

IncyteCARES Program Enrollment Form – Patient Page 1 of 2

P.O. Box 221798 • Charlotte, NC 28222-1798 • Phone: 1-855-4-Jakafi (1-855-452-5234) • Fax: 1-855-525-7207

Enrollment form and instructions for access and education, support, and communications related to Jakafi® (ruxolitinib). See Program web site, materials, and authorization for more details.

Instructions accompany each section. Please write clearly and fill in all form fields.

1 Patient Information: Include patient and alternate contact name and relationship, with alternate phone numbers and best time to call, so the Program can call to discuss benefits and disease treatment and the specialty pharmacy can call to schedule delivery.

Patient Name: _____ **Shipping Address:** _____

City: _____ **State:** _____ **Zip:** _____ **Date of Birth:** _____ **SSN:** _____

Phone Number: _____ **Best Time to Call:** _____ **Alternate Phone Number:** _____

Primary Language: _____ **E-mail Address:** _____

Alternate Contact Name: _____ **Alternate Contact's Phone Number:** _____

Patient is a resident of the United States or Puerto Rico: **No** **Yes**

2 Patient Prescription Insurance Information: Include patient's prescription insurance information: prescription plan name, ID, group # and phone # to facilitate contact with the patient's prescription insurance company to verify benefits. Please include a photocopy of the prescription insurance card(s), if possible.

Primary Prescription Insurer: _____ **Telephone:** _____

Policy ID Number: _____ **Group Number:** _____

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

Secondary Prescription Insurer: _____ **Telephone:** _____

Policy ID Number: _____ **Group Number:** _____

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

Please include a photocopy of the patient's insurance card(s), if possible.

3 Patient Financial Information: FILL IN ALL INFORMATION to be considered for free drug assistance. Patients will be temporarily approved if they meet the eligibility requirements, but must provide income documentation (latest tax return, W2, or 1 month of pay stubs) within 90 days to remain eligible for assistance.

Current annual household income: \$ _____

Number of household members dependent on income stated above: _____ (include applicant)

If you would like to be considered for product support, please provide income information for potential eligibility determination.

If approved for support, documentation (latest tax return, W2, or 1 month of pay stubs) will be required within 90 days.

4 Patient Consent to be Contacted: I agree to be contacted by Incyte, its agents, and the IncyteCARES Program (collectively, "Incyte") regarding information on Incyte products and services at the following e-mail address and phone/facsimile numbers:

E-mail Address: _____

Phone Numbers: Work: _____ Home: _____ Cell: _____ Fax: _____



Any co-pay assistance or free drug provided to me through IncyteCARES is contingent upon meeting certain eligibility criteria, and Incyte may, at any time, and without notice, modify or discontinue IncyteCARES or any assistance provided directly to me.

Please fax completed form to 1-855-525-7207.

Please click here for full Prescribing Information.

Jakafi is a registered trademark of Incyte Corporation.

© 2015, Incyte Corporation. All rights reserved. RUX-1721a 08/15

Patient Name: _____





IncyteCARES Program

P.O. Box 221798 • Charlotte, NC 28222-1798 • Phone: 1-855-4-Jakafi (1-855-452-5234) • Fax: 1-855-525-7207

Patient Authorization for the IncyteCARES Program

I authorize my healthcare providers (e.g., 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, e-mail 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 co-pay 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, e-mail, 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 by fax at 1-855-525-7207, or by mail at P.O. 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 I sign it as shown below unless I cancel it before then.

Name of Patient: _____

Signature: _____ **Date:** ____ / ____ / ____

Name of Legal Representative: _____

Signature: _____ **Date:** ____ / ____ / ____

If signed by Representative, describe the nature of relationship with patient:

Please fax completed form to 1-855-525-7207.



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 X 10⁹/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
- 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 ruxolitinib treatment for myelofibrosis. If PML is suspected, stop Jakafi and evaluate
- Advise patients about early signs and symptoms of herpes zoster and to seek early treatment
- 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
- The three most frequent non-hematologic adverse reactions (incidence >10%) were bruising, dizziness and headache
- A dose modification is recommended 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 breast-feed

[Please click here for accompanying Full Prescribing Information for Jakafi.](#)

Please fax completed form to 1-855-525-7207

Jakafi is a registered trademark of Incyte Corporation.

© 2015, Incyte Corporation. All rights reserved. RUX-1721a 08/15

Patient Name: _____

