TG PatientSupport™
680 Century Point, Lake Mary, FL 32746

Phone: 1-877-TGTXPSP
(1-877-848-9777)
Fax: 1-877-778-1329

Ukoniq.com/patient/patientsupport
Hours of Operation:
Monday - Friday, 8 AM to 8 PM EST

Enrollment Form

About TG Patient Support Services

TG Patient Support provides individualized services and support to patients who have been prescribed a TG product, including help navigating the insurance approval process and learning more about financial assistance program offerings. By completing and signing this form, the following program offerings may be able to help based upon your individual needs:

- Performing a benefits investigation to understand your health insurance coverage for your prescribed medication
- Communicating with your physician, pharmacy, health plan, and other healthcare providers about your TG Therapeutics' medicine and the program
- Determining your eligibility for, and providing information about, copay support or free drug programs:
  - Patients with commercial or private health insurance may be eligible to receive UKONIQ™ (umbralisib) for as little as $5/prescription*
  - Quick Start/Bridge Programs provide free product to eligible patients with a diagnosis that is consistent with an FDA-approved indication for UKONIQ who experience a coverage delay of at least 5 business days. (See Program Terms and Conditions below)
  - Patients with no insurance coverage or who are underinsured and meet financial eligibility criteria of an annual family gross income equal to or less than 600% of the current federal poverty level may be able to receive UKONIQ free of charge
- Providing you with information and education about your disease and TG Therapeutics' medicines and market research. These communications may be considered marketing communications

Quick Start and Bridge Terms and Conditions: The Quick Start and Bridge Programs provide eligible patients with a 15-day supply of the prescribed TG Therapeutics' oral medication. There is no purchase obligation by virtue of participation in the Quick Start or Bridge Programs. Patients receiving free product under the Quick Start or Bridge Programs may not seek reimbursement or credit for this prescription from any insurer, health plan, or government program. For any patient who is a member of a Medicare Part D plan, this prescription, or any cost associated with it, may not be counted as part of their out-of-pocket cost for prescription drugs. An extension period beyond the initial 15-day supply is available for patients experiencing extended delays and is subject to individual approval.

*Up to the annual maximum program benefit for $25,000 per patient, per calendar year. Patients must have commercial health insurance (also known as private insurance) that provides coverage for UKONIQ. Patients must meet all other Terms and Conditions of the program. Visit **https://www.TGCommercialCopayProgram.com** for full Terms and Conditions.

How to enroll in TG Patient Support

1. In order for TG Patient Support to assist you, the enrollment form will need to be completed and signed by both you and your prescriber.
- If you are a patient, please complete sections 1 and 2 and sign the patient authorization on page 4
- For sections 3 through 5, this information will need to be completed and signed by your prescriber

2. Before submitting this form, please ensure:
- This enrollment form is complete with all required information requested and signed by both you and your prescriber
- You provide your health insurance and prescription drug coverage card information or you may send a copy of the front and back of each card

3. Upon completion, please fax the form to TG Patient Support at 1-877-778-1329.

4. After the enrollment form is submitted to TG Patient Support, you will receive a phone call from your dedicated case manager within 1 business day.

What to expect after program enrollment

- **Introductory Call:** Your dedicated case manager will reach out to explain what to expect for enrolling in the program
- **Checking Your Insurance Coverage for UKONIQ:** Your case manager will call your insurance company to gather coverage details for your prescribed medication, UKONIQ. They will also help you understand your eligibility for financial assistance options
- **Filling Your Prescription:** Your physician may dispense your prescribed medication in office or may submit your prescription to a specialty pharmacy. Once your insurance has approved your prescription for UKONIQ, you will receive the medicine from your physician's office, or the medicine may be shipped directly to you from a specialty pharmacy
- **Product and Disease Education:** You may receive information and educational support about your diagnosis and UKONIQ from your TG Patient Support nurse. Any information provided by your TG Patient Support nurse is intended to support, not replace, the treatment plan provided by your healthcare provider. You should always consult your healthcare provider regarding medical questions or treatment concerns

1 Patient Information

*First Name: _____ *Last Name: _____ *Date of Birth: _____

*Street Address: _____ Apt #: _____ Gender: Male ☐ Female ☐

*City: _____ *State: _____ *ZIP: _____ Preferred Language: English ☐ Other ☐ _____

*Are you a permanent US resident? Yes ☐ No ☐ Allergies: _____

*Phone #: _____ Home ☐ Cell ☐ Email: _____

Authorized Caregiver or Alternate Contact Name: _____

Relationship to Patient: _____ Alt. Contact Phone #: _____ Alt. Contact Email: _____

2 Patient Insurance & Financial Information

Do you have insurance coverage? Yes ☐ No ☐

If yes, please complete the insurance information below and you may fax a copy of the front and back of your medical and prescription insurance card(s), if available.

If you do not have insurance coverage and would like to apply for the TG Patient Assistance Program, please complete the financial information below.

	Phone#	Policy ID #	Group #	BIN/PCN	Policy Holder Name/Date of Birth
Prescription Benefit Insurance Name					Name: Date of Birth:
Medical/Health Insurance Name					Name: Date of Birth:
Secondary Benefit Insurance Name					Name: Date of Birth:

Financial Information

Annual Gross Household Income: Number of Household Members (including patient):

3 Prescriber Information

*First and Last Name: _____ *NPI #: _____

*Practice Name: _____ Tax ID #: _____

*Street Address: _____ Suite #: _____ State License #: _____

*City: _____ *State: _____ *ZIP: _____

*Office Phone #: _____ *Office Fax #: _____

Office Contact: _____ Office Contact Title: _____

Preferred Time of Day to Contact: Morning ☐ Afternoon ☐ Evening ☐

Office Contact Phone #: _____ Office Contact Email: _____

4 Free Product for Qualifying Patients

Free product for the Quick Start, Bridge, and PAP Programs will only be available through the Free Product Specialty Pharmacy.

Quick Start ☐ Bridge ☐ Patient Assistance Program (Free Product) ☐

UKONIQ™ (umbralisib)

*Dose: _____ *Quantity: _____

*Directions _____ Rx Start Date: _____

*Refills Authorized: _____

*Primary Diagnosis (ICD-10 Code): _____ Description of Diagnosis (optional): _____

5 Diagnosis and Prescription Information

If required by applicable state law, please attach a copy of all prescriptions on official state prescription forms.

UKONIQ™ (umbralisib) *Dose: _____ *Quantity: _____

*Directions _____ *Refills Authorized: _____

☐ Preferred Pharmacy: In-Office/Institution Dispensing Pharmacy

☐ Onco360

Prescriber Authorization By signing this form, I certify: (a) I am a licensed healthcare provider and have prescribed the TG medication identified above to the patient identified above based on my independent medical judgment; (b) I received the appropriate patient authorization to release the information above to TG Therapeutics, Inc., and TG Patient Support Program together with their respective third-party service providers, contractors or affiliates, and the dispensing pharmacy for the purpose of assisting the patient with initiating or continuing therapy in accordance with my treatment decisions; (c) I will not attempt to seek reimbursement for free product provided to the patient; (d) I request TG Patient Support Program to convey the prescription described herein to the authorized pharmacy; and (e) I am requesting services on behalf of my patient and understand that no action on the services will be taken until the patient authorization has been received.

*Prescriber Signature Required (no stamps) _____ *Date (MM/DD/YYYY) ___/___/___

Dispense as Written _____ Product Substitution Permitted

*Required field

Patient First and Last Name: _____ **Patient Date of Birth:** _____

Patient Authorization for Use and Disclosure of Personal Health Information

Please read the following carefully, then sign and date where indicated.

I acknowledge and understand that in order to enroll in the TG Patient Support Program (the "Program"), I need to provide authorization for the use and disclosure of my personal health information so that TG Therapeutics, its third-party service providers, other vendors, contractors, and consultants (collectively, "TG Therapeutics") may provide me with services under the Program, as described in the About TG Patient Support Program Services section of the Program Enrollment Form (the "Services").

I therefore authorize my physician, my other healthcare providers, my pharmacy, and my health plan to disclose to TG Therapeutics, and I authorize TG Therapeutics to use, my personal health information relevant to the Services (my "PHI") for purposes of providing the Services. Such PHI may include my name, birth date, postal address, telephone number, email address, information related to my medical condition and treatment, information about my health benefits and health insurance coverage, prescription information, and information about my financial status.

I also authorize TG Therapeutics to (i) use my PHI for the purpose of facilitating my access to the TG Therapeutics medicine that my physician has prescribed, and (ii) further disclose my PHI to my healthcare provider(s), pharmacies, and health plan(s). TG Therapeutics also may use my PHI for quality assurance purposes and to evaluate and improve the Program and the Services.

I further authorize TG Therapeutics to use my PHI to contact me by mail, telephone, email, or text message (i) with information, including marketing information about the Program and Services, and (ii) to ask my opinion about my participation in the Program. If I have identified a caregiver on the Patient Enrollment Form (see Section 1), he or she has also agreed to receive such communications from TG Therapeutics for the purposes described above, and I hereby give my permission for TG Therapeutics to use my PHI to contact my caregiver for such purposes. I understand that I (and, if applicable, my caregiver) can opt out of the use of my PHI to make such contacts at any time by notifying TG Therapeutics at 1-877-TGTXPSP (1-877-848-9777) 8:00 AM – 8:00 PM EST Monday through Friday.

I understand that my pharmacies or other healthcare providers may receive payment from TG Therapeutics for making disclosures of my PHI to TG Therapeutics in connection with providing certain Program Services, such as medication support.

I understand that once my PHI has been disclosed to TG Therapeutics, federal and state privacy laws, including the Health Insurance Portability and Accountability Act ("HIPAA"), may no longer protect the PHI from further disclosure. However, I also understand that TG Therapeutics intends to use and disclose my PHI only for the purposes described in this Authorization or as otherwise allowed by law.

I understand that I do not have to sign this Authorization. However, if I do not sign it, I will not be able to participate in the Program. I further understand that if I choose not to sign this Authorization, it will not affect my ability to obtain medical treatment, including any TG Therapeutics medicines, or affect my health plan coverage.

I understand that this Authorization will remain in effect for three (3) years from the date I signed it, unless I withdraw the Authorization or if a shorter time is required by law. I understand that I may withdraw this Authorization at any time by sending a written notice to TG Patient Support, 680 Century Point, Lake Mary, FL 32746 or contacting TG Therapeutics at 1-877-TGTXPSP (1-877-848-9777). If I withdraw this Authorization, that will invalidate further reliance on the Authorization to make uses and disclosures of my PHI, but it will not invalidate uses and disclosures made prior to TG Therapeutics' receipt of my notice of withdrawal. I further understand that withdrawal of this Authorization would mean that I could no longer participate in the Program and TG Therapeutics would no longer be able to provide me with the Services.

Financial Eligibility for Patient Assistance Program

Please read the following carefully, then sign and date where indicated.

I understand that I have the option to consent to having TG Therapeutics perform an electronic verification of my financial information to verify my eligibility and process my application for the TG Therapeutics free product assistance program ("PAP"). By signing here, I understand that I am providing "written instructions" under the Fair Credit Reporting Act ("FCRA") authorizing TG Therapeutics to obtain information from my credit profile, solely for the purpose of determining financial qualifications for PAP. I understand that this authorization allows TG Therapeutics to perform this process as needed for the duration of my participation in PAP.

I certify that the financial and health plan information I have provided is complete and accurate to the best of my knowledge. I understand that the TG Therapeutics PAP includes eligibility criteria, including demonstration of financial need, and that TG Therapeutics will make an assessment about whether I meet that criteria. I may not meet the eligibility criteria and therefore may not qualify for PAP. I will be ineligible to participate in the Program unless I provide proof of income. If I receive free product through PAP, I will not submit, or cause to be submitted, any claims for payment or reimbursement from any third-party payer, including any federal healthcare program such as Medicare or Medicaid, or any private or other insurance plan, or from any other person or entity for such free product. The cost of any product provided under PAP will not count toward any Medicare true out-of-pocket costs. I agree to notify TG Therapeutics promptly if: (1) I obtain coverage for products provided under PAP through another source (federal, state, or private health plan), (2) I no longer meet the income criteria for PAP, or (3) I find any errors in this enrollment form. If required by my health plan, I will notify the health plan of any free product I receive through PAP. I understand that, to the extent applicable, TG Therapeutics will notify my Medicare Part D Plan that I am receiving free product through PAP. I understand that I must reapply for PAP annually. I also understand that TG Therapeutics has the right at any time, and without notice, to modify or discontinue free product that it may be providing under PAP.

Patient Authorization

_____ ____/____/____

*Patient/Authorized Caregiver Name (print) *Date of Birth

_____ ____/____/____

*Patient/Authorized Caregiver Signature *Date

☐ I have read and agree to the Patient Authorization for Use and Disclosure of Personal Health Information on pages 3-4.

☐ I have read and agree to Financial Eligibility for Patient Assistance Program and Fair Credit Reporting Act Authorization on page 4.

I authorize Patient Assistance Program to contact and share my Personal Health Information with my Authorized Caregiver/ Alternative Contact. (Answer only if patient.)

☐ Yes ☐ No

*Required field

September 2020 US-UMB-2000119