Please complete and sign form, then fax all pages to 1-877-251-9475.

VALCHLOR® (mechlorethamine) gel 0.016% Patient Intake and Prescription Form

VALCHLOR® (mechlorethamine) gel 0.016% 60 g tube	For assistance with any questions, call **1-855-4-VALCHLOR** (1-855-482-5245) Monday through Friday from 8 am to 8 pm Eastern Time

PATIENT INFORMATION

Patient First Name	Last Name	Middle Initial	Primary Phone Number

Street Address	City	State	ZIP

Patient Gender ☐ Male ☐ Female	DOB	Secondary Phone Number	Email Address

By providing my information, I understand that I will be enrolled in ***VALCHLOR Support®*** services that are further described in the Patient Authorization and Release form below.

Helsinn Therapeutics (U.S.), has engaged a third party, Engaged Media, to send special offers, product information, and program information via automated text messages to the phone number(s) provided on its behalf. Mobile terms and conditions apply and can be found at https://www.engagedrx.com/vcl/. Msg & data rates may apply. Msg frequency varies. Text HELP for info, STOP to opt-out. Helsinn's privacy policy can be found at helsinn.com/privacy-policy.

ALTERNATE CONTACT INFORMATION ☐ OK to leave message with alternate contact

Full Name	Primary Phone Number	Email Address

PRIMARY INSURANCE ☐ Uninsured — PRESCRIPTION INSURANCE (PBM)

Please provide copies of the front and back of all medical and prescription insurance cards.

PRIMARY INSURANCE	PRESCRIPTION INSURANCE (PBM)	
Plan Name	Plan Name	
Phone Number	Phone Number	
Group Policy Number	Group Policy Number	
Subscriber ID or Rx BIN Number	Rx BIN Number	Member ID Number
Policyholder Name/Relationship to Patient	Relationship to Patient	

PRESCRIBER INFORMATION

Prescriber First Name	Last Name	Specialty

Office/Clinic/Institution Name	NPI	State license no.

Street Address	City	State	ZIP

Office Contact Name	Office Phone Number	Office Fax Number	Office Email Address

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Please see full Prescribing Information at www.valchlorhcp.com

Please complete and sign form, then fax all pages to 1-877-251-9475.

Patient First Name__________________ Middle Initial___________ Patient Last Name:________________

Patient Date of Birth________ Patient Phone Number:__________________________

PRESCRIPTION and CLINICAL INFORMATION: Please complete to avoid Prior Authorization delays.

☐ **Primary diagnosis ICD-10**: C84.00 Mycosis Fungoides, or

☐ **Other ICD-10**: ____________________

Biopsy-confirmed diagnosis of mycosis fungoides-type cutaneous T-cell lymphoma (MF-CTCL): Yes ☐ No ☐

Prior skin-directed therapies: ____________________

Estimated **Body Surface Area (BSA) percentage** affected: ____________________

Date Body Surface Area (BSA) was evaluated:____

MF-CTCL staging: ____________________

VALCHLOR® (mechlorethamine) gel 0.016% 60 g tube ☐ Directions: Apply a thin film once daily to affected areas of the skin ☐ Directions (if different from above): ____________________ ____________________ ____________________ ____________________ **Quantity:** _________ Tube(s) **Need Refills:** _____ for number of refills authorized **Days Supply:** 30 / 60 / __________ ☐ New prescription ☐ Renewal	**Physician's signature (required by law)** ____________________ ____________________ ☐ (no stamps) Dispense as Written ☐ (no stamps) Substitution Allowed Date: ____________________ Prescriber Attestation: I authorize Helsinn Therapeutics (U.S.), Inc., its affiliates, agents, and contractors (collectively, "Helsinn") to transmit the above prescription by any means allowed under applicable law to the appropriate specialty pharmacy for my patient. 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 and add additional delays for the patient. ☐ **No Known Drug Allergies (NKDA)** ☐ **Allergies (please list)** **Other Medications**

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Please see full Prescribing Information at www.valchlorhcp.com

Patient First Name_____________ **Middle Initial**___________ **Patient Last Name:**________________

Please complete and sign form, then fax all pages to 1-877-251-9475

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE MEDICAL INFORMATION

I verify that the information provided herein is true and correct. Information contained in this Enrollment Form, such as my name, address, insurance, and medical information, is considered "protected health information" ("PHI").

By signing below, I authorize my healthcare providers, pharmacies, health plans, and insurers, including their service providers and contractors, to disclose my PHI related to VALCHLOR such as my contact information (e.g., name, address, phone number, email address), diagnosis, medical conditions and history, insurance information (including insurance benefits), treatment and prescription information (e.g., dose, prior medications, adherence to treatment) and general health, to Helsinn Therapeutics (U.S.), Inc. and its affiliates, agents, and contractors ("Helsinn") for the purposes described in this authorization. I authorize Helsinn to receive, use, and disclose my PHI in order to: contact me about the ***VALCHLOR Support®*** services, including by phone, mail, or email; investigate, verify, assist with, and coordinate my coverage for VALCHLOR; conduct analyses related to the quality, efficacy, and safety of VALCHLOR, as well as patient access and adherence to VALCHLOR; and provide educational materials, information, marketing, and services related to VALCHLOR. I agree to allow the entities described in this authorization to leave messages for me on the telephone number(s) that I provide.

I understand that I may refuse to sign this authorization and my healthcare providers or insurers will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my agreement to sign this authorization. I understand that once my PHI is used or disclosed to Helsinn, federal privacy laws may no longer restrict further disclosure. However, I understand that Helsinn agrees to only use or disclose my PHI for the purposes described in this authorization or as permitted by law. I understand that this authorization will remain in effect for ten (10) years after the date I sign this authorization, unless a shorter time frame is mandated by state law. I understand that I have the right to revoke this authorization at any time by calling 1-855-4-VALCHLOR (1-855-482-5245) or mailing a signed written statement of my revocation to 1640 Century Center Parkway, Memphis, TN 38134, but that such a revocation would end my eligibility to participate in the programs as described. Revoking this authorization will prohibit disclosures after the date written revocation is received, except to the extent that action has been taken in reliance on this authorization. This means that, after I revoke this authorization, my information may be disclosed among Helsinn and the company or companies that help Helsinn administer its programs in order to maintain records of my participation, but it will not otherwise be disclosed or used. I understand that my healthcare providers, pharmacies, insurers, and health plans, including their service providers and contractors, may receive payment in connection with the use and disclosure of my information for purposes allowed under this authorization.

Enrollment in ***VALCHLOR Support*** for reimbursement support and patient assistance: The patient, or patient's authorized representative, MUST sign this form in order to receive reimbursement support and assistance from ***VALCHLOR Support***. If an authorized representative signs for the patient, please indicate his or her relationship to the patient. By signing below, you understand and acknowledge that Helsinn does not promise to find ways to pay for your medications, and that you know that you are responsible for the costs of your care. Before signing, you, the patient, should review, understand, and agree to the terms of this authorization and release. This authorization will permit Helsinn to:

1. Request and receive from your doctor, healthcare provider, health insurer, or pharmacist information necessary to investigate and resolve your insurance coverage, coding, and reimbursement inquiry, or review your eligibility for patient assistance programs and co-pay assistance;
2. Collect, use, and disclose to each other any information that you provide to ***VALCHLOR Support*** for the purpose of investigating resolving your insurance coverage, coding, or reimbursement inquiry;
3. Disclose to your treating physician, healthcare provider, or pharmacist information you provided to ***VALCHLOR Support*** necessary to resolve your insurance coverage, coding, or reimbursement inquiry;
4. Contact your insurer, other potential funding sources, social workers, patient advocacy organizations, and/or patient assistance programs on your behalf in order to determine if you are eligible for health insurance coverage or other funds, and disclose to them information about your prescribed medications and medical condition that has been provided by you or your physician, healthcare provider, or pharmacist;
5. Provide you with education and support available through Helsinn financial assistance programs;
6. Provide you with information about Helsinn products, disease education and management programs, and promotional materials, medication reminders and support, and conduct quality assurance, surveys, and other internal business activities in connection with the VALCHLOR Support Program and other related programs; and
7. Disclose any information obtained from the sources listed above to specific individuals you have identified and allowed to receive information on your behalf and to third parties if required by law.

I understand that I, as the patient or signer, have a right to receive a copy of this signed form over the time it is valid.

Patient Name (Print)	**Patient/Authorized Representative Signature (include relationship)**	**Date**

☐ As an authorized representative on behalf of the patient, I reviewed, understand, and agree to the terms of the authorization.

Accredo Health Group, Inc. ("Accredo") specialty pharmacy provides convenient ways to manage your VALCHLOR prescription. In order to begin, you will need to have received a prescription from the Accredo specialty pharmacy. Once you have an active Accredo prescription number you can scan the QR code below to utilize the Accredo mobile app and you may also text "Start" to 877-222-7336 to enroll in Accredo's text messaging features. The Accredo mobile app and text features allow you to receive prescription refill reminders, medication order updates, refill your medication, and more.

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Please see full Prescribing Information at www.valchlorhcp.com