ADVANCING Patient Support
Personalized assistance from ADC Therapeutics

Zynlonta™ loncastuximab tesirine-lpyl for injection, for intravenous use

PATIENT ENROLLMENT FORM

SUBMIT COMPLETED ENROLLMENT FORM

Fax: 1-855-915-3005 or **Email:** support@ADVANCINGPatientSupport.com

Enrollment initiates a benefits investigation, providing a summary of the patient's insurance coverage and out-of-pocket costs.

Personalized assistance and support for patients is available for the services below. Be sure to check the boxes on page 1 based on the support needed for your patient.

Prior Authorization/Precertification helps determine if a prior authorization or precertification is needed for your patient and can provide support throughout the process

Appeals/Claims Support provides guidance on coding and billing, the appeals process, and can help navigate any questions that may arise

Copay Program enrolls your eligible commercially insured patients[a]

Patient Assistance Program (PAP) offers patients who are uninsured or underinsured ZYNLONTA (loncastuximab tesirine-lpyl) for free if they meet certain criteria

Important Note: Let your patient know that once they are enrolled, they will receive a welcome call from **ADVANCING Patient Support**. Have them save **1-855-690-0340** in their contacts so they recognize the number when called.

It's important to complete this form in its entirety to prevent processing delays. Please contact **ADVANCING Patient Support** at **1-855-690-0340**, Monday-Friday (8 AM–8 PM ET) for assistance.

Healthcare Provider SIGN & DATE
- **Section 6** (page 2)
- **Section 7** (page 3)

Patient SIGN & DATE
- **Section 6** (page 2)
- **Section 8** (page 4 & 5)

HOW TO ENROLL YOUR PATIENT

SECTIONS

1. **Patient Information (page 1):** Provide patient information.
2. **Healthcare Provider Information (page 1):** Provide healthcare provider contact information. Be sure to include NPI and DEA numbers to help facilitate the benefits investigation.
3. **Infusion/Administration Site (page 1):** Provide Infusion/Administration Site details if different than Healthcare Provider information.
4. **Insurance Information (page 1):** Provide the patient's insurance information. In addition, you may provide a copy of both sides of the patient's insurance card to help improve accuracy and reduce the frequency of follow-up calls.
5. **Clinical Information (page 2):** Clinical information is important and often needed for the benefits investigation. Diagnosis and appropriate ICD-10 code are required fields. Providing additional information in this section may help reduce the frequency of follow-up calls.
6. **Patient Assistance Program (PAP) (page 2):** This section can serve as the prescription for ZYNLONTA for patients enrolled in **ADVANCING Patient Support**. Please ensure the prescribing healthcare provider and your patient sign this section. **Be sure to attach a separate prescription if this section does not comply with your state's prescription law.**
7. **Healthcare Provider Certification (page 3):** A healthcare provider's signature is required to attest to the review and certification of the program request.
8. **Patient Authorization (page 4 & 5):** Requires patient (or legal representative) signatures for consent for product and program communications and Patient Certification and HIPAA Authorization.

[a]For commercially insured patients only. Eligibility and other restrictions apply. For full Terms and Conditions, visit **ADVANCINGPatientSupport.com/copay-terms-conditions**.

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PATIENT SUPPORT CHECK SERVICES REQUESTED

- ☐ **Prior Authorization/ Precertification**
- ☐ **Appeals/Claims Support**
- ☐ **Copay Program**
- ☐ **Patient Assistant Program (PAP)**

All support is subject to eligibility criteria and Program Terms and Conditions.

1 Patient Information

Sex: ☐ Male ☐ Female Date of Birth:____ / ____ / ____

Patient's Name: ______________________________
First Last

Patient's Address:______________________________

City: ____________________ State: __________ Zip:__________

Home Phone: ____________________ Cell Phone: ____________________

Email:____________________ Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone

Best Time to Contact: ☐ AM (8 AM–10 AM ET) ☐ Day (10 AM–5 PM ET) ☐ Evening (5 PM–8 PM ET)

Legal Representative (if applicable):______________________________

Relationship to Patient: ______________________________

2 Healthcare Provider Information

Provider's Name:______________________________ Provider's Title: ____________________
First Last

NPI#: ____________________ DEA#: ____________________

Tax ID#: ____________________ PTAN#: ____________________

Site of Care/Facility Name: ______________________________

Office Address: ______________________________

City: ____________________ State: __________ Zip: __________

Office Phone: ____________________ Fax: ____________________

Office Contact's Name: ____________________ Office Contact's Title:____________________

3 Infusion/Administration Site (if different from above)

Facility/Site Name: ______________________________

Office Contact's Name: ______________________________

Office Phone: ____________________ Fax: ____________________

Address: ______________________________

City: ____________________ State: __________ Zip: __________

4 Insurance Information

☐ Uninsured ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other: ____________________

☐ Government Programs (please specify):______________________________

For the best experience, please attach a copy of the patient's insurance card

Primary Medical Insurance Payer: ____________________

Phone: ____________________

Subscriber ID#: ____________________

Group#:____________________

BIN: ____________ PCN: ____________

Policy Holder Name:____________________
First Last

Policy Holder Relationship to Patient: ____________________

Prescription Insurance Payer: ____________________

Phone: ____________________

Subscriber ID#: ____________________

Group#:____________________

BIN: ____________ PCN: ____________

Policy Holder Name:____________________
First Last

Policy Holder Relationship to Patient: ____________________

Patient's Name: ______________________________ Date of Birth: ____ / ____ / ____
First Last

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5 Clinical Information

Patient's Diagnosis: ______________________ ☐ ICD-10-CM Code:__________ Diagnosis Date:_____ / _____ / _____

Most Recent Therapies for this Diagnosis: ______________________________

Prior Therapies for this Diagnosis:______________________________

Drug Allergies:______________________________

Other Medications:______________________________

Patient Assistance Program (PAP) Enrollment (if applicable)

6 ZYNLONTA™ (loncastuximab tesirine-lpyl) Prescription for PAP

Patient's Name: ______________________ Date of Birth:_____/_____/_____ Weight: _______________

Prescription 1 (Cycle 1 and 2)

ZYNLONTA Start Date: ____ / _____/_____

Directions: 0.15 mg/kg intravenous infusion every 3 weeks for 2 cycles

Premedicate with dexamethasone 4 mg orally or intravenously twice daily for 3 days beginning the day before ZYNLONTA

Other Directions:______________________________

____

Quantity: ________ 10 mg vial(s) 0 Refills

Prescription 2 (Cycles 3+)

ZYNLONTA Start Date: ____ / _____/_____

Directions: 0.075 mg/kg intravenous infusion every 3 weeks for subsequent cycles

Premedicate with dexamethasone 4 mg orally or intravenously twice daily for 3 days beginning the day before ZYNLONTA

Other Directions:______________________________

____

Quantity: ________ 10 mg vial(s) 0 Refills

SIGN & DATE

Healthcare Provider's Name: ______________________________

Healthcare Provider's Signature: ______________________________ Date: _____ / _____ / _____
No stamps please.

Patient to Complete

I certify that the information provided on this form is complete and accurate, to the best of my knowledge, and I will promptly call ADC Therapeutics at 1-855-690-0340 with any updates, including any changes to my insurance. I understand that all support provided through the ADVANCING Patient Support Program (the "Program") is complimentary, and there is no purchase requirement associated with the Program. To determine my eligibility to enroll into the Patient Assistance Program, ADC Therapeutics and its representatives/agents ("ADC Therapeutics") will assess my income with the appropriate level of evidence set forth by verification of financial information (including W-2 and tax return documentation). I will not seek (or allow others to seek on my behalf) payment or reimbursement for any free drug or other support provided to me through the Program. I will comply with all Program Terms and Conditions and with any requirements from my insurance provider.

Fair Credit Reporting Act (FCRA) Authorization: I am providing written instructions authorizing the Program and its vendor to obtain my consumer report from a consumer reporting agency to be used solely for the eligibility determination process for programs administered by ADC Therapeutics.

SIGN & DATE

Patient's or Legal Representative's Signature: ______________________________ Date: _____ / _____ / _____

Patient's Name: ______________________________ Date of Birth: ____ / ____ / ____
First Last

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7 Healthcare Provider Certification

By signing below, I hereby represent, covenant, and certify as follows:

(1) The above therapy (or medicine) is medically necessary;

(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 ADC Therapeutics America, Inc. and its representatives/agents ("ADC Therapeutics") all patient information needed for processing this application, including, without limitation, my patient's financial and medical information;

(3) I understand and my patient has authorized that this information may be used by ADC Therapeutics to assess the patient's eligibility for participation in ADVANCING Patient Support Program (the "Program") and for other purposes as outlined in the Patient Authorization below;

(4) ADC Therapeutics is authorized to contact me about the information provided on this form and as needed |to facilitate my patient's enrollment and participation in the Program;

(5) I have read and understand the Terms and Conditions of the Copay Assistance Program available from ADVANCING Patient Support Program (the "Program") or at www.ADVANCINGPatientSupport.com/copay-terms-conditions and I agree to be bound by these Copay Assistance Program Terms and Conditions;

(6) I have not received, nor will I seek or accept reimbursement from any federal, state, or private payers for any drug provided for my patient through the Program's free-drug support ("Patient Assistance Program" or "PAP");

(7) If the above-named patient is enrolled in ADC Therapeutics Patient Assistance Program, free ZYNLONTA (loncastuximab tesirine-lpyl) will be provided to this eligible and enrolled patient at no charge of any kind; free ZYNLONTA that is supplied as a result of this enrollment form is for the use of the patient named on this form only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (such as Medicare, Medicaid, or other benefit provider) for reimbursement. I understand that ADC Therapeutics may contact the patient directly to complete the enrollment form and, if authorized by the patient, contact the patient directly in the future to verify Program eligibility and updates to insurance coverage as well as to confirm the receipt of free ZYNLONTA through the Program;

(8) I have not received, nor will I seek or accept payment from my patient or any other payer for any co-insurance or other cost-sharing amount paid for by the Program;

(9) I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible under this Program. I will promptly notify ADC Therapeutics by calling 1-855-690-0340 if I become aware of any such changes;

(10) I understand that any ADC Therapeutics products and other support provided by the Program are complimentary and for the benefit of the patient, that I am under no obligation to prescribe any ADC Therapeutics drugs, including because of my patient's participation in the Program, and I have not received and will not receive any benefit from ADC Therapeutics for prescribing an ADC Therapeutics drug;

(11) I understand that if I receive free ADC Therapeutics product, I will only administer it to the patient identified in this application for whom it was prescribed or return the product to ADC Therapeutics;

(12) The information contained in this form is complete and accurate to the best of my knowledge; and

(13) I will promptly notify ADC Therapeutics of any errors by calling 1-855-690-0340, and will make every effort to correct those errors.

SIGN & DATE

Healthcare Provider's Name: ______________________________

Healthcare Provider's Signature: ______________________________ Date: _____ / _____ / _____

No stamps please.

Patient's Name: ______________________________________ Date of Birth: ____ / ____ / ____
First Last

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8 Patient Authorization

Consent to Receive Product and Support Communications

ADC Therapeutics understands protecting your personal and health information is very important. We do not share any personally identifiable or health information you give us with third parties for their own marketing use. I understand from time to time, ADC Therapeutics Privacy Policy may change and for the most recent version of the Privacy Policy, I should visit https://adctherapeutics.com/privacy-policy/. I understand by signing below that the information provided by me, my healthcare professional, pharmacy, or insurance company may be used for marketing purposes by ADC Therapeutics in order to share updates about its products and services, or other opportunities that may be of interest to me via mail, email, or phone. I can opt out of marketing communications at any time by clicking the unsubscribe link in the emails I receive from ADCT or by sending a letter with my opt out request to 430 Mountain Avenue, Suite #404, New Providence, NJ 07974, Attn: ADCT Marketing.

SIGN & DATE

Patient's or Legal Representative's Signature: ______________________________ Date: _____ / _____ / _____

Patient Certification and HIPAA Authorization

I certify that the information I am providing on this form is true and correct. I further certify that I have read and understand the Terms and Conditions of the Copay Assistance Program available from ADVANCING Patient Support Program (the "Program") or at www.ADVANCINGPatientSupport.com/copay-terms-conditions, that I meet the eligibility requirements for, and I agree to be bound by these Copay Assistance Program Terms and Conditions.

I hereby authorize my healthcare providers, 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 ADC Therapeutics America, Inc. and its representatives/agents ("ADC Therapeutics") so that ADC Therapeutics may use my information: **(a)** to contact me, or the person legally authorized to sign on my behalf, by phone or mail, regarding this application, my participation in ADVANCING Patient Support Program (the "Program"), the services and information available through the Program, and my use or potential use of ZYNLONTA (loncastuximab tesirine-lpyl), including through messages left for me that disclose that I take or may take ZYNLONTA; **(b)** to contact my insurance company on my behalf to verify my coverage for ZYNLONTA; **(c)** to determine my eligibility for enrollment into the Program; **(d)** to enroll me into the Program, if I am eligible, and provide applicable support through the Program, including information on third-party sources that may be able to assist me; **(e)** to coordinate my ZYNLONTA treatment with my healthcare professionals and specialty pharmacy, and send me educational materials or other information that may be of interest to me related to my ZYNLONTA treatment, and/or; **(f)** to conduct other activities as appropriate to administer the Program.

(continued)

Patient's Name: ______________________________ ______________________________ **Date of Birth:** ____ / ____ / ____
First Last

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For more information, contact your **ADVANCING Patient Support** case manager at **1-855-690-0340** Monday-Friday (8 AM–8 PM ET)

8 Patient Authorization *(continued)*

If I have designated a Legal Representative on this form, I authorize ADC Therapeutics to use my PHI to contact the person I have designated as my Legal Representative for the purpose of verifying the information I have provided in this form and/or coordinating the provision of benefits that may be available to me under the Program and to disclose my PHI, including information provided in this enrollment form, to my Legal Representative for the purposes described in this paragraph. Once my PHI has been disclosed to ADC Therapeutics, I understand that federal privacy laws, including HIPAA, may no longer protect my PHI.

I understand that neither treatment from my healthcare professional nor coverage for ZYNLONTA through my insurance are conditioned on me signing this certification and authorization. I understand that this certification and authorization is voluntary. However, if I refuse to sign, or revoke my authorization, ADC Therapeutics may not be able to determine my eligibility for the Program and I may not be eligible to participate in the Program. I may revoke this authorization at any time by contacting ADVANCING Patient Support at 1-855-690-0340 or by sending a written request for cancellation to TrialCard, C/O Advancing Patient Support, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560. If I do not revoke this authorization, it will remain valid for 5 years (or at such lesser time as state law may require). I understand that I will be provided with a copy of this authorization by my healthcare provider or health plan (or I am able to request a copy).

SIGN & DATE

Patient's or Legal Representative's Signature: ______________________________ **Date:** _____ / _____ / _____

ZYNLONTA is a trademark of ADC Therapeutics SA.
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