Please complete and sign form, then fax both pages to 1-877-251-9475

VALCHLOR® (mechlorethamine) gel 0.016% Patient Intake and Prescription Form

VALCHLOR® (mechlorethamine) gel 0.016% 60 g tube	For assistance with any questions, call **1-855-4-VALCHLOR** (1-855-482-5245) Monday through Friday from 8 AM to 8 PM Eastern Time

PATIENT INFORMATION

Patient name		Primary phone no.	
Street address	City	State	ZIP
Patient gender ☐ Male ☐ Female	DOB	Secondary phone no.	

PRIMARY INSURANCE ☐ Uninsured

Plan name
Phone no.
Group policy no.
Subscriber ID or Rx BIN no.
Policyholder name/relationship to patient

PRESCRIPTION INSURANCE (PBM)

Plan name	
Phone no.	
Group policy no.	
Rx BIN no.	Member ID no.
Relationship to patient	

PRESCRIBER INFORMATION

Prescriber name		Specialty	
NPI		State license no.	
Street address	City	State	ZIP
Office contact name	Office phone no.	Office fax no.	

PRESCRIPTION and CLINICAL INFORMATION: Please complete to avoid Prior Authorization delays

☐ **Primary diagnosis ICD-10**: C84.00 Mycosis Fungoides, or

☐ **Other ICD-10**: _____

Biopsy-confirmed diagnosis of mycosis fungoides-type cutaneous T-cell lymphoma (MF-CTCL): Yes ☐ No ☐

Prior skin-directed therapies: _____

Estimated **Body Surface Area (BSA) percentage** affected: _____

MF-CTCL staging: _____

VALCHLOR® (mechlorethamine) gel 0.016%
60 g tube

☐ Directions: apply a thin film once daily to affected areas of the skin

☐ Directions (if different from above):

_____

_____

_____

_____

Quantity: _____ tube(s)

Refills: _____

Days' supply: 30 / 60 / _____

☐ New prescription ☐ Refill

Physician's signature (required by law)

_____ _____

☐ (no stamps) Dispense as written ☐ (no stamps) Substitution allowed

Date: _____

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Allergies

Other medications

Please see full Prescribing Information at www.valchlorhcp.com

Please complete and sign form, then fax both pages to 1-877-251-9475

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE MEDICAL INFORMATION

I verify that the information provided herein is true and correct. I understand that the collection, use, and disclosure of my health information are protected under law. Information contained in this Enrollment Form, such as my name, address, insurance, and medical information, is considered "protected health information."

By signing below, I agree to allow the entities described below to leave messages for me on the telephone number(s) that I provide.

I understand that my healthcare providers will not base any medical treatment decisions on my agreement to sign this Patient Authorization and Release. I understand that once information about me is released based on this authorization, federal privacy laws may not prevent the entities described below from further disclosing my information. However, I understand that such entities have agreed to only use or disclose information received for the purposes described in this authorization or as required by law. I understand that this authorization will remain in effect for ten (10) years after the date I sign this authorization. I understand that I have the right to revoke this authorization at any time by calling 1-855-4-VALCHLOR (1-855-482-5245) or mailing a signed written statement of my revocation to 1640 Century Center Parkway, Memphis TN 38134, but that such a revocation would end my eligibility to participate in the programs as described. Revoking this authorization will prohibit disclosures after the date written revocation is received, except to the extent that action has been taken in reliance on this authorization. This means that, after I revoke this authorization, my information may be disclosed among Helsinn Therapeutics (U.S.), Inc. (Helsinn) and the company or companies that help Helsinn administer its programs in order to maintain records of my participation, but it will not otherwise be disclosed or used. I understand that my specialty pharmacy may receive payment in connection with the use and disclosure of my information for purposes allowed under this authorization.

Enrollment in ***VALCHLOR Support***™ for reimbursement support and patient assistance: The patient, or patient's authorized representative, MUST sign this form in order to receive reimbursement support and assistance from ***VALCHLOR Support***. If an authorized representative signs for the patient, please indicate his or her relationship to the patient. By signing below, you agree and understand that Helsinn does not promise to find ways to pay for your medications, and that you know that you are responsible for the costs of your care. Before signing, you, the patient, should review, understand, and agree to the terms of this authorization and release.

1. Request and receive from your doctor, healthcare provider, health insurer, or pharmacist information necessary to investigate and resolve your insurance coverage, coding, and reimbursement inquiry, or review your eligibility for patient assistance programs and co-pay assistance;
2. Collect, use, and disclose to each other any information that you provide to ***VALCHLOR Support*** for the purpose of investigating resolving your insurance coverage, coding, or reimbursement inquiry;
3. Disclose to your treating physician, healthcare provider, or pharmacist information you provided to ***VALCHLOR Support*** necessary to resolve your insurance coverage, coding, or reimbursement inquiry. By signing below, you also authorize your doctor, healthcare provider, and pharmacist to release information about your prescribed medications and medical condition requested by Helsinn and ***VALCHLOR Support***;
4. Contact your insurer, other potential funding sources, social workers, patient advocacy organizations, and/or patient assistance programs on your behalf in order to determine if you are eligible for health insurance coverage or other funds, and disclose to them information about your prescribed medications and medical condition that has been provided by you or your physician, healthcare provider, or pharmacist;
5. Provide you with education and support available through Helsinn financial assistance programs; and
6. Disclose any information obtained from the sources listed above to specific individuals you have identified and allowed to receive information on your behalf and to third parties if required by law.

Patient name (print)	**Patient/authorized rep signature (include relationship)**	**Date**

COMPLIMENTARY PATIENT SUPPORT SERVICES

By signing below, to amend the above authorization and release, you agree to the additional ***VALCHLOR Support*** patient support services, which are designed to provide you with product information and support that may include, but are not limited to:

1. Contacting you via telephone (including voice mail), mail, and email with information about these services, including providing information about VALCHLOR® (mechlorethamine) gel 0.016% and staying on your prescribed treatment regimen, and information about other support services and treatment offerings provided by Helsinn;
2. Collecting, using, and disclosing any information that you have provided to ***VALCHLOR Support*** or any of the companies administering ***VALCHLOR Support*** for the purpose of providing you with information, contacting you, and otherwise administering the program;
3. Contacting and disclosing information about you to, and receiving information about you from, your treating physician, healthcare professional, or pharmacist for purposes of administering this patient support program. By signing below, you also authorize your doctor, healthcare provider, and pharmacist to release information about your prescribed medications and medical condition if requested by Helsinn or companies working with them for the purpose of administering the patient support program;
4. Providing you with adherence and nurse support programs that will complement your VALCHLOR therapy;
5. Disclosing any information obtained from the sources listed above to third parties if required by law; and
6. Using such information to review, analyze, improve, and measure the effectiveness of the ***VALCHLOR Support*** program.

By signing below, you understand and agree to the terms of this authorization and release. If you are an authorized representative for the patient, please describe your relationship to the patient.

Patient name (print)	**Patient/authorized rep signature (include relationship)**	**Date**

Please see full Prescribing Information at www.valchlorhcp.com