

Please complete and sign form, then fax all 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 <b>1-855-4-VALCHLOR</b> (1-855-482-5245) Monday through Friday from 8 AM to 8 PM Eastern Time
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### PATIENT INFORMATION

Patient first name	Last name	Middle initial	Primary phone no.
Street address	City	State	ZIP
Patient gender <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB	Secondary phone no.	Email address

### ALTERNATE CONTACT INFORMATION OK to leave message with alternate contact

Full name	Primary phone no.	Email address
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### PRIMARY INSURANCE Uninsured

### PRESCRIPTION INSURANCE (PBM)

Please provide copies of the front and back of all medical and prescription insurance cards.

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

### PRESCRIBER INFORMATION

Prescriber first name	Last name	Specialty	
Office/Clinic/Institution name	NPI	State license no.	
Street address	City	State	ZIP
Office contact name	Office phone no.	Office fax no.	Office email address

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**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:** \_\_\_\_\_

<p>VALCHLOR® (mechlorethamine) gel 0.016% 60 g tube</p> <p><input type="checkbox"/> Directions: apply a thin film once daily to affected areas of the skin</p> <p><input type="checkbox"/> Directions (if different from above): _____ _____ _____</p> <p><b>Quantity:</b> _____ tube(s)</p> <p><b>Need refills:</b> _____ for number of refills authorized</p> <p><b>Days' supply:</b> 30 / 60 / _____</p> <p><input type="checkbox"/> New prescription   <input type="checkbox"/> Renewal</p>	<p><b>Physician's signature (required by law)</b></p> <p>_____</p> <p><input type="checkbox"/> (no stamps) Dispense as written      <input type="checkbox"/> (no stamps) Substitution allowed</p> <p>Date: _____</p> <p>Prescriber Attestation: I authorize Helsinn Therapeutics (U.S.), Inc., its affiliates, agents, and contractors (collectively, "Helsinn") to transmit the above prescription by any means allowed under applicable law to the appropriate specialty pharmacy for my patient.</p> <p>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.</p> <p><input type="checkbox"/> <b>No Known Drug Allergies (NKDA)</b></p> <p><input type="checkbox"/> <b>Allergies (please list)</b></p> <p>_____</p> <p><b>Other medications</b></p> <p>_____</p>
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**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, unless a shorter time frame is mandated by state law. 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.
7. I give permission for my healthcare providers (HCPs), pharmacies, service providers and their contractors ("Healthcare Providers"), health Insurer(s) and their contractors ("Insurers"), and third-party contractors to disclose my Personal Information, including information about my insurance benefits, prescriptions, my medical condition and history, adherence to my treatment, and my general health ("Personal Information") to Helsinn, its affiliates, business partners, and agents of Helsinn so that they may: 1) provide me with information about Helsinn products, disease education and management programs, and promotional materials, 2) provide me with medication reminders and support, and 3) conduct quality assurance, surveys, and other internal business activities in connection with the **VALCHLOR Support** Program and other related programs.

I understand that I, as the patient or signer, have a right to receive a copy of this signed form over the time it is valid.

<b>Patient name (print)</b>	<b>Patient/authorized rep signature (include relationship)</b>	<b>Date</b>
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