related to my experience with UNLOXCYT; and (iii) if I check the optional 'Consent for Marketing Communications' box below, to provide me with marketing communications. I understand that once my PHI is disclosed to Sun Pharma, certain federal privacy regulations may no longer apply, so the PHI could permissibly be re-disclosed, but that Sun Pharma intends to disclose my PHI only as described in this Authorization or as legally required.

I understand that I do not have to sign this Authorization in order to receive treatment from my Providers or insurance coverage from my Insurers. I also understand that I can revoke this Authorization at any time by calling Sun Pharma at 1-855-327-3007, but that my revocation will not invalidate any uses or disclosures of my PHI before Sun Pharma receives the revocation. This Authorization expires 10 years from the date it was signed, unless I revoke it earlier or applicable state law requires an earlier expiration. I understand that I have the right to receive a copy of this Authorization when it is signed.

_____ _____
Patient Signature or Legal Representative | Today's Date

If Legal Representative: _____ Relationship: _____
Print Name Here

Marketing Communications Consent (OPTIONAL)

☐ **By checking this box,** I am opting to enroll in UNLOXCYT SUPPORT. I agree to receive optional disease education and other material. I understand providing this agreement is voluntary and plays no role in getting my medicine. I also understand that I may opt out of receiving this information at any time by calling 1-855-865-9994 and that this consent will remain active unless I opt out.

Fair Credit Report Act (REQUIRED for Patient Assistance Program Eligibility)

☐ **By checking this box,** I authorize UNLOXCYT SUPPORT Patient Services to obtain information from my credit profile held by Consumer reporting agencies, solely for the purpose of determining financial qualifications for Patient Assistance Program (PAP) administered by Sun Pharma. I understand that this consent is required in order for Sun Pharma to assess my eligibility. PAP Terms and Conditions apply; see www.unloxcytpro.com/support.

How many people live in your household? _____

What is your total annual household income?† _____

†Salary/wages, Social Security income, unemployment insurance benefits, disability income, any other income for the household.

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