# How to enroll a patient in XcoveryCares by Pharmacy Elite Patient Support Program

1. **COMPLETE ALL INFORMATION** in its entirety with your patient, including product selection, prescriber information, patient information, current insurance information, statement of medical necessity, pharmacy preference, and prescription request.

2. **SIGN AND DATE** the form. Prescriber and patient (or legal representative) authorization is required in the form of an original signature following review of the prescriber authorization and the patient authorization sections. A patient's (or legal representative's) original signature is also required on the program enrollment section.

   **IMPORTANT: Original signatures are required.**
   Please ensure original signatures for the prescriber and patient (or legal representative) are applied. Stamped signatures will not be accepted. Applications that do not include original signatures cannot be processed, and your patient's enrollment may be delayed.

3. **FAX** the completed and signed form along with a copy of your patient's insurance card and prescription to XcoveryCares at 714-689-4780.

   **IMPORTANT: The prescription is only valid if received by fax.**

**NOTE:** Please do not send patient medical records or any other documentation that has not been requested.

## What to expect after enrollment

After your patient's enrollment form is received and processed, an XcoveryCares by Pharmacy Elite case manager will conduct a benefits verification to determine the patient's prescription coverage and potential out-of-pocket costs. A benefits verification will be completed by XcoveryCares by Pharmacy Elite within 2 business days. *

## XcoveryCares offers additional support

For patients who are uninsured or have insurance but are not covered for the prescribed Xcovery medication, XcoveryCares may offer additional support. Learn more about the **Patient Assistance Program**† by calling **1-866-367-2260**.

**For more information, call us at 1-866-367-2260 or visit www.ensacove.com.**
**We're available Monday-Friday, 8AM-8PM ET.**

*Verification of benefits is not a guarantee of payment and does not take the place of written policy information.
†Separate program enrollment is required. Terms and Conditions apply.

**Fax to** 714-689-4780 or **call** 1-866-367-2260.
Monday-Friday, 8AM-8PM ET.

# Enrollment Form

**Is the patient hospitalized?**
■ Yes ■ No

✈ **Ensacove® (ensartinib) 25 mg**
✈ **Ensacove® (ensartinib) 100 mg**

**Please see accompanying Ensacove full Prescribing Information.**

## PRESCRIBER INFORMATION

Name (First, Middle, Last): _____
Practice Name: _____
Address: _____ City: _____
State: _____ ZIP: _____ Phone: _____ Fax: _____
Primary Office Contact: _____
State License #: _____ NPI: _____ Medicare/Medicaid Provider #: _____
Reimbursement Contact: _____
Supervising/Collaborating MD for mid-level providers: _____ NPI: _____

## PATIENT INFORMATION

Name (First, Middle, Last): _____ Preferred Name: _____
Preferred Language: _____ Date of Birth (MM/DD/YYYY): _____ Gender: ❑ Male ❑ Female
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ OK to leave a message? ❑ Yes ❑ No
Mobile: _____ OK to leave a message? ❑ Yes ❑ No
Email: _____

**Please complete this section if you would like XcoveryCares to communicate about the program primarily with your care partner on your behalf.**

Name: _____ Relationship: _____
Phone: _____ OK to leave a message? ❑ Yes ❑ No
Mobile: _____ OK to leave a message? ❑ Yes ❑ No
Email: _____

## CURRENT INSURANCE INFORMATION

**Please attach copies of both sides of the patient's insurance card(s). Include both medical and pharmacy information if available or select no insurance or pending insurance.**

Insurance Type: ❑ Medicare ❑ Medicaid ❑ Private/Commercial ❑ Other: _____
Does your patient have Veterans Administration benefits? ❑ Yes ❑ No
Does your patient belong to a federally recognized tribe? ❑ Yes ❑ No
Is your patient on disability? ❑ Yes ❑ No
Does your patient have Medicare? ❑ Yes ❑ No
Primary Insurer Name: _____ Insurer Phone: _____
Policy Holder Name (First, Middle, Last): _____
Policy Holder Date of Birth (MM/DD/YYYY): _____ Policy ID #: _____ Group #: _____
Rx BIN #: _____ Rx PCN #: _____
Secondary Insurer Name: _____ Insurer Phone: _____
Policy Holder Name (First, Middle, Last): _____
Policy Holder Date of Birth (MM/DD/YYYY): _____ Policy ID #: _____ Group #: _____
Rx BIN #: _____ Rx PCN #: _____
❑ Patient has no insurance
❑ Patient's insurance is pending with (include name of insurer here): _____


MLR-2025-0012

# Enrollment Form

## STATEMENT OF MEDICAL EXCEPTION

ICD-10 Code:_____

## PHARMACY PREFERENCE (select one)

❑ Specialty Pharmacy Name:_____ ❑ In-office dispensing ❑ No pharmacy preference

**PRESCRIPTION REQUEST:** To permit medication to be sent to your patient, the prescription information must be complete and accurate.

Patient Name (First, Middle, Last): _____ Patient Date of Birth (MM/DD/YYYY):_____

| PRODUCT | DOSAGE | DISPENSE | REFILLS (please select) |
|---|---|---|---|
| ❑ **Ensacove® (ensartinib) 25 mg (30 count bottle)**<br>❑ **Ensacove® (ensartinib) 100 mg (60 count bottle)** | _____**mg**<br>*Subsequent refills:*<br>_____**mg** | _____ **Days Supply**<br>_____ **# Ct. - Ensacove 25mg**<br>_____ **# Ct. - Ensacove 100 mg** | ❑ **1** ❑ **2** ❑ **3**<br>❑ **Other** |
| **DIRECTIONS** | | | |

## PRESCRIBER AUTHORIZATION

This form allows Xcovery Holdings, Inc., its affiliates, representatives, agents, partners, vendors and contractors ("Xcovery") to provide patient support, resources and education ("Patient Resources") to eligible patients who have been prescribed ENSACOVE. I have the necessary written authorization from the patient referenced above, or the patient's legal guardian, to release to Xcovery the medical and/or other patient information included herein for allowing participation in programs and services offered through XcoveryCares, which may include, without limitation: (1) financial assistance programs; (2) verifying insurance coverage and/or evaluating the patient's eligibility for alternate funding; and (3) Patient Resources. I certify that: (i) the information in this form is complete and accurate to the best of my knowledge; (ii) the patient on this form has a diagnosis for an FDA-approved indication for ENSACOVE; (iii) any Patient Resource provided through Xcovery to my patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use an Xcovery medication or Patient Resource. I prescribed ENSACOVE solely on my clinical determination and medical necessity, and no claim for reimbursement will be submitted to Medicare, Medicaid, or any third-party payer for medication received free of charge, or for related medical procedures and services; nor will the free product be sold, traded, or distributed for sale. I will notify Xcovery immediately if ENSACOVE is no longer medically necessary for this patient or if my patient's insurance status changes; (iv) I authorize Xcovery to forward the above prescription to the applicable pharmacy as allowed under applicable law.

❑ Dispense As Written ❑ Substitutions Allowed

SIGN HERE

**Prescriber Signature:** (no stamp allowed) _____

**Date:** _____

**ATTENTION New York State Prescribers:** Prescribers in New York State must submit the prescription on an original New York State prescription blank. For all other states, if not faxed, the prescription must be on a state-specific blank if applicable for your state.

## PATIENT AUTHORIZATION FOR XCOVERYCARES BY PHARMACY ELITE

I understand that XcoveryCares by Pharmacy Elite Patient Support is a prescription assistance service offered by Xcovery Holdings, Inc. ("Xcovery") to help eligible patients who have been prescribed Xcovery medication obtain financial assistance and access other patient support programs provided by XcoveryCares by Pharmacy Elite Patient Support.*

By signing the Patient Authorization section of this XcoveryCares by Pharmacy Elite Patient Support Enrollment Form, I authorize any health plan, physician, health care professional, hospital, clinic, pharmacy provider or other health care provider (collectively, "Providers") to disclose my protected health information, including personal information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription ("Information"), to Xcovery Holdings, Inc., its affiliates and their representatives, agents, and contractors (collectively, the "Company" or "Xcovery") in connection with the Company's provision of products, supplies, or services. I understand the Company will provide this Information to a specialty pharmacy to fulfill the prescription. This Information may also be used for internal uses by the Company, including data analysis. Further, I understand that my physician, health insurance, and pharmacy providers may receive financial remuneration from the Companies for providing Protected Health Information, which may be used for marketing purposes.

Further, the Company may use this Information for XcoveryCares by Pharmacy Elite Patient Support Program ("Services") (if I agree below) such as verification of insurance benefits and drug coverage, prior authorization support, financial assistance with co-pays, patient assistance programs, alternate funding sources, other related programs, communication with me or my prescribing physician by mail, email, or telephone about my medical condition, treatment, care management, product information and health insurance.

I understand that once disclosed to the Company, my Personal Health Information disclosed under this Authorization may no longer be protected by federal privacy law, including HIPAA. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time in the future by calling 1-866-367-2260or by sending written notice of revocation to XcoveryCares by Pharmacy Elite Patient Support, Address, City, State, Zip. I understand that such revocation will not apply to any information already used or disclosed through this Authorization. This Authorization will expire within five (5) years from today's date, unless a shorter period is provided for by state law.

I understand that I may refuse to sign this Authorization and that refusing to sign this Authorization will not change the way my physician, health insurance, and pharmacy providers treat me. I also understand that if I do not sign this Authorization, I will not be able to receive XcoveryCares by Pharmacy Elite Patient Support Program products, supplies, or services.

I also authorize XcoveryCares to share my information with my Care Partner, if I have selected that option in this form.

*Restrictions apply.

**Patient Authorization for XcoveryCares by Pharmacy Elite Patient Support Program**

I have read, understand, and agree to the release of my Protected Health Information as described above.

SIGN HERE

**Patient Signature:**_____

**Date:** _____

**I certify that I have been personally selected by the patient as their legal representative.**

**Legal Representative Signature:**_____

**Relationship:**_____ **Date:**_____

**XcoveryCares by Pharmacy Elite Patient Support Program Enrollment**

**Patient Support Program Enrollment**

I am electing to enroll in the Services and direct all disclosures of my Information in connection with such Services (which may include, but is not limited to, verification of insurance benefits and drug coverage, prior authorization support, financial assistance with co-pays, patient assistance programs, alternate funding sources, other related programs, communication with me or my prescribing physician by mail, email, or telephone about my medical condition, treatment, care management, product information and health insurance).

**Text Communication Enrollment for Patient Support Program Services**

I consent to receive recurring automated text messages from the XcoveryCares by Pharmacy Elite Patient Support Program including service updates, enrollment support, refill reminders and educational messages to the provided mobile number. Message and data rates may apply. Message frequency varies. Text HELP for help. Text STOP to opt out. Consent to receiving SMS messages is not a condition of purchase of goods or services. Please see the terms and conditions for text communications below.

❑ **Yes, opt me in. Mobile Phone Number:** _____

❑ **No, I do not consent to receiving text communications**

**Consent for Marketing and Use of De-Identified Data**

By checking this box, I authorize the use of my Information for Xcovery marketing activities and consent to receiving marketing, and promotional communications from Xcovery. I hereby give consent to Xcovery, its affiliates, and their agents and representatives to send communications and information to me via the contact information I have provided above. I further authorize the program to de-identify my health information and use it in performing research, including linkage with other de-identified information the program receives from other sources, education, business analytics, marketing studies, or for other commercial purposes. I understand that this consent will be in effect until I cancel such authorization.

❑ **Yes, opt me in.**

❑ **No, I do not consent to receiving marketing and promotional communications**

**XcoveryCares by Pharmacy Elite Patient Support Program Enrollment**

I have read, understand, and agree to the use of my personal information for the purposes described above.

SIGN HERE **Patient Signature:**_____ **Date:**_____

**I certify that I have been personally selected by the patient as their legal representative.**

**Legal Representative Signature:**_____

**Relationship:**_____ **Date:**_____

## TEXT COMMUNICATION AGREEMENT TERMS AND CONDITIONS (OPTIONAL)

XcoveryCares Support Program text messages are recurring automated program messages, which may include service updates, enrollment support, refill reminders and educational messages. By agreeing to these XcoveryCares (the "Program") text message terms and conditions, you agree to receive text messages on your mobile device subject to the Terms & Conditions: You also consent to receive autodialed and/or pre-recorded calls and/or text messages from or on behalf of the Program at the telephone number provided above. You understand that this consent is not a condition of purchase or use of the Program or of any Xcovery product or service. You can unsubscribe from receiving text messages by texting STOP. For questions about this Program, text HELP or contact the customer support center at 1-866-367-2260. Message frequency varies. Such messages may be nonmarketing messages related to the Patient Support Program. Message and data rates may apply. You represent that you are the account holder for the mobile telephone number(s) that you provide to opt into the Program. Data obtained from you in connection with your registration for, and use of, this SMS service may include your phone number and/or email address, related carrier information, and elements of pharmacy claim information and will be used to administer this Program and to provide Program benefits such as information about your prescription, refill reminders, as well as Program updates and alerts. No mobile information will be shared with third parties/affiliates for marketing/ promotional purposes. We are able to deliver on most of the major and minor carriers: i.e., Verizon, Sprint, AT&T, T-Mobile and MetroPCS. If you are unsure whether your carrier supports short codes, please contact your wireless provider directly. Carriers are not liable for delayed or undelivered messages, please contact us for additional information.