myBeOneSupport™

Patient Enrollment Form

Brukinsa® 80 mg capsules zanubrutinib | TEVIMBRA® (tislelizumab-jsgr) Injection, for intravenous use 10 mg/mL

What is myBeOne Support?

myBeOne Support is a patient support program designed to provide appropriate information and assistance to patients, including:

Simplifying access

- Assistance with assessment of insurance coverage
- Co-pay as low as $0 for commercially insured patients*†
- 30-day bridge supply for insurance coverage delays (BRUKINSA only)*‡
- Free product for uninsured and underinsured patients*

Educating patients and caregivers about their treatment and disease

- Dedicated Oncology Nurse Advocates available for practices, patients, and caregivers

Connecting patients to independent organizations§ that offer day-to-day living support

- Connect patients and caregivers with advocacy groups and free local or national resources

*Terms and conditions apply.

†Up to $25,000 per calendar year. The program will also reimburse up to $100.00 per infusion administration fee for TEVIMBRA for patients who are eligible for commercial co-pay assistance.

‡30-day supply of medication (for on-label use only) in case of a coverage delay lasting longer than 5 days.

§Independent third-party organizations have their own rules for eligibility. BeOne Medicines has no involvement in their decision-making or eligibility criteria. This information is non-exhaustive and not meant as an endorsement from BeOne Medicines.

Complete the form on the following pages to enroll your patient in myBeOne Support today.

Oncology Nurse Advocates are available Monday through Friday from 8 AM to 8 PM Eastern Time (ET) at **1-833-234-4363** to provide information and answer any questions you might have regarding the myBeOne Support program.

myBeOne Support
PO Box 5490
Louisville, KY 40255

For general information about the myBeOne Support program, including financial criteria, please visit myBeOneSupport.com

FAX THE COMPLETED FORM TO 1-877-828-5593

For any questions, call 1-833-234-4363 | Monday through Friday (8 AM-8 PM ET)

Patient Enrollment Form Instructions

myBeOneSupport™

How do I request support through myBeOne Support?

Please complete the required sections on the enrollment form for each service requested for the patient.

- Insurance verification
- Bridge supply*†
  (BRUKINSA® [zanubrutinib] only)
- Free product assistance† (for eligible uninsured or underinsured patients)
- Co-pay/co-insurance assistance†‡
  (for commercially insured patients)
- Patient and caregiver support

Sections 1, 2, 3, 4, 5, and 7 are required for all patients. Complete section 6 for free product assistance for eligible patients.
If you have questions about filling out this form, contact a myBeOne Support Oncology Nurse Advocate (1-833-234-4363). Required information only applies to support through myBeOne Support and is not intended to limit any treatment, payment, or benefit activities with your pharmacy or other healthcare providers.

How do I enroll my patient?

1. **COMPLETE** as much of this enrollment form as possible with the information available. If you leave sections blank, a myBeOne Support Oncology Nurse Advocate will follow up to obtain necessary information for the services requested. **If seeking free product assistance for an eligible patient, please also complete section 6.**
2. **SIGN AND DATE** pages 5, 6, and 7. Both prescriber and patient signatures are required.
3. **FAX** the following to **myBeOne Support at 1-877-828-5593**:
   - Completed form signed by prescriber and patient
   - Prescription (NPI # for eScript: 1699202838)
   - Copy of front and back of patient's insurance card (if seeking insurance verification)

*30-day supply of medication (for on-label use only) in case of a coverage delay lasting longer than 5 days.
†Terms and conditions apply.
‡Up to $25,000 per calendar year. The program will also reimburse up to $100.00 per infusion administration fee for TEVIMBRA® (tislelizumab-jsgr) for patients who are eligible for commercial co-pay assistance.

What should I expect after submitting the enrollment form?

Upon submission of the enrollment form to myBeOne Support, an Oncology Nurse Advocate will confirm receipt to initiate the support you requested. The typical turnaround for a completed form is one business day.

If you have questions about the enrollment form, call
1-833-234-4363

Patient Enrollment Form

myBeOneSupport™

SELECT PRODUCT (check all that apply)

☐ **BRUKINSA® (zanubrutinib)** ☐ **TEVIMBRA® (tislelizumab-jsgr)**

SUPPORT REQUESTED (check all that apply)

All services listed below require sections 1-5 and 7 to be completed. If seeking free product assistance for your patient, please also complete section 6.

☐ Insurance verification ☐ Free product assistance ☐ Patient and caregiver support

☐ Bridge supply (BRUKINSA only) ☐ Co-pay/co-insurance assistance

SECTION 1 PATIENT INFORMATION

Patient Name (First, M.I., Last)

Gender
☐ Male ☐ Female

Date of Birth (MM/DD/YYYY)

Primary Language

Street Address

City / State / ZIP

Email

Preferred Phone (include area code)
☐ Home ☐ Mobile ☐ Work

Best Time to Call
☐ AM ☐ PM

Alt Contact/Caregiver Name

Alt Contact/Caregiver Relationship (optional)

Alt Contact/Caregiver Phone (include area code)

Diagnosis Code (ICD-10 Code)

Has Treatment Begun?
☐ Yes Date: _____ ☐ No

Indicate Line of Therapy
☐ Not Previously Treated ☐ Previously Treated, please specify:

SECTION 2 PRESCRIBER INFORMATION

Physician Name (First, M.I., Last)

Specialty
☐ Hematologist ☐ Oncologist ☐ Other, please specify:

Physician NPI #

Physician Tax ID #

Practice Name

Practice NPI #

Practice Tax ID #

Street Address

City / State / ZIP

Office Contact Name (First, Last)

Phone (include area code)

Best Time to Call
☐ AM ☐ PM

Fax

Office Contact Email

Continue

Patient Enrollment Form

myBeOneSupport™

PATIENT NAME (First, M.I., Last) _____ **DATE OF BIRTH** (MM/DD/YYYY) _____

☐ Check here if patient has no insurance

SECTION 3 INSURANCE INFORMATION

Primary Insurer	**Phone** (include area code)
Policy ID #	**Group #**
Subscriber Name (First, M.I., Last)	
Relationship to Subscriber (write "self" if patient is the cardholder)	**Date of Birth** (MM/DD/YYYY)
Secondary Insurer	**Phone** (include area code)
Policy ID #	**Group #**
Subscriber Name (First, M.I., Last)	
Relationship to Subscriber (write "self" if patient is the cardholder)	**Date of Birth** (MM/DD/YYYY)
Prescription Card Name	**Prescription Card Phone** (include area code)
Primary Cardholder Name (First, M.I., Last)	
Relationship to Patient (write "self" if patient is the cardholder)	**Primary Cardholder Date of Birth** (MM/DD/YYYY)

Member ID	**RxBIN**	**RxPCN**	**RxGRP #**

Please fax copy of front and back of insurance card

SECTION 4 PHARMACY / ADMINISTRATION SITE*

Pharmacy (for oral therapy)	**Site of Administration**† (for infused therapy)
☐ Specialty Pharmacy ☐ Onsite Dispensing Pharmacy	☐ Inpatient ☐ Outpatient Hospital ☐ Outpatient Physician Office ☐ Other
Pharmacy Name	**Infusion Site Name**
Pharmacy NPI #	**Infusion Site NPI #** / **Infusion Site Tax ID #**
Phone (include area code)	**Phone** (include area code)
Pharmacy Contact Name	**Infusion Site Contact Name**

*Unless the patient requests otherwise or the patient's insurance provider requires the patient to use a specific pharmacy, the prescription will be directed to the authorized pharmacy providing the lowest cost sharing for the patient under the patient's insurance plan.
†Complete if different from information provided in Section 2.

Continue

Patient Enrollment Form

myBeOneSupport™

PATIENT NAME (First, M.I., Last) _____ **DATE OF BIRTH** (MM/DD/YYYY) _____

SECTION 5 PRESCRIPTION

Oral Therapy	Infused Therapy
☐ BRUKINSA® (zanubrutinib) / **80 mg (120 capsules)** ☐ Bridge Rx - BRUKINSA® (zanubrutinib) / **80 mg (120 capsules)** / Dispense: 30-day Supply	☐ TEVIMBRA® (tislelizumab-jsgr) **100 mg/10 mL (10 mg/mL)** Dose: _____ mg Dispense Qty: _____ vials Frequency: every _____ weeks
Refill	**Refill**
Directions	**Directions**
Patient Allergies	**Patient Allergies**
Concurrent Medications	**Concurrent Medications**

Prescriber Certification and Authorization: By signing below, I certify that: (1) the above therapy is medically necessary for this patient and that I, as the prescriber, have made the decision to prescribe BRUKINSA® or TEVIMBRA® (the "Product"); (2) I have reviewed the current Product prescribing information before prescribing; and (3) to the full extent required by applicable law, I have obtained written permission from the patient named above (or from the patient's legal representative) to release the patient's personal health information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder, as well as other state and/or federally protected personal information) both as provided on this form and such other PHI that BeOne Medicines, myBeOne Support, the contracted dispensing pharmacy, or other contractors may require (a) to perform a preliminary verification of the patient's insurance coverage for the Product and (b) to assess the patient's eligibility for participation in the myBeOne Support program. I authorize and appoint myBeOne Support to convey on my behalf the prescription(s) I signed for the patient and the other information included on this form to the dispensing pharmacy chosen by or for the patient. I agree that myBeOne Support may contact me, including, without limitation, via email, fax, and telephone to seek additional information relating to myBeOne Support, the Product, or the prescription(s) contained on this form.

I understand that any Product provided at no charge to the patient is provided on a complimentary basis. I will not submit or cause to be submitted any claims for payment or reimbursement for such Product to any third-party payor, including, without limitation, a federal health care program. If I am or become in possession of such Product, I will not resell or attempt to resell the Product. I agree to comply with the myBeOne Support guidelines and understand that BeOne Medicines, at its sole and absolute discretion, reserves the right to modify or discontinue patient support programs, including such programs provided through myBeOne Support, at any time. I certify that the information contained in this form is complete and accurate to the best of my knowledge.

Prescriber Signature*

Sign and Date Here _____ **Date** _____

(Original signature required)

Prescriber Printed Name _____ **Prescriber NPI** _____

*Prescriber shall comply with all applicable state requirements, including but not limited to those concerning e-prescribing, state-specific prescription form(s), and language on fax transmissions. Non-compliance with applicable state prescribing requirements could result in additional communications from myBeOne Support or other contractors to the prescriber.

For free product assistance, continue to page 6
For all other patients, continue to page 7

FAX THE COMPLETED FORM TO 1-877-828-5593

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PATIENT NAME (First, M.I., Last) _____ **DATE OF BIRTH** (MM/DD/YYYY) _____

SECTION 6	FREE PRODUCT ASSISTANCE / PATIENT FINANCIAL INFORMATION*

Current Annual Household Adjusted Gross Income **$**	**US Resident** ☐ Yes ☐ No
Number of people in the household (including you)	
Shipping Address	
City / State / ZIP	

*Eligibility criteria and restrictions apply.

Patient Certification: I certify that, as of the date of my signature, the information provided on this form is complete and accurate to the best of my knowledge and that all of the insurance plans and programs through which I obtain health care coverage are listed above or have been provided separately to myBeOne Support. I further certify that I am not insured for (or am rendered uninsured through the payer denial of) BRUKINSA® (zanubrutinib) or TEVIMBRA® (tislelizumab-jsgr) (the "Product") and that I am a legal resident of the United States. In order to qualify for the free product program ("Program"), I understand that certain eligibility criteria will apply. I will be ineligible to participate in the Program unless I provide proof of income within 30 days after this form is submitted. I also understand that: (1) myBeOne Support may request documentation from me, my employer, my health care provider, or my insurance company to verify my financial or insurance information; (2) completion of this form and the provision of requested documentation does not guarantee that I will be approved to participate in the Program; (3) any free Product provided to me through the Program is contingent upon my meeting myBeOne Support's eligibility criteria; (4) if I am eligible to participate in the Program, there is no purchase requirement associated with such assistance; and (5) myBeOne Support reserves the right to make an independent determination of my financial need. BeOne Medicines reserves the right at any time, and without notice, to modify or discontinue myBeOne Support and any assistance provided to me. I will not submit or cause to be submitted any claims for payment or reimbursement from any third-party payer, including any federal health care program such as Medicare or Medicaid, or any private or other insurance plan, or from any other person or entity for a free supply of the Product supplied under this Program, regardless of whether a payer subsequently determines that it will cover such supply of BRUKINSA® or TEVIMBRA®. I will not sell, trade, or distribute or otherwise transfer the Product supplied under the Program. The cost of the Product provided under the Program will not count toward any Medicare true out-of-pocket ("TrOOP") costs. I agree to notify myBeOne Support if: (1) I obtain coverage through another source (federal, state, or private program), (2) I no longer meet the income criteria for the Program, or (3) I find any errors in this application form. If I am approved, as required by my insurance or other benefit provider, I will notify such provider of my receipt of any free Product received through the Program. I understand that I must re-apply for the Program annually and there is no guarantee I will qualify at this time or in future periods.

Signature of Patient or Legal Representative†

Sign and Date Here

_____ **Date** _____

Name of Patient or Legal Representative _____

(If signed by representative, explain authority to act on behalf of patient and relationship)

†By signing on behalf of the patient, as representative or guardian, I attest that I am legally able to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such representative's or guardian's authority to act for the patient, such as power of attorney or legal court order, may be requested.

Continue

Patient Enrollment Form

myBeOneSupport™

PATIENT NAME (First, M.I., Last) _____ **DATE OF BIRTH** (MM/DD/YYYY) _____

SECTION 7 PATIENT AUTHORIZATION For release of information to myBeOne Support

I authorize my health care providers (including pharmacy providers) and health plans to release or disclose, in electronic or other form, my personal health information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder, as well as other state and/or federally protected personal information), including my personal contact and other information on this form, all medical records and financial information, with respect to my treatment, my eligibility for assistance, the coordination of my treatment, and receipt of my medication (collectively, my "Information") to myBeOne Support, including any third parties engaged to assist BeOne Medicines in administering myBeOne Support, for the purposes of: (1) establishing my benefit eligibility for BRUKINSA® (zanubrutinib) or TEVIMBRA® (tislelizumab-jsgr) (the "Product"); (2) communicating with my health care providers and health plans about my eligibility for support through myBeOne Support, my benefit and coverage status, and/or my medical care; (3) providing support through myBeOne Support, including facilitating the provision of the Product to me, as well as any information or materials related to such support or BeOne Medicines products, including promotional or educational communications; (4) evaluating the effectiveness of myBeOne Support; (5) reporting safety information, including communications with the U.S. Food and Drug Administration and other government authorities; (6) contacting me regarding this enrollment form or my use or potential use of the Product and providing me with related patient support communications, including through messages left for me that disclose that I take or may take the Product; and (7) administering, evaluating, and improving myBeOne Support, including by analyzing the usage patterns and the effectiveness of BeOne Medicines products, services, and programs and helping to develop new products, services, and programs, and for other BeOne Medicines general business and administrative purposes.

I understand that my pharmacy provider(s) may receive remuneration for the use or disclosure of my Information, as authorized above, and that, once my Information has been disclosed to myBeOne Support, my Information may not be subject to all of the protections and safeguards provided by HIPAA or other federal and state privacy laws. I also understand, however, that myBeOne Support plans to use and disclose my Information only for the purposes described above or as required by law.

I understand that I may refuse to sign this Authorization and that my refusal to sign this Authorization will not affect my right to treatment or payment of benefits for health care. I understand that if I refuse to sign, I will not be eligible to receive assistance through BeOne Medicines. I may later withdraw this Authorization by sending written notice of my withdrawal from myBeOne Support to PO Box 5490, Louisville, KY 40255. Withdrawal of this Authorization will end further uses and disclosures of my Information by BeOne Medicines, except to the extent those uses and disclosures have been made in reliance on this Authorization and as permitted by applicable law. I am entitled to receive a copy of this signed Authorization, which expires 5 years after the date it is signed by me unless otherwise specified by law or revoked earlier in writing.

Signature of Patient or Legal Representative*

Sign and Date Here

_____ **Date** _____

Name of Patient or Legal Representative _____

(If signed by representative, explain authority to act on behalf of patient and relationship)

*By signing on behalf of the patient, as representative or guardian, I attest that I am legally able to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient may be requested such as power of attorney or legal court order.

Please fax completed form and supporting documents to
myBeOne Support at 1-877-828-5593