YOU&i™ Support Program

Enrollment Form and Prescription Information

Please complete and fax this form to 1-800-752-5896
For assistance or additional information, call 1-877-877-3536, Monday-Friday, 8:00 AM-8:00 PM ET

1. Patient Information

NAME (First, MI, Last) _____

E-MAIL _____ DOB (MM/DD/YYYY) _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ BEST TIME TO CONTACT _____

(Complete caregiver information only if you authorize or prefer that caregiver(s) be contacted in place of you)

CAREGIVER/CONTACT _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ BEST TIME TO CONTACT _____

2. Prescriber Information

PRESCRIBER NAME (First, Last) _____

SPECIALTY _____

PRACTICE NAME _____

OFFICE CONTACT _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

E-MAIL _____

PHONE _____ FAX _____

MEDICAID/MEDICARE PROVIDER# _____

TAX ID# _____

STATE LICENSE# _____

UPIN/NPI# _____

3. Insurance Information (Complete this section or provide a copy of prescription insurance card)

PRIMARY INSURANCE _____

CARDHOLDER _____

RELATIONSHIP TO CARDHOLDER _____

EMPLOYER _____ INS. CO. PHONE _____

POLICY# _____

GROUP# _____

SECONDARY INSURANCE _____

CARDHOLDER _____

RELATIONSHIP TO CARDHOLDER _____

EMPLOYER _____ INS. CO. PHONE _____

POLICY# _____

GROUP# _____

PRESCRIPTION DRUG INSURER _____ CARD/BIN# _____ PHONE _____

4. Patient Authorization for YOU&i™ Support Program

My signature below certifies that I have read, understand, and agree to the Patient Authorization to release my protected health information to Pharmacyclics LLC and Janssen Biotech, Inc., and companies working on their behalf, as defined on the attached Patient Copy.

I authorize the YOU&i™ Support Program to leave a message, including the prescription name IMBRUVICA® (ibrutinib) capsules, if I am unavailable when they call. ❑ **Yes** ❑ **No**

→ PATIENT SIGNATURE _____ DATE _____ PATIENT NAME _____
If patient cannot sign, patient's legally authorized representative must sign below.

PATIENT NAME _____ BY _____
Signature of person legally authorized to sign for patient

NAME OF PERSON LEGALLY AUTHORIZED TO SIGN _____ RELATIONSHIP _____ PHONE NUMBER _____

5. Prescription Information (If requesting benefits investigation only, do not complete this section)

Rx: IMBRUVICA® (ibrutinib) 140 mg capsule (30 day supply)
Qty: 120 Caps. Directions: 4 (140 mg) capsules taken orally once daily
ICD Diagnosis Code: _____

Rx: IMBRUVICA® (ibrutinib) 140 mg capsule (30 day supply)
Qty: 90 Caps. Directions: 3 (140 mg) capsules taken orally once daily
ICD Diagnosis Code: _____

NAME (if different than above) _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PRESCRIBER SIGNATURE REQUIRED. I certify that therapy with IMBRUVICA® is medically necessary for this patient. I will be supervising the patient's treatment accordingly and I have reviewed the current IMBRUVICA® Prescribing Information.

PRESCRIBER SIGNATURE _____ DATE _____

SUPERVISING PHYSICIAN NAME (if applicable) _____

SPECIAL NOTE: New York Prescribers please submit prescription on an original NY State prescription blank. For all other states, if not faxed, prescription must be submitted on state-specific blank, if applicable for your state. If requesting benefits investigation only, do not complete this section. The prescription is only valid if received by fax.

6. Provider Preferred Specialty Pharmacy

As the treating physician, I have discussed preference for a Specialty Pharmacy (SP) with this patient. This patient prefers use of the SP indicated below. I authorize Pharmacyclics LLC and Janssen Biotech, Inc., and its representatives to fax this prescription to: **1.** The SP designated as checked below, provided it is approved by this patient's plan. **2.** An SP approved by the patient's plan, if the SP designated is not a plan-approved SP. **3.** Any SP approved by this patient's plan, if there is no preferred SP indicated.

❑ Avella Specialty Pharmacy ❑ Biologics ❑ Diplomat Specialty Pharmacy ❑ Onco360 ❑ Approved in-office dispensing pharmacy _____

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Patient insurance benefit investigation is provided as a service by the support services administrator under contract for Pharmacyclics LLC and Janssen Biotech, Inc. In this regard, the support services administrator assists healthcare professionals in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer and patient information provided by the healthcare provider under appropriate authorization following the provider's exclusive determination of medical necessity.

Importantly, insurance verification is the ultimate responsibility of the provider. Third-party reimbursement is affected by many factors. Therefore, the support services administrator, and Pharmacyclics LLC and Janssen Biotech, Inc. make no representation or guarantee that full or partial insurance reimbursement or any other payment will be available. This information is provided as an information service only. While the support services administrator tries to provide correct information, it and Pharmacyclics LLC and Janssen Biotech, Inc. make no representations or warranties, expressed or implied, as to the accuracy of the information. In no event shall the support services administrator, or Pharmacyclics LLC and Janssen Biotech, Inc. or its employees or agents be liable for any damages resulting from or relating to the services. All providers and other users of this information agree that they accept responsibility for the use of this service.

Pharmacyclics LLC and Janssen Biotech, Inc. assumes no responsibility for, and does not guarantee, the quality, scope, or availability of the services including, but not limited to, reimbursement support services, patient education, and other support services. Each provider, not Pharmacyclics LLC and Janssen Biotech, Inc., is responsible for the services they provide. These support services have no independent value to providers apart from the product and are included within the cost of the product.

Before prescribing IMBRUVICA® (ibrutinib), please see full Prescribing Information available at www.imbruvica.com.

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PATIENT COPY

PATIENT AUTHORIZATION for the YOU&i™ Support Program brought to you by Pharmacyclics LLC and Janssen Biotech, Inc.

My signature on the YOU&i™ Support Program Enrollment Form confirms that I authorize each of my physicians, pharmacists, including any specialty pharmacy and/or self-dispensing office, patient assistance program pharmacy, which receives my prescription for IMBRUVICA® (ibrutinib) and other healthcare providers (together, "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my protected health information, including, but not limited to, medical records and treatment, my health insurance coverage, my name, address, telephone number, insurance plan, and/or group numbers (together, "Health Information") to Pharmacyclics LLC and Janssen Biotech, Inc. and its affiliated companies, vendors, agents, collaboration partners, and representatives (collectively, "Pharmacyclics LLC and Janssen Biotech, Inc."), and including providers of alternate sources of funding for prescription drug costs, and other service providers supporting access programs for Healthcare Providers and Patients for the purposes described below. Specifically, I authorize disclosure of my Health Information in order for Pharmacyclics LLC and Janssen Biotech, Inc. to receive, use, and disclose my Health Information in order to i) enroll me in, and contact me (and/or the person legally authorized to sign on my behalf, or the caregiver(s) I have authorized to be contacted on my behalf), ii) provide me (and/or the person legally authorized to sign on my behalf, or the caregiver(s) I have authorized on my behalf) with educational materials, nursing educational calls (if selected), and other support services related to IMBRUVICA®, iii) verify, investigate, assist with, and coordinate my coverage for IMBRUVICA® with my insurers, iv) coordinate prescription fulfillment, v) assist with analyses related to the quality, efficacy, and safety of IMBRUVICA®, and vi) provide me with other product informational materials, treatment reminders, or surveys about my treatment experience with IMBRUVICA®. I also understand that specialty pharmacies and/or self-dispensing offices may receive direct or indirect compensation from Pharmacyclics LLC and Janssen Biotech, Inc. for the use or disclosure of my personal information to the YOU&i™ Support Program for the above-stated purposes. I understand that once my Health Information has been disclosed to Pharmacyclics LLC and Janssen Biotech, Inc., federal and state privacy laws may no longer protect it. However, Pharmacyclics LLC and Janssen Biotech, Inc. agree to protect my Health Information by using and disclosing it only for the purposes described in this authorization or as permitted by law. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me. If I refuse to sign the Enrollment Form, or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from the Pharmacyclics LLC and Janssen Biotech, Inc. Patient Support Program. I understand that I may cancel (revoke) this Authorization at any time by mailing a request to 2730 S Edmonds Lane, Suite 300, Lewisville, TX 75067, calling 1-877-877-3536 or by going to www.imbruvica.com/unsubscribe. I understand that revoking this authorization will end further uses and disclosures of my information by the parties identified above except to the extent those uses and disclosures have been made in reliance upon this authorization and as permitted by applicable law. This authorization expires 3 years from the date indicated on the Patient Authorization section, unless I revoke it earlier. I am entitled to receive a copy of this authorization.

Please read the accompanying Important Product Information for IMBRUVICA® and discuss any questions you have with your doctor.

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