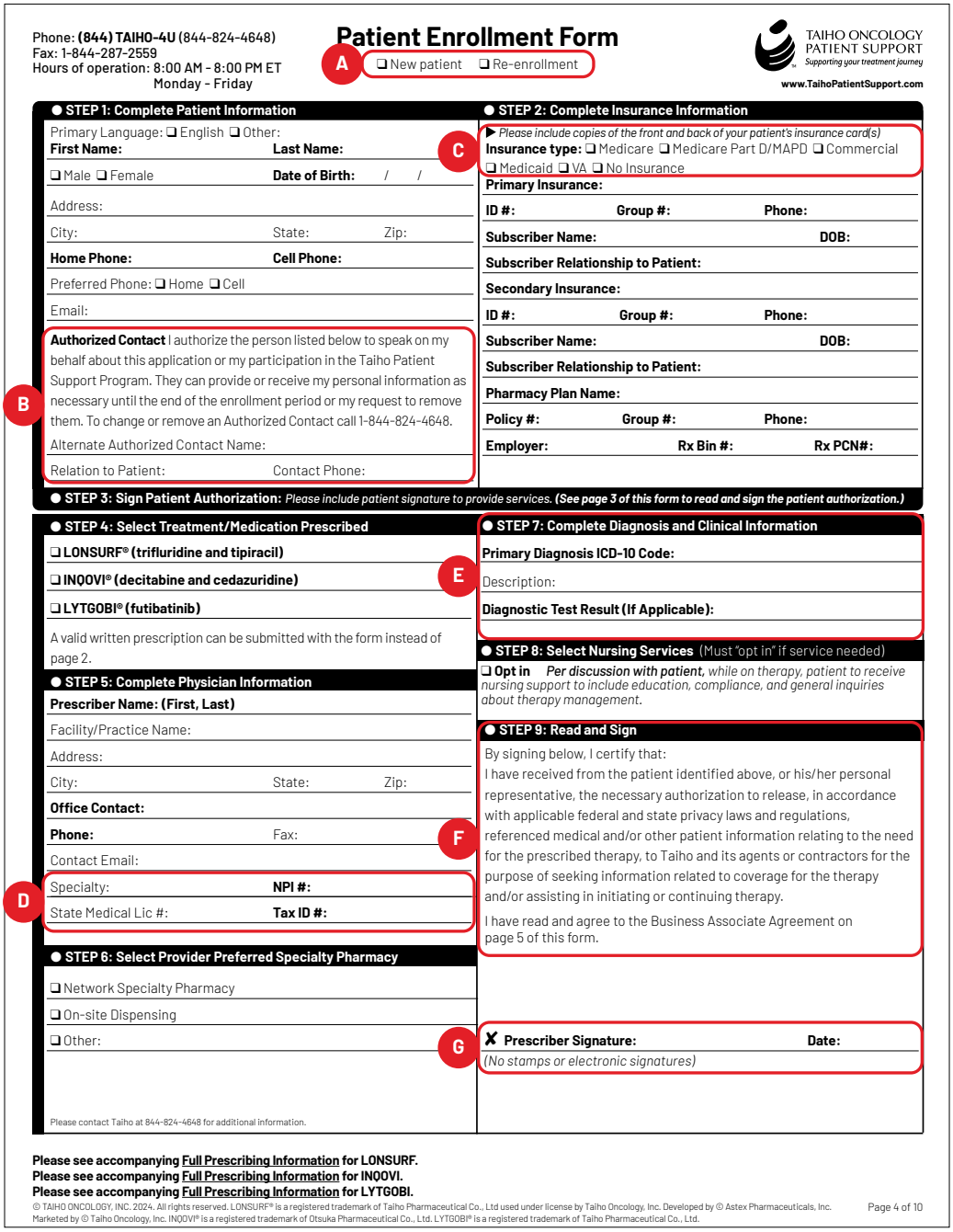
Phone: **(844) TAIHO-4U** (844-824-4648)
Fax: 1-844-287-2559
Hours of operation: 8:00 AM - 8:00 PM ET
Monday - Friday

TAIHO ONCOLOGY PATIENT SUPPORT
Supporting your treatment journey
www.TaihoPatientSupport.com

Instructions for Completing the Patient Enrollment Form

The highlighted areas below are sections that are often overlooked. Review them to ensure that you are properly filling out the form. **It is important to complete all required fields, including patient and physician signatures, to avoid delays in treatment.**



Phone: **(844) TAIHO-4U** (844-824-4648)
Fax: 1-844-287-2559
Hours of operation: 8:00 AM - 8:00 PM ET
Monday - Friday

Patient Enrollment Form

A ❑ New patient ❑ Re-enrollment

TAIHO ONCOLOGY PATIENT SUPPORT
Supporting your treatment journey
www.TaihoPatientSupport.com

● **STEP 1: Complete Patient Information**

Primary Language: ❑ English ❑ Other:
First Name: **Last Name:**
❑ Male ❑ Female **Date of Birth:** / /
Address:
City: State: Zip:
Home Phone: **Cell Phone:**
Preferred Phone: ❑ Home ❑ Cell
Email:

B **Authorized Contact** I authorize the person listed below to speak on my behalf about this application or my participation in the Taiho Patient Support Program. They can provide or receive my personal information as necessary until the end of the enrollment period or my request to remove them. To change or remove an Authorized Contact call 1-844-824-4648.
Alternate Authorized Contact Name:
Relation to Patient: Contact Phone:

● **STEP 2: Complete Insurance Information**

C ▶ *Please include copies of the front and back of your patient's insurance card(s)*
Insurance type: ❑ Medicare ❑ Medicare Part D/MAPD ❑ Commercial ❑ Medicaid ❑ VA ❑ No Insurance
Primary Insurance:
ID #: **Group #:** **Phone:**
Subscriber Name: **DOB:**
Subscriber Relationship to Patient:
Secondary Insurance:
ID #: **Group #:** **Phone:**
Subscriber Name: **DOB:**
Subscriber Relationship to Patient:
Pharmacy Plan Name:
Policy #: **Group #:** **Phone:**
Employer: **Rx Bin #:** **Rx PCN#:**

● **STEP 3: Sign Patient Authorization:** *Please include patient signature to provide services.* ***(See page 3 of this form to read and sign the patient authorization.)***

● **STEP 4: Select Treatment/Medication Prescribed**

❑ **LONSURF® (trifluridine and tipiracil)**
❑ **INQOVI® (decitabine and cedazuridine)**
❑ **LYTGOBI® (futibatinib)**

A valid written prescription can be submitted with the form instead of page 2.

● **STEP 5: Complete Physician Information**

Prescriber Name: (First, Last)
Facility/Practice Name:
Address:
City: State: Zip:
Office Contact:
Phone: Fax:
Contact Email:
D Specialty: **NPI #:**
State Medical Lic #: **Tax ID #:**

● **STEP 6: Select Provider Preferred Specialty Pharmacy**

❑ Network Specialty Pharmacy
❑ On-site Dispensing
❑ Other:

Please contact Taiho at 844-824-4648 for additional information.

● **STEP 7: Complete Diagnosis and Clinical Information**

E **Primary Diagnosis ICD-10 Code:**
Description:
Diagnostic Test Result (If Applicable):

● **STEP 8: Select Nursing Services** (Must "opt in" if service needed)

❑ **Opt in** ***Per discussion with patient,*** *while on therapy, patient to receive nursing support to include education, compliance, and general inquiries about therapy management.*

● **STEP 9: Read and Sign**

By signing below, I certify that:
I have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for the prescribed therapy, to Taiho and its agents or contractors for the purpose of seeking information related to coverage for the therapy and/or assisting in initiating or continuing therapy.

I have read and agree to the Business Associate Agreement on page 5 of this form.

F

G ✘ **Prescriber Signature:** **Date:**
(No stamps or electronic signatures)

Please see accompanying Full Prescribing Information for LONSURF.
Please see accompanying Full Prescribing Information for INQOVI.
Please see accompanying Full Prescribing Information for LYTGOBI.

Page 4 of 10

A. Select if the patient is NEW or re-enrolling in the program.

STEP 1: Complete Patient Information

B. Review the Authorized Contact consent and ensure the patient understands the type of information that will be shared if they elect an Alternate Authorized Contact. If the patient agrees, have them complete the fields in this section.

STEP 2: Complete Insurance Information

C. Select the type of insurance. Include copies of the front and back of all insurance cards. If the patient has no insurance, continue to Step 3 on this page. In addition, fill out the Patient Assistance Program Form on page 6 of the enrollment form.

STEP 5: Complete Physician Information

D. The prescribing healthcare provider must complete the NPI # and Tax ID # fields since some health plans require both.

STEP 7: Complete Diagnosis and Clinical Information

E. Provide documentation for all test results. Documentation can be attached to this form.

STEP 9: Read and Sign

F. The prescribing healthcare provider must read the agreement on page 5 of the enrollment form.

G. The prescribing healthcare provider must sign and date the form. Stamps and electronic signatures are not accepted, and the form will not be processed.

Phone: **(844) TAIHO-4U** (844-824-4648)
Fax: 1-844-287-2559
Hours of operation: 8:00 AM - 8:00 PM ET
Monday - Friday

Prescription Information

TAIHO ONCOLOGY PATIENT SUPPORT
Supporting your treatment journey
www.TaihoPatientSupport.com

Patient Name: (First, MI, Last) **Patient Date of Birth:**

H **A valid written prescription can be submitted with the form instead of completing this section.**

LONSURF® (trifluridine and tipiracil)
FDA-Approved Dose

- LONSURF is calculated by body surface area (BSA)
- FDA-approved dosage is: 35 mg/m² (based on trifluridine component) twice daily with food
  - Round dose up to the nearest 5-mg increment
  - Do not exceed 80 mg per dose (160 mg per day)
- Active treatment days include days 1 through 5 and days 8 through 12 of each 28-day treatment cycle

Height (cm): Weight (kg): BSA (m²):

J **Dosing Calculator**

Take _____ mg 2 times per day for days 1 through 5, then rest for 2 days, then

Take _____ mg 2 times per day for days 8 through 12, then rest for 16 days.

tablets per 28-day cycle: 15 mg: _____ Refills: _____ 20 mg: _____ Refills: _____

SIG (alternate to above): _____

I **INQOVI® (decitabine and cedazuridine)**
FDA-Approved Dose

- Take 1 tablet per day, days 1 through 5, every 28-day treatment cycle

tablets per cycle: _____ Refills: _____

SIG (alternate to above): _____

LYTGOBI® (futibatinib)
FDA-Approved Dose

- 20 mg once daily
- 28-day treatment cycle
- By selecting LYTGOBI, the prescriber confirms presence of FGFR2 fusion or other rearrangement

Take _____ mg once daily. Refills: _____

SIG (alternate to above): _____

By signing below, I certify that the above-prescribed therapy is medically necessary, and I authorize Taiho and its agents or contractors to forward the prescription above, by fax or other mode of delivery, to a pharmacy within the Taiho Oncology Patient Support Network.

K ✘ **Prescriber Signature:** **Date:**
(No stamps or electronic signatures) *(Substitution Permitted)*

✘ **Prescriber Signature:** **Date:**
(No stamps or electronic signatures) *(Dispense as Written)*

▶ *The prescriber must comply with all state specific prescription requirements.*

Please see accompanying Full Prescribing Information for LONSURF.
Please see accompanying Full Prescribing Information for INQOVI.
Please see accompanying Full Prescribing Information for LYTGOBI.

H. Healthcare providers can submit a written prescription instead of filling out this portion of the enrollment form.

I. The healthcare provider should complete all of the fields for the product being prescribed.

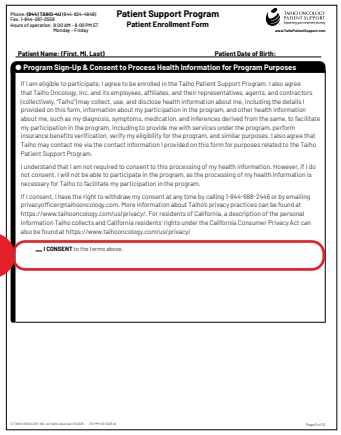
J. The Dosing Calculator can help calculate the appropriate LONSURF dosage and create a treatment calendar for your patients.

K. The prescribing healthcare provider must sign and date the prescription. Stamps and electronic signatures are not accepted, and the form will not be processed.

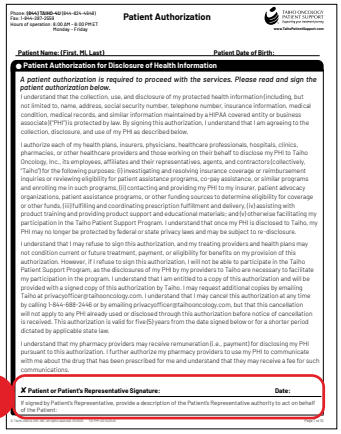
Phone: **(844) TAIHO-4U** (844-824-4648)
Fax: 1-844-287-2559
Hours of operation: 8:00 AM - 8:00 PM ET
Monday - Friday

TAIHO ONCOLOGY PATIENT SUPPORT
Supporting your treatment journey
www.TaihoPatientSupport.com

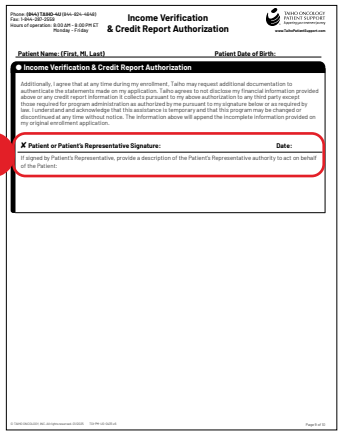
Instructions for Pages 6 through 10 of the Patient Enrollment Form



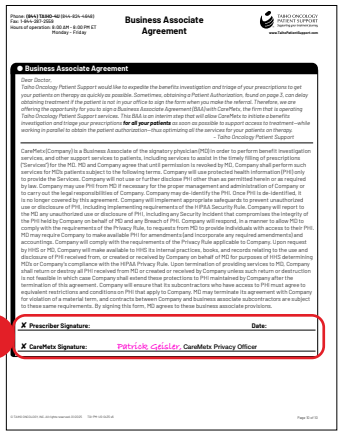
L. Page 6 of the form applies to patients without insurance or those who are underinsured. These patients must consent to electronic health information verification and/or provide additional documentation to determine eligibility for program support.



M. The patient or their authorized representative must sign page 7 of the enrollment form. The application will not be processed if the page is not signed.



N. The patient or their authorized representative must sign page 9 of the enrollment form. The application will not be processed if the page is not signed.



O. The prescribing healthcare provider must sign the bottom of page 10 of the enrollment form.

Phone: **(844) TAIHO-4U** (844-824-4648)
Fax: 1-844-287-2559
Hours of operation: 8:00 AM - 8:00 PM ET
Monday - Friday

Patient Enrollment Form

❑ New patient ❑ Re-enrollment

TAIHO ONCOLOGY PATIENT SUPPORT
Supporting your treatment journey
www.TaihoPatientSupport.com

● STEP 1: Complete Patient Information

Primary Language: ❑ English ❑ Other:

First Name: **Last Name:**

❑ Male ❑ Female **Date of Birth:** / /

Address:

City: State: Zip:

Home Phone: **Cell Phone:**

Preferred Phone: ❑ Home ❑ Cell

Email:

Authorized Contact I authorize the person listed below to speak on my behalf about this application or my participation in the Taiho Patient Support Program. They can provide or receive my personal information as necessary until the end of the enrollment period or my request to remove them. To change or remove an Authorized Contact call 1-844-824-4648.

Alternate Authorized Contact Name:

Relation to Patient: Contact Phone:

● STEP 2: Complete Insurance Information

▶ *Please include copies of the front and back of your patient's insurance card(s)*

Insurance type: ❑ Medicare ❑ Medicare Part D/MAPD ❑ Commercial ❑ Medicaid ❑ VA ❑ No Insurance

Primary Insurance:

ID #: **Group #:** **Phone:**

Subscriber Name: **DOB:**

Subscriber Relationship to Patient:

Secondary Insurance:

ID #: **Group #:** **Phone:**

Subscriber Name: **DOB:**

Subscriber Relationship to Patient:

Pharmacy Plan Name:

Policy #: **Group #:** **Phone:**

Employer: **Rx Bin #:** **Rx PCN#:**

● STEP 3: Sign Patient Authorization:

Please include patient signature to provide services. ***(See page 3 of this form to read and sign the patient authorization.)***

● STEP 4: Select Treatment/Medication Prescribed

❑ **LONSURF® (trifluridine and tipiracil)**

❑ **INQOVI® (decitabine and cedazuridine)**

❑ **LYTGOBI® (futibatinib)**

A valid written prescription can be submitted with the form instead of page 2.

● STEP 5: Complete Physician Information

Prescriber Name: (First, Last)

Facility/Practice Name:

Address:

City: State: Zip:

Office Contact:

Phone: Fax:

Contact Email:

Specialty: **NPI #:**

State Medical Lic #: **Tax ID #:**

● STEP 6: Select Provider Preferred Specialty Pharmacy

❑ Network Specialty Pharmacy

❑ On-site Dispensing

❑ Other:

Please contact Taiho at 844-824-4648 for additional information.

● STEP 7: Complete Diagnosis and Clinical Information

Primary Diagnosis ICD-10 Code:

Description:

Diagnostic Test Result (If Applicable):

● STEP 8: Select Nursing Services (Must "opt in" if service needed)

❑ **Opt in** ***Per discussion with patient,*** *while on therapy, patient to receive nursing support to include education, compliance, and general inquiries about therapy management.*

● STEP 9: Read and Sign

By signing below, I certify that:

I have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for the prescribed therapy, to Taiho and its agents or contractors for the purpose of seeking information related to coverage for the therapy and/or assisting in initiating or continuing therapy.

I have read and agree to the Business Associate Agreement on page 5 of this form.

✘ **Prescriber Signature:** **Date:**

(No stamps or electronic signatures)

Please see accompanying Full Prescribing Information for LONSURF.
Please see accompanying Full Prescribing Information for INQOVI.
Please see accompanying Full Prescribing Information for LYTGOBI.

Phone: **(844) TAIHO-4U** (844-824-4648)
Fax: 1-844-287-2559
Hours of operation: 8:00 AM - 8:00 PM ET
Monday - Friday

Prescription Information

TAIHO ONCOLOGY PATIENT SUPPORT
Supporting your treatment journey
www.TaihoPatientSupport.com

Patient Name: (First, MI, Last) **Patient Date of Birth:**

A valid written prescription can be submitted with the form instead of completing this section.

LONSURF® (trifluridine and tipiracil)
FDA-Approved Dose

- LONSURF is calculated by body surface area (BSA)
- FDA-approved dosage is: 35 mg/m^2 (based on trifluridine component) twice daily with food
  - — Round dose up to the nearest 5-mg increment
  - — Do not exceed 80 mg per dose (160 mg per day)
- Active treatment days include days 1 through 5 and days 8 through 12 of each 28-day treatment cycle

Dosing Calculator

Height (cm): Weight (kg): BSA (m^2):

Take _____ mg 2 times per day for days 1 through 5, then rest for 2 days, then

Take _____ mg 2 times per day for days 8 through 12, then rest for 16 days.

tablets per 28-day cycle: 15 mg: _____ Refills: _____ 20 mg: _____ Refills: _____

SIG (alternate to above): _____

INQOVI® (decitabine and cedazuridine)
FDA-Approved Dose

- Take 1 tablet per day, days 1 through 5, every 28-day treatment cycle

tablets per cycle: _____ Refills: _____

SIG (alternate to above): _____

LYTGOBI® (futibatinib)
FDA-Approved Dose

- 20 mg once daily
- 28-day treatment cycle
- By selecting LYTGOBI, the prescriber confirms presence of FGFR2 fusion or other rearrangement

Take _____ mg once daily. Refills: _____

SIG (alternate to above): _____

By signing below, I certify that the above-prescribed therapy is medically necessary, and I authorize Taiho and its agents or contractors to forward the prescription above, by fax or other mode of delivery, to a pharmacy within the Taiho Oncology Patient Support Network.

✘ **Prescriber Signature:** **Date:**

(No stamps or electronic signatures) *(Substitution Permitted)*

✘ **Prescriber Signature:** **Date:**

(No stamps or electronic signatures) *(Dispense as Written)*

▶ *The prescriber must comply with all state specific prescription requirements.*

Please see accompanying Full Prescribing Information for LONSURF.
Please see accompanying Full Prescribing Information for INQOVI.
Please see accompanying Full Prescribing Information for LYTGOBI.

Phone: **(844) TAIHO-4U** (844-824-4648)
Fax: 1-844-287-2559
Hours of operation: 8:00 AM - 8:00 PM ET
Monday - Friday

Patient Support Program
Patient Enrollment Form

TAIHO ONCOLOGY PATIENT SUPPORT
Supporting your treatment journey
www.TaihoPatientSupport.com

Patient Name: (First, MI, Last) **Patient Date of Birth:**

Program Sign-Up & Consent to Process Health Information for Program Purposes

If I am eligible to participate, I agree to be enrolled in the Taiho Patient Support Program. I also agree that Taiho Oncology, Inc. and its employees, affiliates, and their representatives, agents, and contractors (collectively, "Taiho") may collect, use, and disclose health information about me, including the details I provided on this form, information about my participation in the program, and other health information about me, such as my diagnosis, symptoms, medication, and inferences derived from the same, to facilitate my participation in the program, including to provide me with services under the program, perform insurance benefits verification, verify my eligibility for the program, and similar purposes. I also agree that Taiho may contact me via the contact information I provided on this form for purposes related to the Taiho Patient Support Program.

I understand that I am not required to consent to this processing of my health information. However, if I do not consent, I will not be able to participate in the program, as the processing of my health information is necessary for Taiho to facilitate my participation in the program.

If I consent, I have the right to withdraw my consent at any time by calling 1-844-688-2446 or by emailing privacyofficer@taihooncology.com. More information about Taiho's privacy practices can be found at https://www.taihooncology.com/us/privacy/. For residents of California, a description of the personal information Taiho collects and California residents' rights under the California Consumer Privacy Act can also be found at https://www.taihooncology.com/us/privacy/

___ **I CONSENT** to the terms above.

Phone: **(844) TAIHO-4U** (844-824-4648)
Fax: 1-844-287-2559
Hours of operation: 8:00 AM - 8:00 PM ET
Monday - Friday

Patient Authorization

TAIHO ONCOLOGY PATIENT SUPPORT
Supporting your treatment journey
www.TaihoPatientSupport.com

Patient Name: (First, MI, Last) **Patient Date of Birth:**

Patient Authorization for Disclosure of Health Information

A patient authorization is required to proceed with the services. Please read and sign the patient authorization below.

I understand that the collection, use, and disclosure of my protected health information (including, but not limited to, name, address, social security number, telephone number, insurance information, medical condition, medical records, and similar information maintained by a HIPAA covered entity or business associate) ("PHI") is protected by law. By signing this authorization, I understand that I am agreeing to the collection, disclosure, and use of my PHI as described below.

I authorize each of my health plans, insurers, physicians, healthcare professionals, hospitals, clinics, pharmacies, or other healthcare providers and those working on their behalf to disclose my PHI to Taiho Oncology, Inc., its employees, affiliates and their representatives, agents, and contractors (collectively, "Taiho") for the following purposes: (i) investigating and resolving insurance coverage or reimbursement inquiries or reviewing eligibility for patient assistance programs, co-pay assistance, or similar programs and enrolling me in such programs, (ii) contacting and providing my PHI to my insurer, patient advocacy organizations, patient assistance programs, or other funding sources to determine eligibility for coverage or other funds, (iii) fulfilling and coordinating prescription fulfillment and delivery, (iv) assisting with product training and providing product support and educational materials; and (v) otherwise facilitating my participation in the Taiho Patient Support Program. I understand that once my PHI is disclosed to Taiho, my PHI may no longer be protected by federal or state privacy laws and may be subject to re-disclosure.

I understand that I may refuse to sign this authorization, and my treating providers and health plans may not condition current or future treatment, payment, or eligibility for benefits on my provision of this authorization. However, if I refuse to sign this authorization, I will not be able to participate in the Taiho Patient Support Program, as the disclosures of my PHI by my providers to Taiho are necessary to facilitate my participation in the program. I understand that I am entitled to a copy of this authorization and will be provided with a signed copy of this authorization by Taiho. I may request additional copies by emailing Taiho at privacyofficer@taihooncology.com. I understand that I may cancel this authorization at any time by calling 1-844-688-2446 or by emailing privacyofficer@taihooncology.com, but that this cancellation will not apply to any PHI already used or disclosed through this authorization before notice of cancellation is received. This authorization is valid for five (5) years from the date signed below or for a shorter period dictated by applicable state law.

I understand that my pharmacy providers may receive remuneration (i.e., payment) for disclosing my PHI pursuant to this authorization. I further authorize my pharmacy providers to use my PHI to communicate with me about the drug that has been prescribed for me and understand that they may receive a fee for such communications.

✘ Patient or Patient's Representative Signature: **Date:**

If signed by Patient's Representative, provide a description of the Patient's Representative authority to act on behalf of the Patient:

Phone: **(844) TAIHO-4U** (844-824-4648)
Fax: 1-844-287-2559
Hours of operation: 8:00 AM - 8:00 PM ET
Monday - Friday

Income Verification & Credit Report Authorization

TAIHO ONCOLOGY PATIENT SUPPORT
Supporting your treatment journey
www.TaihoPatientSupport.com

Patient Name: (First, MI, Last) **Patient Date of Birth:**

Income Verification & Credit Report Authorization

Number of People in Your Household, Including You? 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8+__

What Is Your Total Annual Household Income? (Including SSI, gross wages, etc) $

▶ *To verify the above, you will need to provide one of the following: (1) copies of federal tax returns or other documents like bank statements, proof of Social Security Income, etc. or (2) authorization to obtain your credit profile from Experian Health for the purposes of verifying your income eligibility.* ***Please choose which option you prefer:***

You understand that by checking the "I Agree" box immediately following this notice, you are providing 'written instructions' to Taiho Oncology, Inc and their agents (collectively, "Taiho") under federal and state law authorizing electronic income verification by obtaining information from your personal credit profile or other information from Experian Health.

You authorize Taiho to obtain such information solely to validate your income eligibility for the purposes of determining your eligibility for patient assistance.

__ **I AGREE** to the terms above for electronic income verification using Experian Health.

__ **I DO NOT AGREE** with the terms above and do not wish to have my income verified by Experian Health. I understand that I will be asked to provide supporting documentation to authenticate my income and eligibility.

I attest that the above information is complete and accurate. I attest that I am eligible to receive PAP medication under the terms and conditions of the PAP program, including that **I have no or insufficient prescription insurance coverage for the indicated medication, including Medicaid, Medicare, or any other public or private program, and I have insufficient financial resources to pay for the prescribed therapy.**

I understand that the PAP medication has been prescribed to me by my physician and is provided at no charge to me or any other party. I further agree that I will seek no reimbursement for any drug(s) obtained under this program. I agree and understand that the PAP medication is being provided to me unrelated to any insurance coverage I might have for prescription drugs. I agree that I have not submitted and will not submit a claim for reimbursement from insurance or any other third party for the prescription for which I am receiving PAP medication, and that I will not count the cost of PAP medication towards my deductible. Additionally, as applicable, I agree that PAP medication will not count toward my true out-of-pocket costs (TrOOP) and that I will not seek TrOOP credit under the Medicare Part D program for any portion of the cost of PAP medication. If I have prescription drug coverage through Medicare, including Medicare Part D, then I agree that I will not submit any claim to my Medicare coverage for any PAP medication prescriptions for the remainder of the current coverage year, including for my current prescription and any additional prescriptions or refills for the drug during the coverage year. I understand that Taiho reserves the right to rescind, revoke, or amend the PAP program at any time without notice.

By my signature below, I authorize the release of the above information about me and my medical condition to Taiho. I authorize Taiho to use and disclose such information for the assessment of my eligibility for and enrollment and administration of Taiho patient assistance, which may include contacting my insurer, public funding programs, social workers, advocacy organizations, healthcare providers, or other persons or entities Taiho may deem appropriate to release all medical records or requested information bearing on my eligibility to and benefits under the program.

Continued on next page.

Phone: **(844) TAIHO-4U** (844-824-4648)
Fax: 1-844-287-2559
Hours of operation: 8:00 AM - 8:00 PM ET
Monday - Friday

Income Verification & Credit Report Authorization

TAIHO ONCOLOGY PATIENT SUPPORT
Supporting your treatment journey
www.TaihoPatientSupport.com

Patient Name: (First, MI, Last) **Patient Date of Birth:**

Income Verification & Credit Report Authorization

Additionally, I agree that at any time during my enrollment, Taiho may request additional documentation to authenticate the statements made on my application. Taiho agrees to not disclose my financial information provided above or any credit report information it collects pursuant to my above authorization to any third party except those required for program administration as authorized by me pursuant to my signature below or as required by law. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice. The information above will append the incomplete information provided on my original enrollment application.

✘ Patient or Patient's Representative Signature: **Date:**

If signed by Patient's Representative, provide a description of the Patient's Representative authority to act on behalf of the Patient:

Phone: **(844) TAIHO-4U** (844-824-4648)
Fax: 1-844-287-2559
Hours of operation: 8:00 AM - 8:00 PM ET
Monday - Friday

Business Associate Agreement

TAIHO ONCOLOGY PATIENT SUPPORT
Supporting your treatment journey
www.TaihoPatientSupport.com

Business Associate Agreement

Dear Doctor,
Taiho Oncology Patient Support would like to expedite the benefits investigation and triage of your prescriptions to get your patients on therapy as quickly as possible. Sometimes, obtaining a Patient Authorization, found on page 3, can delay obtaining treatment if the patient is not in your office to sign the form when you make the referral. Therefore, we are offering the opportunity for you to sign a Business Associate Agreement (BAA) with CareMetx, the firm that is operating Taiho Oncology Patient Support services. This BAA is an interim step that will allow CareMetx to initiate a benefits investigation and triage your prescriptions ***for all your patients*** *as soon as possible to support access to treatment—while working in parallel to obtain the patient authorization—thus optimizing all the services for your patients on therapy.*
– Taiho Oncology Patient Support

CareMetx (Company) is a Business Associate of the signatory physician (MD) in order to perform benefit investigation services, and other support services to patients, including services to assist in the timely filling of prescriptions ("Services") for the MD. MD and Company agree that until permission is revoked by MD, Company shall perform such services for MD's patients subject to the following terms. Company will use protected health information (PHI) only to provide the Services. Company will not use or further disclose PHI other than as permitted herein or as required by law. Company may use PHI from MD if necessary for the proper management and administration of Company or to carry out the legal responsibilities of Company. Company may de-identify the PHI. Once PHI is de-identified, it is no longer covered by this agreement. Company will implement appropriate safeguards to prevent unauthorized use or disclosure of PHI, including implementing requirements of the HIPAA Security Rule. Company will report to the MD any unauthorized use or disclosure of PHI, including any Security Incident that compromises the integrity of the PHI held by Company on behalf of MD and any Breach of PHI. Company will respond, in a manner to allow MD to comply with the requirements of the Privacy Rule, to requests from MD to provide individuals with access to their PHI. MD may require Company to make available PHI for amendments (and incorporate any required amendments) and accountings. Company will comply with the requirements of the Privacy Rule applicable to Company. Upon request by HHS or MD, Company will make available to HHS its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Company on behalf of MD for purposes of HHS determining MD's or Company's compliance with the HIPAA Privacy Rule. Upon termination of providing services to MD, Company shall return or destroy all PHI received from MD or created or received by Company unless such return or destruction is not feasible in which case Company shall extend these protections to PHI maintained by Company after the termination of this agreement. Company will ensure that its subcontractors who have access to PHI must agree to equivalent restrictions and conditions on PHI that apply to Company. MD may terminate its agreement with Company for violation of a material term, and contracts between Company and business associate subcontractors are subject to these same requirements. By signing this form, MD agrees to these business associate provisions.

✘ **Prescriber Signature:** **Date:**

✘ **CareMetx Signature:** Patrick Geisler, CareMetx Privacy Officer

