

Check for services requested:

- Coverage Support (Benefits Investigation, Prior Authorization/Precertification Information, and/or Appeals Support) (complete side 1)
- Patient Assistance Program (complete both sides of form)

1 Prescriber/Facility Information

Prescriber's Name: _____
 NPI #: _____ STATE LIC #: _____
 PTAN #: _____ Tax ID #: _____
 Site/Facility Name: _____
 Mailing Address: _____
 City: _____ State: _____ ZIP: _____
 Office Contact's Name: _____
 Select Preferred Method of Contact:
 Office Contact's Phone #: _____ Fax #: _____
 Office Contact's Email: _____

2 Patient Information

Patient's Name: _____
 Sex: Male Female Date of Birth: _____
 Patient's Address: _____
 City: _____ State: _____ ZIP: _____
 Home Phone #: _____ Cell Phone #: _____
 Email: _____
 Best Time to Contact Patient: _____
 Alt. Contact Name: _____
 Alt. Contact Relationship: _____
 Alt. Contact Phone #: _____

3 Clinical Information

Primary Diagnosis: _____ Primary Diagnosis ICD-10 Code: _____
 Supportive Care Diagnosis: _____ Supportive Care ICD-10 Code: _____
 Expected Chemotherapy Regimen: _____
 Expected Chemotherapy Duration: _____ Expected Chemotherapy Cycle Frequency: _____
 Prior Supportive Care Therapies: _____ Drug Allergies: _____
 Target Start Date: ____/____/____ Notes: _____

4 Insurance Information (Check the relevant box)

Copy of both sides of the patient's insurance card attached

Medicare Medicaid Commercial/Private Other/Uninsured

Medical Insurance Plan

Insurance Name: _____
 Phone #: _____
 Policy ID #: _____ Group #: _____
 Policyholder Name (if not patient): _____
 Policyholder Relationship to Patient: _____

Prescription Drug or Secondary Insurance Plan

Insurance Name: _____
 Phone #: _____
 Policy ID #: _____ Group #: _____
 BIN: _____ PCN: _____
 Policyholder Name (if not patient): _____
 Policyholder Relationship to Patient: _____

Please submit copies of both sides of patient's insurance card(s)

5 REQUIRED: Healthcare Professional Policy and Consent

TerSera Therapeutics and its contractors and agents (together "TerSera"), will use the information you provide to administer and improve TerSera SupportSource (the "Program") in accordance with its privacy notice <https://tersera.com/privacy-policy>. By signing below, you represent, covenant, and certify as follows: (i) My patient has provided all required written authorization(s) as required by all applicable federal or state laws to release to TerSera and the Program all patient information needed for this application, including without limitation financial and personally identifiable information in order to (1) conduct coverage support services, and (2) determine eligibility and enroll patient for financial assistance; (ii) All of the information provided in this application is complete and accurate; (iii) VARUBI® (rolapitant) was prescribed based on my medical judgment or the medical judgment of another healthcare professional in my office; (iv) I understand and have explained to my patient that TerSera may modify or terminate the Program at any time without notice and that completion of this application does not guarantee enrollment in any particular part of the Program; (v) I understand and agree that any medications supplied by TerSera under the Program are for use of the named patient only and shall not be sold, traded, bartered, transferred, returned for credit, submitted to any third party payor (private or government) for reimbursement, or counted toward the patient's Medicare Part D out-of-pocket costs; (vi) I have not received nor will I seek or accept payment from my patient for any co-insurance amount paid for by the Program; (vii) I understand that I am under no obligation to prescribe any TerSera drug and I have not received and will not receive any benefit from TerSera for prescribing a TerSera drug; and (viii) if I become aware of any errors in the information provided, I will promptly notify TerSera of those errors.

I authorize TerSera and the Program to act as my representative, and on behalf of myself and my patient, to initiate any benefits investigation (BI), prior authorization (PA) and appeals support, co-pay card, and co-pay assistance foundation referrals. By signing below, I request that TerSera and the Program assist my office in providing the requirements of this patient's health plan related to prior authorization for treatment with the product noted in the Drug Therapy portion of this form. I understand that assistance includes obtaining the health plan-specific prior authorization form, and providing it based upon the patient-specific information provided on this form. I understand that the partially completed forms will be provided to my office by TerSera and the Program for possible completion and submission to the health plan. I request that TerSera and the Program actively monitor the status of the prior authorization submission. I request that TerSera and the Program provide status updates to my office with respect to this patient's prior authorization for treatment with the product noted in the Drug Therapy portion of this form.

Prescriber Name (Please print): _____
 Prescriber Signature (No Stamps Please): _____ Date: _____

Please share a copy of this application with your patient for his or her records.



TerSera SupportSource Enrollment Form for VARUBI® (rolapitant) tablets

Fax completed enrollment form to 1-855-836-3066



Financial Assistance

This section should only be completed for financial assistance or enrollment into the Patient Assistance Program (PAP)

1 Patient Financial Information (Required for financial assistance)

Annual Gross Household Income: \$ _____ # of Household Members (Including patient) _____

Please attach or complete the embedded prescription if you are seeking PAP for your patient. Please note, eligibility for the PAP is based on the Federal Poverty Level and may change year to year. Income will be verified using tax returns or other alternate financial documentation. In cases where income cannot be verified, or there are discrepancies, additional proof of income may be required.

2 Prescription Information (Check below to apply for PAP)

- Rx for VARUBI® (rolapitant) tablets Patient Assistance Program I authorize the dispensing pharmacy to dispense all doses (including refills) as one prescription*

Quantity: 2 tablets (1 wallet card) Refills: _____ Target Start Date: _____ / _____ / _____

Directions for Use: Take two tablets by mouth within 2 hours prior to initiation of chemotherapy, as directed by your physician.

Other Directions:

With signature, I authorize TerSera Therapeutics and the specialty pharmacy to dispense VARUBI directly to the patient (if indicated in Section 5) as part of the Patient Assistance Program.

Prescriber Name (Please print): _____

Prescriber Signature (No Stamps Please): _____ Date: _____

Please attach a separate prescription if this section does not comply with your state's prescription law. Rx for VARUBI is included or embedded with this fax

*Maximum 6 doses of VARUBI per shipment will be sent to patient's address unless otherwise specified. Additional PAP shipments allowed, pending continued patient eligibility.

3 Preferred Shipping Location

- Prescriber's Office (as provided on page 1)
 Patient's Address

Other Location (eg, infusion center):

Facility Name: _____

Recipient Name: _____

Street: _____

City: _____ State: _____ ZIP: _____

4 REQUIRED: Patient Signature for Income Verification

I give my doctor, TerSera Therapeutics LLC (TerSera), and the Program administrator and their employees, agents, and contractors permission to use my personal information related to my medical condition, treatment, and management, as well as all information provided on this form, including contact and any prescription information ("Personal Health Information") to verify the information is true and complete; contact me about the Program and about other products, programs, or services that might interest me or for which I may be eligible; and contact me to ensure that I have received the medicines sent by the Program. I promise that all the information in this application, including all copies of documents proving my income, is true and complete; I am authorized to sign this application; I do not have any assistance or insurance that would help pay for my medicines; and I will contact the Program if any of my information about my prescription drug coverage or insurance changes. I understand that once disclosed to TerSera, my Personal Health Information disclosed under this consent form may be further disclosed and used to determine if I qualify to participate in the Program, administer or improve the Program, and/or communicate with insurance plans. I understand that I can call 1-855-686-8725 at any time to withdraw from the Program; cancel my permission to use my information and withdraw from the Program; and/or get a copy of the TerSera Privacy Policy. I understand that the Program can request more information from me at any time; and TerSera can change or stop the Program at any time for any reason. I understand that once my information has been disclosed, federal privacy laws, including HIPAA, may no longer restrict its use or disclosure. I may refuse to sign this authorization form, and if I refuse, my eligibility for health plan benefits and treatment by my healthcare provider will not change, but I will not have access to the Program. I give the Program, and the Program administrators, permission to contact the person named below with follow-up questions about my application (this only applies if someone completed this application for you). I understand that I may revoke this authorization at any time by sending written notice of revocation to TerSera Therapeutics LLC at 520 Lake Cook Road, Suite 500, Deerfield, IL 60015, except to the extent that action already has been taken in reliance on this authorization. I understand that I have a right to receive a copy of this signed authorization. This authorization form will be effective for 1 year unless it expires earlier by law or I cancel it in writing. I have a right to receive a copy of this form after I have signed it.

Patient/Guardian Name (Please print): _____

Patient Signature: _____ Date: ____/____/____

Upon receipt of a completed application, the healthcare professional and patient will be notified of program eligibility. If patient is eligible for this program, the prescribed quantity of VARUBI will be shipped to the address indicated in Section 3 above.