Y-mAbs Connect®
Phone: 1-833-33YMABS / 1-833-339-6227, Option 2
Fax: 1-877-209-6227
Email: ymabsconnect@pharmacord.com
PO Box 5490
Louisville, KY 40255
Hours of Operation: Monday - Friday 8AM - 8PM EST

Y-mAbs Connect® Enrollment Form

INSTRUCTIONS FOR HEALTHCARE PROVIDER

- ✓ *Please fax the completed enrollment form to Y-mAbs Connect at 1-877-209-6227.*
- ✓ *Include copies of front and back of the patient's insurance card.*
- ✓ *All fields denoted with an asterisk(*) are required fields. Missing information may delay processing.*
- ✓ *Have the patient/patient representative read the Patient Authorization Statement on Page 3 and provide their signature and date to certify they have read, understand, and agree to the Statement.*
- ✓ *Have the healthcare provider (HCP) read the Prescriber Certification and Attestation Statement on page 2 and provide their signature and date to certify that they have read, understand, and agree to the Statement.*

REQUESTED SUPPORT*

☐ **New Enrollment:** Check Drug Coverage ☐ **Enrolled Patient:** Product Reorder (Drug coverage will be reverified)

PATIENT INFORMATION *

Name (First): (Last):

Street Address: City: State: ZIP:

Date of Birth (mm/dd/yyyy): / / Gender: ☐ Male ☐ Female

PATIENT/PATIENT REPRESENTATIVE CONTACT INFORMATION

Primary Phone*: Patient's Authorized Representative Name*:

Secondary Phone*: Relationship to Patient*:

Best Time to Call: Monday - Friday ☐ Morning ☐ Afternoon ☐ Evening

Email:

PATIENT'S MEDICAL INSURANCE INFORMATION

Primary Medical Insurance Information* (Please include copies of the front and back of insurance card)

☐ Private/Commercial ☐ Medicaid ☐ Medicare ☐ Medicare Advantage ☐ No insurance

Primary Insurance Name*:	Insurance Phone Number*:
Plan Name*:	Member ID*:
Policy Holder Name*:	Policy Holder Date of Birth* (mm/dd/yyyy): / /

Policy Holder's Relationship to Patient*:

Secondary Medical Insurance Information

☐ Private/Commercial ☐ Medicaid ☐ Medicare ☐ Medicare Advantage ☐ No insurance

Secondary Insurance Name:	Insurance Phone Number:
Plan Name:	Member ID:
Policy Holder Name:	Policy Holder Date of Birth (mm/dd/yyyy): / /

Policy Holder's Relationship to Patient:

COPAY ELIGIBILITY

Is the patient enrolled in any state or federal health care program, including but not limited to, Medicare, Medicaid, Managed Medicare, Managed Medicaid, Medigap, Veterans Affairs, TRICARE, CHIP, CHAMPUS, or Indian Health?* ☐ Yes ☐ No

PRESCRIBER INFORMATION

Prescriber Name (First)*:	(Last)*:	
Prescriber Tax ID*:	Prescriber NPI*:	Prescriber DEA:

OFFICE CONTACT INFORMATION

Primary Office Contact Name (First)*:	(Last)*:	
Phone*:	Email*:	Fax*:

Additional Contact Information:

TREATMENT CENTER INFORMATION

Center/Hospital Name*:		
Center Tax ID*:	Center NPI:	
Center/Hospital Street Address*:		
City*:	State*:	ZIP*:

CLINICAL INFORMATION

Primary ICD 10 Code(s)*:

☐ C74.90: Malignant neoplasm of unspecified part of unspecified adrenal gland

☐ Other : _____

Secondary ICD 10 Code(s):

_____

_____

Additional Information

☐ Relapsed or Refractory High-risk Neuroblastoma w/Bone or Bone Marrow involvement

PRODUCT INFORMATION

Product Name*	NDC*	Estimated Quantity	Anticipated Date of Infusion*
Danyelza® (Naxitamab)	73042-201-01		/ / (mm/dd/yyyy)

Y-mAbs Connect®

Patient Name (First, Last)*: _____ **Patient DOB (mm/dd/yyyy)*:** _____

PRESCRIBER CERTIFICATION AND ATTESTATION STATEMENT*

Please read the Prescriber Certification and Attestation Statement below and provide your signature to certify that you have read, understand, and agree to the terms and conditions.

By signing below, I hereby attest that I am the prescribing healthcare provider and I have determined that the Y-mAbs Product selected in the Product Information section is medically appropriate for this patient and I have explained such to my patient. I agree to notify Y-mAbs Connect if I become aware at any time in the future of changes in my patient's circumstances that would affect his or her eligibility, including but not limited to changes in health insurance status or coverage, financial status, United States residency status, or the indication for which the Y-mAbs Product has been prescribed for this patient. My signature certifies that I have read, understand, and agree to this Prescriber Certification and Attestation Statement and that the information being disclosed on this enrollment form is complete and accurate to the best of my knowledge, that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

X _____ _____

Prescriber Signature (Original – Stamps NOT ACCEPTED) **Date** (mm/dd/yyyy)

Y-mAbs Connect®

Patient Name (First, Last)*: _____ Patient DOB (mm/dd/yyyy)*: _____

PATIENT AUTHORIZATION STATEMENT*

By signing below, I authorize my healthcare providers and insurance companies to disclose to Y-mAbs Therapeutics, Inc. and its authorized agents and assignees, its business partners, service providers, and third-party contractors, including PharmaCord, the company providing HUB services to Y-mAbs, and other companies that Y-mAbs uses to administer the Y-mAbs Connect Program (collectively, "Y-mAbs"), all medical records, insurance information and necessary documentation relevant to my treatment with Y-mAbs Products, including information about my eligibility for limited financial assistance and the coordination of my treatment or proposed treatment (collectively, my "Information"). I understand that when disclosed to Y-mAbs, my Information may no longer be protected by certain federal privacy rules. I authorize Y-mAbs to use or disclose my Information to (i) facilitate my participation in the services provided by Y-mAbs, including, but not limited to, helping to verify or coordinate insurance coverage (the "Services"), (ii) send me information or materials related to my treatment or other programs in which I might be interested, (iii) contact me on occasion for feedback to Y-mAbs about my treatment and/or the information or programs, (iv) operate and improve the quality of the information or programs, and (v) conduct data analytics for purposes of strategic business decision-making. I understand that if I do not sign this authorization, that will not affect my medical treatment or my health insurance coverage, but it will make me ineligible to enroll in the Y-mAbs Connect Patient Support Program, such as the Patient Assistance Program and the Copay Program. I may withdraw this authorization by calling 1-833-33YMABS or by writing to ymabsconnect@pharmacord.com. If I do withdraw the authorization, it cannot be relied upon after the date Y-mAbs receives my notice of withdrawal, but my withdrawal will not invalidate uses and disclosures already made in reliance on the authorization. If I do not withdraw the authorization sooner, it will remain valid for 5 years (or such lesser time as state law may require). I understand that I am entitled to receive a copy of this authorization.

By signing this authorization, either as the patient or a legal representative or guardian of the patient, I attest that I am legally able to sign such documents and am properly acting in my capacity to do so. Proof of such guardian's or representative's authority to act for the patient may be requested such as power of attorney or legal court order.

X _____ _____

Patient/Authorized Representative Printed Name **Relationship to Patient**

X _____ _____

Patient/Authorized Representative Signature **Date** (mm/dd/yyyy)