Patient Enrollment Form

To enroll your patient in Urogen Support, please complete the form and submit via one of the methods below.

Fax: 833-664-7216 | **Email: contact@Urogensupport.com**
Provider Portal: UroGenSupport.com

Zusduri (mitomycin) for intravesical solution

UroGen Support™

Business Hours: 8AM-8PM ET M-F
833-UROGEN1 (833-876-4361)

* **Indicates a required field**

1 SELECT PROGRAM SERVICE OFFERING (Please select one option below) REQUIRED

Please select **all** services you'd like to enroll in:

- ☐ Patient Support Services (Benefit Investigation, Prior Authorization and Appeals Information, Financial Assistance Eligibility Screening)
- ☐ Product Ordering, Mixing, and Delivery of ZUSDURI to the treatment site of care
- ☐ Co-Pay Program Eligibility Screening

2 ENTER PATIENT INFORMATION (Complete all fields. If attaching a Patient Face Sheet, complete only *fields) REQUIRED

☐ I have included a copy of the Patient Face (Demographic) sheet

First name:*		**Last name:***
DOB:*	Sex:	US Resident: ☐ Yes ☐ No
Address:		
City:	State:	Zip code:
Email address:	Preferred phone:	
Allergies:	Current Medications:	

3 PROVIDE PATIENT INSURANCE INFORMATION (Complete all fields unless submitting copy of the patient's insurance card) REQUIRED

Is the patient uninsured? ☐ Yes ☐ No	☐ I have included a copy of the patient's insurance card	☐ I have entered the information below
Primary medical insurance provider:		
Insurance provider phone number:	Primary insurance holder (if not patient):	
Primary insurance holder DOB:	Policy number:	Group number:
☐ **Patient secondary or supplemental medical insurance provider**:		
Insurance provider phone number:	Primary insurance holder (if not patient):	
Primary insurance holder DOB:	Policy number:	Group number:

4 SELECT PATIENT DIAGNOSIS (Select the patient's ICD10 Diagnosis Code) REQUIRED

- ☐ C67.0 Malignant neoplasm of trigone of bladder
- ☐ C67.1 Malignant neoplasm of dome of bladder
- ☐ C67.2 Malignant neoplasm of lateral wall of bladder
- ☐ C67.3 Malignant neoplasm of anterior wall of bladder
- ☐ C67.4 Malignant neoplasm of posterior wall of bladder
- ☐ C67.5 Malignant neoplasm of bladder neck
- ☐ C67.6 Malignant neoplasm of ureteric orifice
- ☐ C67.7 Malignant neoplasm of urachus
- ☐ C67.8 Malignant neoplasm of overlapping sites of bladder
- ☐ C67.9 Malignant neoplasm of bladder, unspecified
- ☐ Other:_____

Patient Enrollment Form

To enroll your patient in Urogen Support, please complete the form and submit via one of the methods below.

Fax: **833-664-7216** | Email: **contact@Urogensupport.com**
Provider Portal: **UroGenSupport.com**

Zusduri (mitomycin) for intravesical solution

UroGen Support™

Business Hours: 8AM-8PM ET M-F
833-UROGEN1 (833-876-4361)

* Indicates a required field

Patient first name:*	Patient last name:*	DOB:*

5 PRESCRIPTION INFORMATION — REQUIRED

Instructions to Pharmacy: Prepare one kit of Zusduri 80 mg weekly (PRN) according to Zusduri Instructions for Pharmacy.* For Instillation via urethral catheter for instillations. Refill: 8

*The recommended administration schedule for Zusduri is once weekly for six weeks.

By signing below, I certify that (1) the above therapy is medically necessary and in the best interest of the patient listed above; (2) I authorize UroGen Pharma, Inc. and its contractors and business partners ("Contractors") to (i) supply insurance information to the insurer of the above named patient, (ii) forward the above prescription by fax or other means of delivery to a licensed UroGen pharmacy partner, and (iii) verify benefits and coordinate the dispense of ZUSDURI where appropriate; and (3) I represent to that I have obtained all necessary Federal and state authorizations and consents from my patient to allow me to release patient health information to UroGen Support and its contracted third parties.

Anticipated Treatment Date: ____/____/_____

Prescribing Physician signature (Signature required. Stamp not acceptable):*

Printed name:*	**Date:***

6 PRESCRIBER INFORMATION (All fields required to be completed by the office) — REQUIRED

Practice name:	Practice NPI number:
Prescriber name:	
Prescriber address:	
City:	State:	Zip code:
Prescriber NPI number:	Medicaid number:
State license number:	Phone number:	Fax number:
Email address:	Preferred method of contact: ☐ Phone ☐ Fax ☐ Email

7 TREATMENT SITE OF CARE INFORMATION (Please provide if different from Prescriber Information) — REQUIRED

Site of care name:		
Address 1:		
Address 2:		
City:	State:	Zip code:
NPI number:	Medicaid number:	Tax ID number:

8 TREATMENT COORDINATION CONTACTS (Please provide important Site of Care information) — REQUIRED

Contact name for patient treatment scheduling:	
Phone number:	Email (optional):
Contact name for coverage, claims, and billing:	
Phone number:	Email (optional):

Patient Enrollment Form

To enroll your patient in Urogen Support, please complete the form and submit via one of the methods below.

Fax: **833-664-7216** | Email: **contact@Urogensupport.com**
Provider Portal: **UroGenSupport.com**

Zusduri (mitomycin) for intravesical solution

UroGen Support™

Business Hours: 8AM-8PM ET M-F
833-UROGEN1 (833-876-4361)

* Indicates a required field

Patient first name:*	Patient last name:*	DOB:*

9 PATIENT AUTHORIZATION — REQUIRED

Health Insurance Portability and Accountability Act authorization

I authorize my healthcare providers (including those pharmacies that may receive my prescription for a UroGen Support program product) and my health insurers to disclose personal health information (PHI) about me, including health information relating to my medical condition, treatment, prescription, financial, including results from a soft credit check, insurance coverage, as well as identifying information about me (e.g., name, address, and date of birth) to UroGen Pharma, Ltd., its affiliates, employees, representatives and its agents (collectively "UroGen" or "UroGen Support") that have been hired to administer the UroGen Support program on its behalf in order for UroGen Support to (1) enroll me in UroGen Support; (2) determine my benefit eligibility and potential out-of pocket costs for the prescribed UroGen Support program product; (3) communicate with my healthcare providers and health plans about my treatment plan; (4) provide support offerings including patient education and access to financial assistance for the prescribed UroGen Support program product; (5) help get the prescribed UroGen Support program product prepared and delivered to my healthcare providers; (6) facilitate my participation in UroGen Support programs that I have elected to receive information about as indicated below; and (7) provide education and instruction to my healthcare providers during the instillation of UroGen Support program products. I agree that, using the contact information I provide, UroGen Support may contact me me by phone, email, or text for reasons related to the UroGen Support program offerings and may leave messages for me that may disclose that I am on a prescribed UroGen Support program therapy. I consent to being contacted by a UroGen Support program representative in order for the program to obtain further information or clarification regarding any adverse event I may experience or otherwise concerning UroGen Support offerings. UroGen may also use PHI about me for quality assurance purposes and to evaluate the operations and services of UroGen Support.

I understand that once my PHI has been disclosed to UroGen Support, it is no longer protected by federal privacy laws and UroGen Support may re-disclose it; however, UroGen Support has agreed to protect my PHI by using and disclosing it only for the purposes described above or as required by law. I can withdraw this authorization by calling UroGen Support at 833-UROGEN1 (833-876-4361) or mailing a letter requesting such revocation to UroGen Support, PO Box 592188, Orlando, FL 32859, but it will not change any actions taken before I withdraw authorization. Withdrawal of authorization will end further uses and disclosures of PHI by the parties identified in this form except to the extent those uses and disclosures have been made in reliance upon my authorization. I understand that I may refuse to sign this form and, if I do so, I will not be able to participate in the UroGen Support program, but it will not affect my eligibility to obtain medical treatment or my ability to seek payment for this treatment or affect my insurance enrollment or eligibility for insurance coverage. Once this form is signed, my healthcare providers are authorized to send my enrollment to UroGen Support via email, fax, or text message and communicate information via phone. This authorization expires three (3) years after the date I sign below, or the maximum period allowed under applicable law if less than three years. I understand that I will receive a copy of the signed authorization.

Patient Consent & Privacy Notice (REQUIRED)

☐ I consent to the collection, use, and disclosure of my personal health data by UroGen as described above. My consent is required to process personal data under certain privacy laws, and I have the right to withdraw my consent by contacting UroGen Support.

Patient Education and Support Materials Consent (OPTIONAL)

I authorize UroGen to send me relevant informational disease state, treatment, or product educational and support communications via email, direct mail, phone, or text. This may include materials from UroGen Pharma or a third party working on UroGen Pharma's behalf. Opting in of these communications will not affect your enrollment in the Program and you will still receive patient assistance through the Program, as prescribed by your physician.

☐ Check this box if you want to receive patient education and support.

UroGen Support Patient Assistance Program and Commercial Copay Program authorization (REQUIRED ONLY FOR PAP OR COPAY)

☐ By checking this box, I understand that UroGen Support will determine my eligibility for and enroll me in the Patient Assistance Program (PAP) if I am eligible. Generally, patients are eligible for PAP if they have been prescribed a product, do not have insurance coverage for the prescribed UroGen Support program product, and have a household adjusted gross income level less than or equal to 400% of the federal poverty level based on their household size. I understand that in order for determine my eligibility for PAP the UroGen Support program will conduct an e-income verification, which will include a soft credit check to determine household income. I understand that I am hereby providing "written instructions," under the Fair Credit Reporting Act (FCRA), authorizing the PAP and its vendors to run a soft credit check or other information about me for the purpose of determining my financial eligibility for the PAP. I understand that I must agree to these terms to proceed in this financial screen process for PAP. I also understand that I may need to provide additional documentation and that additional eligibility requirements apply for the PAP.

☐ By checking this box, I understand that UroGen Support will determine my eligibility and enroll me in the Commercial Copay Program if I am commercially insured with a valid prescription for a UroGen Support program product. Enrolled patients are eligible to receive an annual benefit maximum of up to $14,000. Patient is responsible for $50 per dose, and any remaining costs after any maximum monthly and/or annual benefit is reached. I also certify that information submitted for any affordability program is accurate, that expenses requested for payment are eligible, actually incurred, and that they were not and will not be paid by my insurance, Flexible Spending Account (FSA), Health Savings Account (HSA), Health Reimbursement Account (HRA), or any other payor or discount/copay program. I certify that submitted rebate claims will not be paid by Medicare, Medicaid, Tricare, CHAMPUS, VA, or any other government (state or federally funded) program, and that I am not covered under any of these programs. I understand that I am liable for any misrepresentations herein to the full extent of applicable law. Offer good only in the United States and its territories.

PRIVACY NOTICE: For more information on what data we collect about you and how we use it, as well as information about the rights you may have under the California Consumer Privacy Act, please see our Privacy Policy available at **www.urogen.com/privacy-policy/**.

Patient signature (REQUIRED): By signing this document, I authorize the release of my information as set forth above.

Patient signature:*	Date:*