TOGETHER with TESARO™
Patient Resource Program

TOGETHER with TESARO™ Program Enrollment Application

Instructions for Prescriber:

Please complete the first 2 pages of this form for all assistance. Also complete page 3 for Patient Assistance Program (PAP) referrals.

Sign and date Sections 4 and 8. Also complete page 3 for PAP referrals.

Fax completed enrollment form to TOGETHER with TESARO.
Fax #: 1-800-645-9043

1 Services Requested for Patient
(Check all that apply)

- ◯ Insurance benefits investigation, prior authorization, and/or appeal
- ◯ Co-pay assistance
- ◯ Referral to PAP for uninsured or underinsured patients. PAP application is provided with this program enrollment form; both the enrollment form and PAP application must be sent in together
- ◯ Free First Dose of VARUBI™ (rolapitant), if there is a delay in coverage determination

Please indicate the preferred dispensing location (check one):

- ◯ Specialty Pharmacy (Biologics, Inc.)
- ◯ In-office Dispensing

2 Prescriber Information

Prescriber's Name: _____

NPI #: _____

DEA #: _____

PTAN #: _____

Tax ID #: _____

Site/Facility Name: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Office Contact's Name: _____

Office Contact's Phone #: _____

Fax #: _____

Office Contact's Email: _____

3 Patient Information

Patient's Name: _____

Sex: ◯ Male ◯ Female Date of Birth: _____

Patient's Address: _____

City: _____ State: _____ ZIP: _____

Home Phone #: _____

Cell Phone #: _____

Email: _____

Alt. Contact Name: _____

Alt. Contact Relationship: _____

Alt. Contact Phone #: _____

4 Prescription Information
(Check all that apply)

◯ **Rx for VARUBI (rolapitant). VARUBI is supplied as a single dose wallet card containing two 90 mg tablets**

Quantity: _____ wallet card(s) Refills: _____

Directions for Use:

Prescriber's Signature (No Stamps Please):

_____ Date: _____

Please attach a separate prescription if this section does not comply with your state's prescription law.

◯ **Rx for VARUBI (rolapitant) First Dose Program. VARUBI is supplied as a single dose wallet card containing two 90 mg tablets**

Quantity: 2 tablets (1 wallet card) Refills: None

Directions for Use:

In the event there is a delay in securing prescription coverage, I authorize TESARO, Inc. and the exclusive Specialty Pharmacy provider to dispense VARUBI directly to the patient as part of the First Dose Program.

Prescriber's Signature (No Stamps Please):

_____ Date: _____

For assistance completing this form, please call TOGETHER with TESARO at 1-844-2TESARO (1-844-283-7276) Monday through Friday (8 AM to 8 PM ET).

TOGETHER with TESARO™ Program Enrollment Application

5 Clinical Information

Patient's Diagnosis: _____ ICD-9/10 Code:_____Target Start Date: _____

Drug Allergies:

6 Insurance Information

Please check the relevant box below.

- ◯ Patient does not have insurance. Check the box in Section 1 for "Referral to PAP". Also complete page 3 for Patient Assistance Program (PAP) referrals.
- ◯ Insurance information provided below
- ◯ Copy of both sides of the patient's insurance card attached

Medical Insurance Plan:

◯ Medicare ◯ Medicaid ◯ Commercial/Private ◯ Other

Primary Insurance: _____

Phone #: _____

Policy ID #: _____ Group #: _____

Policy Holder's Name:

_____

Policy Holder's Date of Birth: _____

Policy Holder's Relationship to Patient: _____

Prescription Drug Insurance Plan:

◯ Medicare ◯ Medicaid ◯ Commercial/Private ◯ Other

Prescription Insurance: _____

Phone #: _____

Policy ID #: _____ Group #: _____

Policy Holder's Name:

_____

Policy Holder's Date of Birth: _____

Policy Holder's Relationship to Patient: _____

7 Preferred Shipping Location

Please indicate the preferred shipping address (Check one):

- ◯ Prescriber's Office (address from Section 2 on previous page)
- ◯ Patient's Address (address from Section 3 on previous page)
- ◯ Other Address:

Street: _____

City: _____

State: _____

ZIP: _____

8 REQUIRED: Prescriber Policy and Consent

TESARO, Inc., and its contractors and agents (together "TESARO"), will use the information you provide to administer and improve TOGETHER with TESARO (the "Program").

By signing below, I (the prescriber) understand and agree that:

- I have prescribed VARUBI™ (rolapitant) based on my professional judgment of medical necessity
- Any medications supplied by TESARO as a result of this form are for use of 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
- TESARO may modify or terminate the Program at any time without notice
- My patient has provided a signed HIPAA Authorization that allows me to share protected health information with TESARO for purposes of the Program

Prescriber's Signature (No Stamps Please):

_____ Date: _____

Patient's Last Name: _____ Patient's Date of Birth:____ /____ /_____
(MM) (DD) (YYYY)

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TOGETHER with TESARO™
Patient Resource Program

TOGETHER with TESARO™ Patient Assistance Program (PAP) Application

Instructions for Prescriber:

This page should only be completed for enrollment into the Patient Assistance Program.
Ensure all sections of the application are completed. Incomplete applications will be returned for further information.
Patients or Authorized Representatives, please sign section 3 where indicated.

Fax completed enrollment form and application to TOGETHER with TESARO. **Fax #: 1-800-645-9043.**

Upon receipt of a completed application, the prescriber and patient will be notified of program eligibility. If patient is eligible for this program, the prescribed quantity of VARUBI™ (rolapitant) will be shipped from the exclusive Specialty Pharmacy of TESARO to the address indicated on Program Enrollment Application.

1 Prescription Information (Check below to apply)

◯ **Rx for VARUBI (rolapitant) PAP. VARUBI is supplied as a single dose wallet card containing two 90 mg tablets**

Refills:_____ wallet card(s)

Directions for Use:

I authorize TESARO, Inc. and the exclusive Specialty Pharmacy provider to dispense VARUBI directly to the patient as part of the PAP.

Prescriber's Signature (No Stamps Please):_____ Date:_____

Please attach a separate prescription if this section does not comply with your state's prescription law.

2 Patient Financial Information

Annual Gross Household Income: $_____ # of Household Members (Including Patient):_____

3 REQUIRED: Patient Or Authorized Representative Declarations and Authorizations

I certify that all of the information provided in this application, including household income, is complete and accurate. I understand that program assistance will terminate if the program becomes aware of any fraud or if this medication is no longer prescribed for me. I understand that completing this application does not ensure that I will qualify for this program. I certify that I cannot afford this medication. I certify that I will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program. If I am a member of a Medicare Part D plan, I will not seek to have this prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. I understand that TOGETHER with TESARO PAP reserves the right to modify the application form, modify or discontinue this program, or terminate assistance at any time and without notice. I authorize TOGETHER with TESARO PAP and its affiliates to forward this prescription to a dispensing pharmacy on my behalf. TOGETHER with TESARO PAP is not acting as a dispensing pharmacy. TOGETHER with TESARO PAP is not responsible for verifying any information contained in this application form, including without limitation, allergies, medical conditions, or other medications being taken by me. With respect to this application, I understand that only the dispensing pharmacy will be responsible for the information contained in this application form.

Patient's Signature: _____ Date:_____

I certify that: (i) the patient named below (the "Patient") provided me with the financial information included on this form; (ii) I have reviewed with the Patient the Patient Declaration and Authorizations language and; (iii) the Patient has authorized me to sign this application on his or her behalf.

Authorized Representative's Name: _____ Relationship/Title: _____

Authorized Representative's Signature: _____ Date:_____

Patient's Last Name: _____ Patient's Date of Birth:____ /____ /_____
(MM) (DD) (YYYY)

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TESARO, Inc. | 1000 Winter Street, Suite 3300 | Waltham, MA 02451

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