TRAKAssist™

Access. Resources. Support.

Instructions for completing the VITRAKVI® (larotrectinib) prescription and patient support program enrollment form

Please complete the following short steps to enroll your patients in support services available through TRAK Assist™ for VITRAKVI.

STEP 1

VITRAKVI Prescription

Prescriber completes the Patient Contact Information, Prescriber Contact Information, Diagnostics Information, and Prescription Information sections, and signs and dates where indicated

STEP 2

Patient Support Opt-In

Patient checks the services he/she wishes to receive, initials where indicated, and signs and dates the "Written Permission to Share Protected Health Information"

STEP 3

Submission

Fax the form, along with copies of the patient's pharmacy insurance card(s) (front and back), to **1-888-506-TRAK** (1-888-506-8725)

For more information and assistance completing the form, please call **1-844-634-TRAK** (1-844-634-8725). Additional copies of the form are available at VITRAKVI.com.

Please see Indication and full Important Safety Information on page 5 and accompanying full Prescribing Information.

1-888-506-TRAK 1-844-634-TRAK

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PRESCRIBER

PATIENT CONTACT INFORMATION

Patient name* ______ DOB* ___/___/______ (MM/DD/YYYY) ◯ Male ◯ Female

Address* ______ City* ______ State* ______ Zip* ______

Preferred phone* ______ Email ______

Alternate phone ______ Preferred language ______

Please fax a copy of the patient's insurance card(s) (front and back) along with this form. Please complete section below or include a copy of the patient's pharmacy benefits.

Primary caregiver ______ Preferred contact method ______

PRIMARY PRESCRIPTION INSURER

Prescription insurer ______ Phone ______ Policy ID ______

Group number ______ Prescription BIN ______ Prescription PCN ______ Subscriber name ______

SECONDARY PRESCRIPTION INSURER

Prescription insurer ______ Phone ______ Policy ID ______

Group number ______ Prescription BIN ______ Prescription PCN ______ Subscriber name ______

PRESCRIBER CONTACT INFORMATION

Prescriber name* ______ NPI* ______

Name of supervising/collaborating physician (if applicable) ______

Address* ______ City ______ State ______ ZIP ______

Office contact ______ Phone ______

Fax ______ Email ______

DIAGNOSTICS INFORMATION

Has the patient tested positive for *NTRK* gene fusion?

◯ **Yes.** If yes, please include copy of results or provide lab name and lab test date.

Lab name ______ Lab test date ______

◯ **No.** If no, is assistance needed to find an appropriate lab? ◯ Yes ◯ No

Test type

◯ Next-Generation Sequencing (NGS) ◯ Fluorescence in situ hybridization (FISH) ◯ Immunohistochemistry (IHC)† ◯ Polymerase chain reaction (PCR)

◯ Select if patient needs appeal or financial assistance with diagnostic support for *NTRK* gene fusion testing.

*Required field.

†Following a positive TRK IHC test, confirmation of *NTRK* gene fusion is needed prior to initiation of VITRAKVI treatment.

To report any adverse events, product technical complaints, or medication errors associated with the use of VITRAKVI, contact Bayer at 1-888-842-2937, or send the information to DrugSafety.GPV.US@bayer.com.

FAX THIS FORM AND THE PATIENT INSURANCE INFORMATION TO 1-888-506-TRAK (1-888-506-8725).

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Name of patient* ______________________ DOB* ___/___/_____ MM/DD/YYYY

PRESCRIBER

PRESCRIPTION INFORMATION

ICD-10 Diagnosis Code(s) ______________________

Dosage Form* VITRAKVI in: ◯ 25-mg capsule ◯ 100-mg capsule ◯ 20-mg/mL 100 mL bottle oral solution

◯ **SIG*** ______________________ **Quantity/Supply***__________ **Refills** __________

Home Healthcare Visits (physician please select an option):

◯ Home healthcare nurse visit (During the home visit, the home healthcare nurse will educate patient/caregiver on insertion of adapter and use of syringes for medication withdrawal)

◯ Patient/caregiver will be seen in this physician's office for education on insertion of adapter and use of syringes for medication withdrawal

Preferred Pharmacy (not guaranteed): ◯ Accredo – **Phone:** 1-855-540-1797 **Fax:** 1-877-327-7120

◯ CVS Specialty – **Phone:** 1-800-790-1698 **Fax:** 1-855-296-0210

◯ US Bioservices – **Phone:** 1-833-230-1407 **Fax:** 1-833-878-5917

Allergies ______________________ Other medications taken ______________________

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge.
I appoint TRAK Assist™, on my behalf, to convey this prescription to the dispensing pharmacy. I understand that I may not delegate signature authority.

Prescriber Signature and Date* (sign and indicate the date on only one of the lines below; no stamps allowed)

Dispense as written ______________________ Date __________

Substitutions permitted ______________________ Date __________

*Required field.

PATIENT

◯ **I grant permission for TRAK Assist™ to leave a message at the phone number(s) listed on the previous page, including the name of the drug, if I am not available.**

PATIENT SUPPORT PROGRAM ENROLLMENT

Bayer provides patient support services for VITRAKVI patients that include (A) financial assistance for eligible patients and temporary assistance for eligible patients; (B) temporary assistance through the Bridge Program for eligible patients with delays or lapses in coverage. You may enroll in one or both of these programs. Enrollment allows TRAK Assist counselors to contact you and discuss support options available to you through Bayer or external resources. Any assistance provided through TRAK Assist is at no cost to you, and any free drug or resources received should not be billed to you or any third party. If you experience an adverse event, it will be forwarded to Bayer Drug Safety, which may contact you or your treating physician. Enrollment will be for five years. You may opt out of this program at any time by calling 1-844-634-8725 or writing to: TRAK Assist, PO Box 220765, Charlotte, NC 28222-0765. You do not have to provide HIPAA Authorization to enroll in Option A (financial assistance).

Enroll me in (check all that apply): ◯ **(A) Financial Assistance** ◯ **(B) Bridge Program**

Please initial here to confirm your elections __________

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Name of patient* ______________________ DOB* ___/___/_____ MM/DD/YYYY

PATIENT

WRITTEN PERMISSION TO SHARE PROTECTED HEALTH INFORMATION

I authorize the use and disclosure of my Protected Health Information ("PHI") as defined by the Health Insurance Portability and Accountability Act of 1996, which was amended by the Health Information Technology for Economic and Clinical Health Act (as amended, "HIPAA"). I understand that Protected Health Information is health information that identifies me or that could reasonably be used to identify me and that this authorization to release my information is voluntary.

I authorize my healthcare provider, including my physician, pharmacies and my health plan, to disclose my name, address, and telephone number along with certain medical information including my treatment, my eligibility for assistance, the coordination of my treatment, the receipt of my medication and my participation in the Patient Support Program, TRAK Assist, to Bayer and its agents.

I allow the use and disclosure of my PHI for the following purposes: (1) To verify my insurance information; (2) to ensure the accuracy and completeness of the TRAK Assist enrollment form; (3) to help with my reimbursement questions; (4) to determine if I qualify for patient assistance; (5) to determine my eligibility for other sources of funding; (6) to provide education, training, and ongoing support on the use of my medication; (7) to send me information on related products and services related to my treatment; (8) to send me refill reminders for my prescription and to encourage appropriate use; (9) to communicate with me, my healthcare providers and health plan insurers about my medical care and treatment; (10) to contact me for market research feedback; (11) for sales support purposes and (12) to comply with applicable law.

This authorization shall be in effect for 10 years from the date of my signature, or the date of last enrollment, whichever comes first, unless a shorter period is required by law. If I (or my representative) revoke this authorization, healthcare providers will stop using my PHI for the purposes outlined in this authorization, but the revocation will not affect prior use or disclosure of my PHI in reliance on this authorization. I (or my representative) may revoke this authorization at any time by calling 1-844-634-8725 or writing to: TRAK Assist, PO Box 220765, Charlotte, NC 28222-0765.

I also understand that, under this authorization, entities that receive my PHI may not be required by law to keep the information private and it will no longer be protected by the privacy law. It may become available in the public domain.

I understand that I do not need to sign this form to receive medical treatment or medication. I (or my representative) have read and understand the terms of this authorization form, and have had an opportunity to ask questions about the uses and disclosures of PHI described above. All of my questions have been answered to my satisfaction. I authorize the use and disclosure of my information as described in this form.

I (or my representative) have the right to receive a copy of this authorization upon request. I understand that my healthcare providers, insurers, and health plans may receive remuneration (payment) from Bayer in exchange for disclosing my PHI to Bayer.

Patient or Patient Representative Signature

____

Date ______________

Name of Patient Representative

____

Relation to Patient‡

____

‡If signed by the Patient's Representative, a description of the representative's relationship to the Patient and such person's authority to act for the Patient must be provided in the space above.

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