ENROLLMENT FORM FOR PROVENGE® (SIPULEUCEL-T) AND PATIENT ASSISTANCE

Please complete and submit the enrollment form by faxing it to (877) 556-3737. Your patient may also choose to investigate eligibility for Patient Assistance Programs by completing the second page of this form. Patient Care Representatives can be reached at (877) 336-3736 to answer general questions, Monday–Friday from 8:00 AM–9:00 PM ET and 24/7 in the event of a product-related health emergency.

PRESCRIBING PHYSICIAN INFORMATION AND PHYSICIAN ENROLLMENT CERTIFICATION (REQUIRED)

Physician's Name: _____ Infusion Site's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail Address: _____

Physician's Specialty: _____ Physician's DEA #: _____

Physician's Patient Transaction Access #: _____ Physician's Tax ID #: _____
(Required to process Medicare claims)

Physician's National Provider Identifier: _____ Site's National Provider Identifier: _____

Site's Patient Transaction Access #: _____ Primary Office Contact: _____

Phone: _____ Fax: _____ E-mail Address: _____

Request PHS* Price ☑ YES ☐ NO PHS Eligible Entity ☑ YES ☐ NO If YES, provide **PHS Identifier #:** _____
*Public Health Service 340B pricing.

Ship to PO # required ☑ YES ☐ NO If YES, provide **PO #:** _____ ☐ Physician's Office ☐ Hospital Outpatient Department

I verify that the information I have provided in this enrollment form is complete and accurate to the best of my knowledge. I have obtained my patient's authorization, as indicated below, to disclose his health information related to treatment with PROVENGE to Dendreon Corporation and its designated agents for Dendreon to use and disclose as necessary in the provision of health services or to offer patient care and support services and/or reimbursement support services.

Physician's Signature: _____ **Date:** _____

PATIENT INFORMATION AND INSURANCE INFORMATION

Patient's First Name: _____ Middle Initial: ____ Last Name: _____ Suffix: _____
(As it appears on your government-issued photo ID)

Date of Birth: _____ SSN: _____

Patient's E-mail Address: _____ Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Patient's Primary Diagnosis (ICD-9): _____ Patient's Secondary Diagnosis (ICD-9): _____
(Required to process Medicare and some other types of payer claims. Contact *Dendreon ON Call* if you have any questions regarding payer requirements.)

Contact phone number for day of treatment: _____

☐ **Please check box to indicate alternate form of payment.**
If paying with a means other than health insurance, patient does not need to provide insurance information.

Primary Insurance: _____ **Secondary Insurance:** _____

Primary Insured's Name: _____ Primary Insured's Name: _____

Employer†: _____ Employer†: _____

Phone: _____ Phone: _____

Policy Number: _____ Policy Number: _____

Group Number: _____ Group Number: _____

Health Plan's Name: _____ Health Plan's Name: _____

†If applicable.

PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION (REQUIRED)

I authorize my prescribing physician and any health insurers, plans, or programs that provide me health care benefits (collectively, "Health Plans") to disclose my medical or other information, including information about my treatment with PROVENGE (taken together, "Information") and related medical condition to Dendreon Corporation and its agents (collectively "Dendreon") so that Dendreon may use and disclose the Information for the following specific purposes: ordering, manufacturing, delivering, and infusing PROVENGE; obtaining payment from my Health Plan(s); conducting reimbursement verification; applying for or making referrals for Patient Assistance Programs upon request; and providing me with educational and treatment support services by mail, e-mail, and/or telephone. I understand that support services may include product information materials, treatment reminders, or surveys about my treatment experience with PROVENGE. I understand that, once my Information has been disclosed to Dendreon, federal and state privacy laws may no longer protect it. However, Dendreon agrees to protect my Information by using it only for the purposes authorized in this Authorization or as permitted by law. I understand that signing this Authorization is voluntary and, if I do not sign this Authorization, it will not affect my ability to obtain treatment from my prescribing physician or obtain insurance or insurance benefits. I understand, however, that if I do not sign this Authorization, I will not be eligible to receive the educational and support services and other services described above. I may withdraw this Authorization at any time by mailing or faxing a written request to *Dendreon ON Call*; PO Box 221705; Charlotte, NC 28222 or by calling (877) 336-3736. Withdrawal of this Authorization will end further uses and disclosures of my Information by the parties identified in this Authorization, except to the extent those uses and disclosures have been made in reliance upon this Authorization and as permitted by applicable law. This Authorization expires 10 years from the date indicated below unless I withdraw it earlier. I am entitled to receive a copy of this Authorization.

***Dendreon ON Call* provides regimen coordination, including scheduling, leukapheresis reminder calls, and benefits verification services. If you do not want to receive phone calls regarding regimen coordination, please indicate so by marking this box:** ☑

Patient's Signature: _____ **Date:** _____

PATIENT ASSISTANCE ELIGIBILITY AND ENROLLMENT APPLICATION

Please complete this page if you are interested in applying for, or referrals to, available Patient Assistance Programs.

PATIENTS INSURED THROUGH GOVERNMENT PROGRAMS (eg, MEDICARE)

☐ **Please select if you are interested in having your eligibility reviewed for co-pay assistance.**

Please indicate: Your annual household adjusted gross income: _____ **Number of household members:** _____

Medicare co-pay foundations provide assistance regardless of the choice of medicine, and decisions are based on financial need and according to criteria established by individual foundations. Dendreon can assist patients by referring them to these independent organizations. Dendreon cannot guarantee that patients will be eligible for or receive assistance after referral. Dendreon does not have controlling or managerial influence on these independent organizations.

PATIENTS INSURED THROUGH COMMERCIAL HEALTH PLANS

☐ **Please select if you are interested in the PROvide™ Commercial Co-pay Program. PROvide supports eligible patients with private commercial (nongovernment payers) insurance by covering any combination of cost—co-pays, co-insurance, or deductible costs—to a maximum of $6000 over the 3 PROVENGE treatments.**

You may be eligible for the PROvide Commercial Co-pay Program if:

- Your annual household adjusted gross income is $150,000 or less: ☑ YES ☐ NO
- You are a US resident or permanent citizen: ☑ YES ☐ NO

Patient Attestation: I verify that the information I have provided to enroll in the PROvide Commercial Co-pay Program is complete and accurate to the best of my knowledge. I agree that if requested I will provide proof of income or any other eligibility requirement in a timely manner.

Patient's Signature: _____ **Date:** _____

Physician Attestation: By participating in this program, I agree that I will not submit any third-party claims for patient cost-sharing expenses (including co-pays, deductibles, and/or co-insurance) that are covered by the PROvide Commercial Co-pay Program. I also agree that I will disclose my participation in the Commercial Co-pay Program to third-party payers as required. In addition, I certify that my participation in this program is consistent with my obligations as a participating provider with any third-party payers.

Physician's Signature: _____ **Date:** _____

TRAVEL ASSISTANCE (MEDICARE AND COMMERCIAL PATIENTS)

☐ **Please select if you are interested in having your eligibility reviewed for travel cost assistance.**

Please indicate: Your annual household adjusted gross income: _____ **Number of household members:** _____

Travel assistance foundations provide assistance regardless of the choice of medicine, and decisions are based on financial need and according to criteria established by individual foundations. Dendreon can assist patients by referring them to these independent organizations. Dendreon cannot guarantee that patients will be eligible for or receive assistance after referral. Dendreon does not have controlling or managerial influence on these independent organizations.

UNINSURED PATIENTS

☐ **Please select if you are interested in the PROVENGE Uninsured Patient Program. The Uninsured Patient Program can provide PROVENGE at no cost if you have no health insurance, including if you do not have drug coverage due to a drug benefit carve-out, or are rendered uninsured due to a payer claim denial.**

You may be eligible for the Uninsured Patient Program if:

- Your annual household adjusted gross income is $150,000 or less: ☑ YES ☐ NO
- You are a US resident or permanent citizen: ☑ YES ☐ NO
- Income documentation is attached* (1040, 1040EZ, IRS-W2, SSI Letter, SDI, or Notarized Letter of Income): ☑ YES ☐ NO

*Income documentation and residency verification will be required for this program.

PHYSICIAN AND PATIENT CERTIFICATION

(Only required if patient has no health insurance at the time of enrollment and is applying to receive PROVENGE free of charge)

My signature below certifies that the person named on this form is my patient, the information provided on this application is complete and accurate, and the PROVENGE received in response to this application is only for the approved indicated use of PROVENGE for the patient named on this form. I acknowledge that this medication will not be offered for sale, and no claim for reimbursement of either PROVENGE or related medical procedures and services will be submitted to Medicare, Medicaid, or any third-party payer. I understand that Dendreon Corporation and its agents have the right to contact my patient directly to confirm receipt of PROVENGE and that Dendreon Corporation may revise, change, or terminate this program at any time.

Physician's Signature: _____ **Date:** _____

I would like to receive PROVENGE at no charge under the PROVENGE Uninsured Patient Program. I understand that all the information I provide in connection with this application will be used to determine my eligibility to participate in the program. I certify that I do not have coverage for prescription drugs under Medicare, Medicaid, or any other public or private insurance plan, or that it has been determined that I am functionally uninsured. I understand that Dendreon Corporation, the manufacturer of PROVENGE, reserves the right to modify the eligibility requirements or discontinue the program at any time. I hereby certify the accuracy of the information submitted on, and in connection with, this application. I acknowledge that Dendreon Corporation has the right pursuant to my authorization for use/disclosure of health information to verify my eligibility for this Patient Assistance Program, to audit reported financial income and insurance information and medical records, and to contact me directly to confirm receipt of PROVENGE.

Patient's Signature: _____ **Date:** _____

PATIENT ACKNOWLEDGMENT (REQUIRED FOR ALL PROGRAMS)

By signing this form, I acknowledge that all eligibility information provided is accurate to the best of my knowledge. I acknowledge that by indicating I am interested in any of the Patient Assistance Programs described above, Dendreon Corporation may provide the information included on this form to the independent foundations that manage the Patient Assistance Programs pursuant to my authorization for use/disclosure of health information.

A representative of the nonprofit foundation that administers the respective program will contact you. If you do not want to be contacted by phone, please indicate so by marking this box: ☐

Patient's Signature: _____ **Date:** _____

Patient's Full Name (Please Print): _____ **Date of Birth:** _____

Dendreon
Targeting Cancer, Transforming Lives®

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PROVENGE®
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