

# YONSA SUPPORT® Patient Assistance Program

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



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			<b>GENDER:</b>	Male    Female    Prefer not to say
Previous treatment history, if any				

### 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	<b>PREFERRED:</b> 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])
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Primary insurance

Insurance phone #

Group #

Rx BIN

Policy holder

Policy ID

PCN

## PATIENT ATTESTATION AND HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

By signing this form below, I give permission for my healthcare providers (HCPs), my pharmacies, and my health insurer(s) to disclose my personal information, including information about my health insurance and payment/benefits, prescriptions, medical condition and treatment, and my demographic and contact information ("Personal Information") to Sun Pharmaceutical Industries, Inc., its affiliates, business partners, service providers, third-party contractors, and agents (together, "Sun Pharma") for the purposes described below.

I understand the purpose of this Authorization is to (1) apply for the YONSA SUPPORT® Patient Assistance Program (the "Program"), including to help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with YONSA®, coordinate my receipt of and payment for YONSA®, facilitate my access to YONSA®, and assist in an appeal, grievance, and/or independent review request of a denial of insurance benefits and/or coverage; (2) manage the Program, which may include conducting quality assurance and other internal business activities in connection with the Program; (3) provide me with adherence reminders and treatment support; (4) for marketing purposes which includes, but is not limited to, providing me with educational and promotional materials, information, special offers, and services related to my therapy or my medical condition, which may be funded or sent by a Program affiliate; and (5) for market research purposes, which includes contacting me to participate in focus groups, surveys, or interviews. Please complete this form in its entirety. Once completed, please print, sign, and fax to the YONSA SUPPORT® Patient Assistance Program at 1-877-872-6575 or mail to PO Box 29051, Phoenix, AZ 85038-9051. If you have any questions on the application, please call 1-855-44YONSA (1-855-449-6672) Monday - Friday, 8 AM - 8 PM EST.

I understand that my Personal Information may be summarized for statistical or other purposes and provided to Sun Pharma.

While the Program will safeguard my Personal Information and only use it for intended purposes, 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 sending a written notice to PO Box 29051, Phoenix, AZ 85038-9051, or by calling 1-855-44YONSA (1-855-449-6672), but I understand that this revocation will only apply to my HCPs, pharmacies, and health insurer(s) once they receive notification of my revocation and only to the extent they have not already taken action based on it. My refusal to sign this Authorization or future revocation will not affect the commencement or continuation of my treatment, payment for treatment, insurance enrollment, or eligibility for benefits; however, if I refuse to sign this Authorization or if I revoke this Authorization, I may no longer be eligible to participate in the Program. I understand that this Authorization will remain valid for five (5) years after the date of my signature, unless a shorter period is mandated by state law or I revoke it before then. I understand that I have the right to receive a copy of this Authorization.

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

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

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

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## 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)	
<b>ICD-10-CM DIAGNOSIS CODE:</b>	C61 - malignant neoplasm of the prostate Other	<b>SECONDARY DIAGNOSIS/ICD-10-CM:</b>	<input checked="" type="radio"/> 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)	<b>DISPENSE AS WRITTEN</b>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	

## 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)	
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	

## PRESCRIBER ATTESTATION AND SIGNATURE

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

Prescriber signature (wet signature required)	Print prescriber name	Date (MM/DD/YYYY)
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

