VERSION 3, OCTOBER 2022

YONSA® Patient Assistance Program

Please complete this form in its entirety. Once completed, please print, sign, and fax to the YONSA® 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

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 | Social Security Number (last 4 digits)

Previous treatment history, if any

GENDER: ○ Male ○ Female ○ Prefer not to say

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 | Policyholder

Insurance phone # | Policy ID

Group # | Rx BIN | PCN

Part A and/or Part B ID (Medicare Beneficiary ID)
***Required field if the patient is a Medicare beneficiary**

PATIENT ATTESTATION AND HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

By signing this form, I give permission for my health care providers (HCPs), my pharmacies, my health insurer(s), and third-party contractors or service providers acting on their behalf ("Health Care Entities") to disclose my personal information, including information about my insurance, prescriptions, medical condition, and health ("Personal Information"), to Sun Pharmaceutical Industries, Inc., its affiliates, business partners, service providers, third-party contractors, and agents (together, "Sun Pharma") so that Sun Pharma can (1) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with the Sun Pharma Oncology medication prescribed by the HCP on the Service Request Form; (2) coordinate my receipt of and payment for the Sun Pharma Oncology medication prescribed by the HCP on this Service Request Form; (3) facilitate my access to the Sun Pharma Oncology medication prescribed by the HCP on this Service Request Form; (4) provide me with information about the Sun Pharma Oncology medication prescribed by the HCP on this Service Request Form, disease awareness and management programs, and educational materials; and (5) manage the Patient Assistance Program.

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 calling 1-855-44YONSA (1-855-449-6672). My refusal or future revocation will not affect the commencement or continuation of my treatment by my doctor(s) and/or my eligibility for, enrollment in, or payment of benefits from my health plan(s); however, if I revoke this Authorization, I may no longer be eligible to participate in the Patient Assistance Program. If I revoke this Authorization, my Health Care Entities will stop using or sharing my information as authorized in this Authorization once they receive notification of my revocation, but my revocation will not affect uses and disclosures of my Personal Information previously disclosed in reliance upon this Authorization by them before they receive notification of my revocation. I understand that this Authorization will remain valid for one (1) year after the date of my signature, unless I revoke it earlier or it ends earlier under applicable law. I understand I am entitled to receive a copy of this Authorization after I sign it.

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

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

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

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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) (wet date required)

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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) (wet date required)

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PRESCRIBER ATTESTATION AND SIGNATURE

Methylprednisolone is required to be taken with YONSA®. NOTE: YONSA® PAP 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 ® 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® Patient Assistance Program may contact me for additional information relating to the Program, by methods including, but not limited to, email, fax, telephone, and text

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

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SUN PHARMA