SECURA CARE™
ENROLLMENT FORM

phone: (844) 973-2872
fax: (800) 452-6744
www.farydak.com
www.copiktra.com

Print and fax completed enrollments forms to Secura Care (800) 452-6744.
All pages must be received to process enrollment.

FARYDAK® (panobinostat) capsules 10mg/15mg/20mg
Copiktra® (duvelisib) 15mg | 25mg capsules

Support Requested (check all that apply)

☐ **COPAY ASSISTANCE***
Up to $25,000 in copay assistance
(Sections 1-5 must be completed)

☐ **PATIENT ASSISTANCE PROGRAM**
Access to FARYDAK® or COPIKTRA® at no cost for eligible patients
(Sections 1-4, 6 & 8 must be completed)

☐ **QUICKSTART PROGRAM**
Access to FARYDAK® or COPIKTRA® at no cost for eligible patients who have a >5 day delay in getting prior authorization
(Sections 1-4, 7 - 8 must be completed)

Support Requested By:

☐ IN OFFICE DISPENSING PHARMACY ☐ OTHER

*Those with federal and state government insurance, such as Medicare, Medicaid, or TRICARE® are not eligible. Other eligibility requirements may apply. Secura Bio, Inc, reserves the right to modify or discontinue the programs at any time. Please visit www.FARYDAK.com or www. COPIKITRA.com for TRICARE is a registered trademark of the Department of Defense (DoD), Defense Health Agency (DHA). All rights reserved.

Section 1: Patient Information PATIENT TO FILL OUT

Patient Name (First, MI, Last) _____ Alternate Phone _____
Preferred ☐ Voicemail ☐

Address _____

City _____ State _____ Zip Code _____ Mobile Phone _____
Preferred ☐ Voicemail ☐

Date of Birth (mm/dd/yyyy) _____ Gender Male ☐ Female ☐

Email _____ Preferred Language (if not English) _____

Do you have Commercial or Private Insurance? Yes ☐ No ☐

SELECT
Private

Are you a resident of the United States or US Territory? Yes ☐ No ☐

Are your prescriptions paid for in part of in full under any state or federally funded programs, including but not limited to Medicare, Medicare Part D, Medigap, Veterans affairs, Department of Defense or Tricare? Yes ☐ No ☐

Are you in the military, or the dependent of someone that is active or retired military? Yes ☐ No ☐

Section 2: Insurance Information PATIENT TO FILL OUT

*Please attach copies (front and back) of all available insurance cards No Insurance? ☐

Primary Medical (Insurance Name) _____

Phone _____ Policy ID # _____

Group # _____ Policy Holder Name (First, Last) _____

Relationship to patient _____

Primary Rx (Insurance Name, if different) _____

Phone _____ Policy ID # _____

Group # dfsf RxBin # _____ RxPCN # _____

Section 3: Prescriber Information

Prescriber Name _____ Prescriber NPI _____

Group Tax ID # _____ Office Contact Name (First, Last) _____

Specialty _____ Office Contact Email _____

Address _____ Phone _____

City _____ State _____ Zip Code _____ Fax _____

Section 4: Treatment and Prescription Information PRESCRIBER TO FILL OUT

QUICKSTART PROGRAM

Rx: FARYDAK® (panobinostat)

Dosage strength: ☐ 10 mg ☐ 15 mg ☐ 20 mg

SIG: Take 1 capsule on days 1, 3, 5, 8, 10 & 12 for weeks 1 and 21 day cycle, or Other _____

Diagnosis: _____ Qty 6 Refill 0

ICD 10 Code: _____

Rx: COPKITRA® (duvelisib)

Dosage strength: ☐ 15 mg ☐ 25 mg

SIG: Take 1 capsule twice daily, or Other _____

Diagnosis: _____ Qty 56 Refill 0

ICD 10 Code: _____

I acknowledge that I have obtained authorization to release the patient's personal health information and the information on this form and any prescription to Secura Bio, Inc. (together with its affiliates) and its third-party business partners, vendors and other agents ("Agents"), for the purpose of providing product support services. I further certify that any service provided by Secura Bio, Inc, on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use any Secura Bio, Inc, product or service for anyone, and my decision to prescribe FARYDAK® or COPIKTRA® was based solely on my determination of medical necessity. I understand that free product is not contingent on any purchase obligations. I also understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale. I will notify Biologics immediately if FARYDAK® and COPIKTRA® is no longer medically necessary for this patient's treatment or if my patient's insurance status changes. I authorize Secura Bio, Inc, as my designated agent and on behalf of my patient to (1) forward the above service request form and furnish any information on this form to the insurer of the above-named patient and (2) forward the above prescription, by fax or other mode of delivery, to needed dispensing specialty pharmacy.

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.

Prescriber Signature Required (no stamps)	Printed Name	Date

PATIENT PRESCRIPTION

(Complete only if the prescription will be triaged to a Specialty Pharmacy or the Patient Assistance Program)

Rx: FARYDAK® (panobinostat)

Dosage strength: ☐ 10 mg ☐ 15 mg ☐ 20 mg

SIG: Take 1 capsule on days 1, 3, 5, 8, 10 & 12 for weeks 1 and 21 day cycle, or Other _____

Diagnosis: _____ Qty _____ Refill _____

ICD 10 Code: _____

Rx: COPKITRA® (duvelisib)

Dosage strength: ☐ 15 mg ☐ 25 mg

SIG: Take 1 capsule twice daily, or Other _____

Diagnosis: _____ Qty _____ Refill _____

ICD 10 Code: _____

I acknowledge that I have obtained authorization to release the patient's personal health information and the information on this form and any prescription to Secura Bio, Inc. (together with its affiliates) and its third-party business partners, vendors and other agents ("Agents"), for the purpose of providing product support services. I further certify that any service provided by Secura Bio, Inc, on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use any Secura Bio, Inc, product or service for anyone, and my decision to prescribe FARYDAK® or COPIKTRA® was based solely on my determination of medical necessity. I understand that free product is not contingent on any purchase obligations. I also understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale. I will notify Biologics immediately if FARYDAK® or COPIKTRA® is no longer medically necessary for this patient's treatment or if my patient's insurance status changes. I authorize Secura Bio, Inc, as my designated agent and on behalf of my patient to (1) forward the above service request form and furnish any information on this form to the insurer of the above-named patient and (2) forward the above prescription, by fax or other mode of delivery, to needed dispensing specialty pharmacy.

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.

Prescriber Signature Required (no stamps)	Printed Name	Date

5. Copay / Coinsurance Assistance Program: Patient Authorization

I am enrolling in the Secura Care™ Copay / Coinsurance Assistance Program (the "Copay Program"), provided by Secura Bio, Inc, and its third party business partners, vendors and other agents ("Agents") . By enrolling in the Copay Program, I acknowledge and understand that (1) I am responsible for paying any amounts over the program maximum (2) only product dispensed to my home is eligible (3) the Program will pay all but $5 of my FARYDAK® or COPIKITRA® copay and coinsurance expenses up to the program maximum. By signing this Copay Program Authorization, I authorize Secura Bio, Inc, and its Agents to use and share with my healthcare providers, pharmacy and insurers information about me for the purpose of coordinating my enrollment and participation in the Copay Program. I also authorize Secura Bio, Inc, and its Agents to contact me by mail, telephone, or e- mail, in connection with the Copay Program and to inform me of available assistance programs, treatment and therapies, and insurance-related information. I further authorize Secura Bio, and its Agents to de-identify my health information and use it in performing clinical research, patient and community education, business analytics, marketing studies or for other commercial purposes. I understand a representative from Secura Bio, Inc, Inc may contact me for follow-up on any adverse event I may report regarding a Secura Bio, Inc, Inc Product. I also confirm that my personal and insurance information in Sections 1 and 2 of this form are accurately completed and that I am not a beneficiary of a federal or state healthcare system.

I understand that I do not have to enroll in the Copay Program and that if I choose not to enroll I can still receive my medication as prescribed by my physician. I may opt out of the Copay Program at any time by writing to the Secura Care™ Support Program at 11800 Weston Parkway, NC 27513.

By signing below, I certify that I have read and understand the Copay Program Authorization and agree to its terms.

Patient or Legal Representative	Printed Name	Date

* Release of Health Information must also be signed to complete enrollment

6. Patient Assistance Program: Patient Authorization

Secura Bio, Inc Patient Assistance Program ("PAP") provides drug at no cost to patients who are uninsured or underinsured and meet all eligibility requirements of the FARYDAK® or COPIKTRA® PAP program. If approved, shipment will be coordinated with the requesting physician. This is not a replacement program; applications must be submitted prior to FARYDAK® or COPIKTRA® use. I acknowledge that no free product received via the PAP program may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale. I understand that this program is not meant to induce a physician to use or prescribe FARYDAK® or COPIKTRA®. I also understand that the program provides drug only and that I will need to find alternative means to support other medical costs associated with the use of this medication. Secura Bio, Inc reserves the right to review patient profiles, grant requests based on patient need and to change program guidelines or terminate the program at any time without notification. I will notify Secura Care™ PAP Program immediately if my insurance status changes. By signing this Program Authorization, I authorize Secura Bio, Inc, and its Agents to use and share with my healthcare providers, McKesson specialty pharmacy and insurers information about me for the purpose of coordinating my enrollment and participation in the Secura Care™ PAP Program. I also authorize Secura Bio, Inc, and its Agents to contact me by mail, telephone, or e-mail, or, in connection with the Secura Care™ PAP Program. I further authorize Secura Bio, Inc, and its Agents to de-identify my health information and use it in performing clinical research, patient and community education, business analytics, marketing studies or for other commercial purposes. I understand a representative from Secura Bio, Inc, may contact me for follow-up on any adverse event I may report regarding a Secura Bio, Inc. product.
I understand that I do not have to enroll in the Secura Care™ PAP Program and that if I choose not to enroll I can still receive my medication as prescribed by my physician. I may opt out of the Program at any time by writing to the Secura Care™ Support Program at 11800 Weston Parkway, NC 27513.

By signing below, I certify that I have read and understand the PAP Program Authorization and agree to its terms.

Patient or Legal Representative	Printed Name	Date

7. QUICKSTART Program

Secura Bio, Inc QUICKSTART Program provides the first cycle of drug at no cost to patients who have a delay of 5 days or more in obtaining prior authorization to received FARYDAK® or COPIKTRA® and meet all eligibility requirements of the FARYDAK® and COPIKTRA® QUICKSTART program. If approved, shipment will be coordinated with the requesting physician. This is not a replacement program; applications must be submitted prior to FARYDAK® or COPIKTRA® use. I acknowledge that no free product received via the PAP program may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale. I understand that this program is not meant to induce a physician to use or prescribe FARYDAK® or COPIKTRA®. I also understand that the program provides drug only and that I will need to find alternative means to support other medical costs associated with the use of this medication. Secura Bio, Inc reserves the right to review patient profiles, grant requests based on patient need and to change program guidelines or terminate the program at any time without notification.
By signing this Program Authorization, I authorize Secura Bio, Inc, and its Agents to use and share with my healthcare providers, McKesson specialty pharmacy and insurers information about me for the purpose of coordinating my enrollment and participation in the Secura Care QUICKSTART Program. I also authorize Secura Bio, Inc, and its Agents to contact me by mail, telephone, or e-mail, or, in connection with the Secura Care™ QUICKSTART Program. I further authorize Secura Bio, Inc, and its Agents to de-identify my health information and use it in performing clinical research, patient and community education, business analytics, marketing studies or for other commercial purposes. I understand a representative from Secura Bio, Inc, may contact me for follow-up on any adverse event I may report regarding a Secura Bio, Inc. product.
I understand that I do not have to enroll in the Secura Care™ QUICKSTART Program and that if I choose not to enroll I can still receive my medication as prescribed by my physician. I may opt out of the Program at any time by writing to the Secura Care™ Support Program at 11800 Weston Parkway, NC 27513

By signing below, I certify that I have read and understand the QUICKSTART Program authorization and agree to its terms.

Patient or Legal Representative	Printed Name	Date

* Release of Health Information must also be signed to complete enrollment

8. Authorization to Release Personal Health Information

By signing this Authorization to Release Health Information ("Authorization"), I authorize my Providers, Payers, Caregivers, and Distributors (collectively, the "Parties") to disclose to Secura Bio, Inc, Inc and its Agents information about my disease, treatment, insurance coverage and payment for my Therapy ("my Information") for the purposes of providing the Services and allowing Secura Bio, Inc, Inc to send the communications described in the Support Services on page 2. These services include but are not limited to:
(1) to determine if I am eligible to participate in the Secura Care™ Support Program, patient assistance programs or other support programs (the "Program") (2) to investigate my health insurance coverage for FARYDAK® and COPIKTRA® (3) for the operation and administration of the Program (4) to refer me to, or to determine my eligibility for other programs, foundations or alternative sources of funding or coverage that may be available to provide assistance to me with the costs of my medication. Once my Information has been disclosed to Secura Bio, Inc, Inc and its Agents, I understand that federal privacy laws may no longer protect it from further disclosure. However, Secura Bio, Inc, Inc and its Agents agree to use and disclose my Information only as allowed by me in this Authorization or as otherwise allowed by law. I understand that Secura Bio, Inc, may have arrangements with certain Parties that involve remuneration to those Parties in exchange for

my Information. I understand a representative from Secura Bio, Inc, Inc may contact me for follow-up on any adverse event I may report regarding a Secura Bio, Inc, Inc product.
I understand that I may refuse to sign this Authorization, that I may refuse to disclose all or some of my information, and that a refusal to sign will not affect my ability to obtain medical care, insurance coverage or access to health benefits, including access to Therapy. However, if I do not sign this Authorization Secura Bio, Inc, cannot provide me with the Services. This Authorization shall remain in effect throughout my participation in the Program unless and until I cancel it; provided, however, that if I am a Minnesota resident, this Authorization is effective for one year. I may cancel this Authorization at any time by writing to the Secura Care™ Support Program at 11800 Weston Parkway, NC 27513. I understand that canceling this Authorization will end my participation in the Program and will not affect any use or disclosure of the Information made before my request is received and processed.

By signing below, I certify that I have read and understand the Authorization to Release Health Information and agree to its terms. I understand that I am entitled to a copy of this Authorization upon request.

Patient or Legal Representative	Printed Name	Date

I authorize Secura Bio, Inc, and its Agents to discuss Patient's Information with the following designated individual(s) in connection with the Services (optional):

Name	Relationship to Patient
Email	Phone

Print and fax completed enrollments forms to Secura Care (800) 452-6744.
All pages must be received to process enrollment.

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