AVEO ACE
Access Center of Excellence

FOTIVDA® (tivozanib) capsules

Enrollment Form

Fax the Completed Enrollment Form to: 1-888-920-2830

Call us at: 1-833-FOTIVDA (1-833-368-4832) Monday-Friday (8 am to 8 pm ET)

AVEO ACE Options – Please check all that apply

Insurance Coverage Support

- ☐ Benefit Investigation, Prior Authorization, and/or Appeal Assistance
- ☐ Quick Start Program
- ☐ Bridge Program

Financial Assistance Support

- ☐ AVEO ACE Co-pay Assistance Program (for commercially insured patients)
- ☐ AVEO ACE Patient Assistance Program (PAP)

Ongoing Education and Support

- ☐ Nursing Support Program

All services and programs are subject to eligibility requirements.

1 Healthcare Professional Information

Prescriber Name: _____

Prescriber Title: _____

NPI #: _____ DEA #: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Contact Name: _____

Office Contact Phone: (_____) _____ - _____

Office Contact Fax: (_____) _____ - _____

Office Contact Email: _____

Preferred Contact Method: ○ Office Contact Phone ○ Office Contact Email

Best Time to Contact:

○ AM (8 am to 10 am ET) ○ Day (10 am to 5 pm ET) ○ PM (after 5 pm ET)

2 Patient Information

Patient Name: _____

Sex: ○ Male ○ Female Date of Birth: _____ / _____ / _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____

Email: _____

Preferred Contact Method: ○ Home Phone ○ Cell Phone ○ Email

Best Time to Contact:

○ AM (8 am to 10 am ET) ○ Day (10 am to 5 pm ET) ○ PM (after 5 pm ET)

Caregiver Name: _____

Caregiver Phone: (_____) _____ - _____

3 Insurance Information ☐ Uninsured

Primary Medical Insurance Provider: _____

Phone: (_____) _____ - _____

Member ID #: _____ Group #: _____

Member Name: _____

Primary Pharmacy Benefit Manager (PBM)

PBM Name: _____

Phone: (_____) _____ - _____

Insurance ID #: _____ Group #: _____

BIN: _____ PCN: _____

Secondary Medical Insurance Provider: _____

Phone: (_____) _____ - _____

Member ID #: _____ Group #: _____

Member Name: _____

Secondary Pharmacy Benefit Manager (PBM)

PBM Name: _____

Phone: (_____) _____ - _____

Insurance ID #: _____ Group #: _____

BIN: _____ PCN: _____

Please attach a copy of insurance card(s) (front and back)

Please see the FOTIVDA website to view full program and eligibility requirements and terms &conditions

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4 Preferred Specialty Pharmacy (select one)

○ Biologics, Inc. ○ Onco360 ○ In-office Dispense ○ No preference

5 Quick Start Prescription Information (for payer delays)

Patient Name: _____ Date of Birth: _____/_____/_____

Rx for FOTIVDA®

Quantity: **7** Strength: ○ 1.34mg or ○ 0.89mg Refills: _____ Start Date: _____/_____/_____

Directions for Use: Once daily with or without food for 21 days on treatment followed by 7 days off treatment (28-day cycle)

Additional Directions: _____

Prescriber Name: _____

SIGN HERE Prescriber Signature: _____ Date: _____/_____/_____

Prescriber should comply with any state-specific prescription requirements such as state-specific prescription form, original prescription, and/or e-prescribing.

6 Prescription Information

Patient Name: _____ Date of Birth: _____/_____/_____

Rx for FOTIVDA®

Quantity: _____ Strength: ○ 1.34mg or ○ 0.89mg Refills: _____ Start Date: _____/_____/_____

Directions for Use: Once daily with or without food for 21 days on treatment followed by 7 days off treatment (28-day cycle)

Additional Directions: _____

Prescriber Name: _____

SIGN HERE Prescriber Signature: _____ Date: _____/_____/_____

Prescriber should comply with any state-specific prescription requirements such as state-specific prescription form, original prescription, and/or e-prescribing.

7 Clinical Information

Patient Diagnosis: _____ ICD-10 Code: _____ Diagnosis Date: _____/_____/_____

Most Recent Therapies for this Diagnosis: _____

Prior Therapies for this Diagnosis: _____

8 Healthcare Professional Certification

By signing below, I hereby represent, covenant, and certify as follows: (1) Therapy with FOTIVDA (tivozanib) is medically necessary for the above-named patient; (2) I have obtained from my patient his or her consent and any required written authorization as required by HIPAA and other federal or state laws to release to AVEO and AVEO ACE and its representatives/agents all patient information provided on and accompanying this application, including, without limitation, my patient's financial and medical information; (3) I understand that this information will be used by AVEO ACE for the purpose of assessing the patient's insurance coverage and eligibility for participation in AVEO ACE patient support programs, coordinating the dispensing of my patient's prescription, and contacting my patient by telephone or mail to share information about AVEO ACE; (4) I authorize AVEO ACE to transmit the above prescription to the appropriate specialty pharmacy for my patient; (5) I have not received, nor will I seek or accept reimbursement from any federal, state, or private payers for any drug provided free of charge by the AVEO ACE Patient Assistance Program (PAP); (6) I have not received, nor will I seek or accept payment from my patient for any co-insurance amount paid for by the AVEO ACE Co-pay Program or for any AVEO Oncology product; (7) I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible under this program. I will notify AVEO ACE if I become aware of any such changes; (8) I understand that I am under no obligation to prescribe any AVEO Oncology drug and I have not received and will not receive any benefit from AVEO Oncology, an LG Chem company for prescribing their drug; (9) the information contained in this form is complete and accurate to the best of my knowledge; and (10) I will notify AVEO ACE of any errors regarding the foregoing, and will make every effort to correct those errors.

Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form.

Healthcare Professional Name: _____

SIGN HERE Healthcare Professional Signature: _____ Date: _____/_____/_____

9 Patient Consent to Release Healthcare Information

I hereby authorize my healthcare professionals, my health insurance company, and my pharmacy to disclose my protected health information (PHI) including, but not limited to, my name, address, telephone number, medical records, health insurance coverage, and financial information to AVEO Oncology, an LG Chem company, and its affiliates and service providers that work on behalf of AVEO Oncology in order to: (a) contact me, or the person legally authorized to sign on my behalf, by phone, mail or text message, regarding my participation in AVEO ACE, (b) contact my insurance company on my behalf to obtain information on my insurance coverage for FOTIVDA, (c) determine my eligibility for enrollment in the AVEO ACE Patient Support Programs, (d) manage my participation in any AVEO ACE programs, (e) share information regarding alternate sources of funding or coverage that may be available to provide assistance with out-of-pocket expenses, (f) coordinate my treatment fulfillment, including through communication with my healthcare professionals and specialty pharmacy, (g) provide me with adherence reminders and support, and (h) send me educational materials or other program information that may be of interest to me or for other marketing purposes.

I understand that once my health information has been disclosed, federal privacy laws may no longer protect the information. However, I understand that AVEO Oncology and other companies authorized to receive my health information pursuant to this Authorization will use and disclose it only for purposes authorized in this Authorization or as required by law or regulations. 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 1-833-FOTIVDA (1-833-368-4832). If I do not sign this Authorization, I understand my eligibility for health plan benefits and treatment by my doctor will not change, but I will no longer be eligible to participate in AVEO ACE, or additional patient support programs provided by AVEO Oncology. If I revoke this Authorization, AVEO Oncology will stop using or sharing my Protected Health Information, but my revocation will not affect uses and disclosures of my Protected Health Information previously disclosed in reliance on this Authorization If I do not withdraw this Authorization, it will remain valid for 3 years (or at such lesser time as state law may require). I understand I am entitled to receive a copy of this Authorization.

Patient Name: _____

SIGN HERE Patient/Legal Guardian Signature: _____ Date: ____/____/_____

Patient Assistance Program

Patients who are uninsured or underinsured and meet certain eligibility requirements may access FOTIVDA® (tivozanib) free of charge through the AVEO ACE Patient Assistance Program.

To See If You Are Eligible, You Will Need to Provide Information as Indicated Below

US Resident: ○ Yes ○ No

Total Number of People in Household (including self): _____

Total Gross Monthly Household Income: $ _____

Patient Authorization – Required for Processing

I understand that I am providing "written instructions" authorizing AVEO ACE, and its vendor, under the Fair Credit Reporting Act ("FCRA"), to obtain information from my credit profile or other information from Experian Health for the purpose of determining financial qualification for the AVEO ACE Patient Assistance Program. I understand that I must affirmatively agree to these terms in order to proceed with the financial screening process. I certify that any information that I provide is complete and accurate. If my income or health coverage changes, I will call AVEO ACE at 1-833-368-4832 to notify.

This information will only be used to determine eligibility for the AVEO ACE Patient Assistance Program. Applicants may be required to submit documented verification for all sources of income. No party may seek reimbursement for any free drug provided to the patient under the AVEO ACE Patient Assistance Program. Free drug (1) may not count toward a patient's out-of-pocket costs under their insurance plan and (2) is not contingent on any purchase.

By signing here, I agree to enrollment in the AVEO ACE Patient Assistance Program upon a determination that I am eligible.

SIGN HERE Patient/Legal Guardian Signature: _____ Date: _____/_____/_____

Please see the FOTIVDA website to view full program and eligibility requirements and terms&conditions
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AVEO ONCOLOGY an LG Chem company