Y-mAbs Connect™

Phone: 1-833-33YMABS / 1-833-339-6227 | 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

Please submit the completed enrollment form and required documentation to Y-mAbs Connect. Asterisk (*) indicates **required** information.

REQUESTED SUPPORT*

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

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 (*Please include copies of the front and back of insurance card*)

Primary Medical Insurance Information*

☐ 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)*:

NPI*: DEA*: Tax ID*:

Center / Hospital Name*:

Street Address*: City*: State*: ZIP*:

Prescriber Direct Contact #: Primary Office Contact Name*:

Phone*: Ext.

Email: Fax*:

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*	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 (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 my Information to (i) facilitate my participation in the services provided by Y-mAbs (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)