

MyNavCare by Genmab® Enrollment Form

Phone 1-866-NAV-CAR1 (1-866-628-2271) Fax 1-866-NAV-CAR6 (1-866-628-2276) MyNavCare.com

Please complete entirely. Note that fields with an asterisk (*) are required. Incomplete forms may result in a delay of enrollment processing.

STEP 1 Services Requested TO BE COMPLETED BY THE PHYSICIAN'S OFFICE

Check all that apply.

☐ Benefits Verification (BV)

☐ MyNavCare Co-pay Assistance Program (Patient must have commercial insurance)

☐ Prior Authorization (PA) Follow-up & Appeal Support

☐ Genmab Patient Assistance Program (GPAP) (Patient will be evaluated for eligibility)

STEP 2 Patient Information

*First name: _____

*Last name: _____

*Gender ☐ Male ☐ Female ☐ Prefer not to answer

*Date of birth: _____ / _____ / _____

*Email: _____

Preferred phone number: () - ☐ Text

Preferred method of communication

Best time to reach me ☐ Morning ☐ Afternoon

☐ Email ☐ Home Phone ☐ Mobile Phone

OK to leave message ☐ Yes ☐ No

*Address: _____

Preferred language ☐ English ☐ Spanish

*City: _____ *State: _____ *Zip: _____

☐ Other: _____

By completing this section, you authorize us to speak with the individual indicated in Step 3B on your behalf.

Care partner information (optional)

Full name: _____

Relationship: _____

Phone: () - _____

Email: _____

STEP 3A Patient Authorization and Additional Program Consents

Please review the options below for various services provided by MyNavCare Patient Support and, if you agree to the terms for obtaining some or all of those services, as set forth on page 3 of this form, check the appropriate boxes to signify your agreement.

By signing this section, you agree to the terms in the "Authorization for Use and Disclosure of Personal Health Information" in Section A, page 2.

MyNavCare

Co-pay Certification

☐ I certify that I have commercial insurance and agree to the terms and conditions outlined in Section B1, page 3.

Genmab Patient Assistance Program (GPAP) Income Verification

☐ I agree to the terms and conditions outlined in Sections B2 and B3, page 3, for the Genmab Patient Assistance Program and Income Verification via Experian.
☐ I do not agree to the terms and conditions of Income Verification outlined in Section B3, page 3 and do not wish to have my credit verified through Experian. I understand that I will be asked to provide supporting documentation to authenticate my income and eligibility.

Ongoing Support & Education

☐ I agree to the terms and conditions for Ongoing Support and Education from Genmab outlined in Section B4, page 3 regarding receiving communication by phone to the phone number listed above.

STEP 3B *Patient Signature

Name of person signing (if not patient): _____ Date: _____ / _____ / _____

Relationship: _____

STEP 4 Insurance Information

Complete this section and/or include a copy of the front and back of the patient's insurance card(s).

☐ Attached copy of insurance cards

☐ Patient has no insurance

	Insurance name	Subscriber name (if not patient)	Subscriber ID	Policy/Group #	Insurance phone
Primary insurance					() -
Secondary insurance					() -
Prescription insurance					() -

STEP 5 Prescriber Information

*Physician name: _____ *Practice name: _____ *Office contact: _____

*Street: _____ Suite: _____ *City: _____ *State: _____ *Zip: _____

Prescriber NPI # _____ PTAN # _____ Group NPI # _____ Prescriber tax ID # _____

*Office phone: () - _____ Office fax: () - _____ Office email: _____

STEP 6 Clinical Information

Please fill out as completely and specifically as possible.

☐ Do not contact patient

Previous therapies: _____

Genmab Medication: _____ Patient previously on product clinical trial ☐ Yes ☐ No Patient has started therapy ☐ Yes ☐ No

*Primary diagnosis code: _____ Secondary diagnosis code: _____ Next date of treatment: _____ / _____ / _____

Acquisition method ☐ Buy & bill ☐ Specialty pharmacy ☐ Unsure/Undecided Site of care ☐ HCP ☐ Alt site (complete below)

Facility name: _____ NPI # _____ Phone: () - _____ Fax: () - _____

Street: _____ Suite: _____ City: _____ State: _____ Zip: _____

STEP 7A Prescriber Certification

By submitting this form, I certify the following:

1. The above therapy is medically necessary for this patient and the treatment decision has been made by the prescribing physician. 2. If the indication for which the medication indicated is not listed in the FDA-approved label, I am prescribing the medication for an "unapproved" use, meaning I have prescribed the medication for a use that is not within the FDA-approved prescribing information for the medication. I have independently determined that this use is medically appropriate for the patient. 3. My office has received an authorization from the above-mentioned patient to release the information included here and additional protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) for Genmab and its service providers ("Providers") for the purposes of verifying the patient's coverage and assessing the patient for financial assistance. 4. If free product through GPAP is provided for the above-mentioned patient, I will not attempt to seek reimbursement for the product from any third party, including any health insurance companies or government health care programs. 5. A patient signature is required to provide any further services outside of contacting the patient to obtain their authorization (if not included with this form).

STEP 7B *Prescriber Signature

Date: _____ / _____ / _____

What Is MyNavCare by Genmab?

MyNavCare is a patient support service program that helps patients understand their insurance coverage and financial support options when prescribed a Genmab product. If you wish to participate in this program, Genmab must receive, use, and disclose certain pieces of your personal information, including personal health information:

- Name and birthday
- Address, telephone number, and email address
- Important financial information (if necessary)
- Information on your medical condition
- Information about your health benefits or health insurance coverage

Please read the Patient Authorization (Section A) below carefully and, if you are comfortable with it, provide your signature on the Enrollment Form (Step 3B). If you have any questions, you may contact Genmab at 1-866-NAV-CAR1 (1-866-628-2271). Once you have signed the Enrollment Form and the other patient consents in this form, you may fax the signed form to 1-866-NAV-CAR6 (1-866-628-2276) or submit it online at MyNavCareHCPportal.com.

SECTION A Authorization for Use and Disclosure of Personal Health Information

I understand that, in order for Genmab US, Inc., and its agents (collectively, “Genmab”) to provide me with the services offered through the Genmab Patient Support Program (the “Program”), Genmab will need to collect, use and disclose certain parts of my personally identifiable health information (my “PHI”). I therefore direct and authorize my physician(s), pharmacy, and health plan(s) to disclose my PHI relevant to my diagnosis, treatment, finances, and identity, including but not limited to the information about me in this Enrollment Form, to Genmab for Genmab to use and disclose in order to provide the Program services, as described below.

I authorize Genmab to (i) use my PHI to facilitate my access to Genmab products and to provide the services described below, and (ii) further disclose my PHI to any individual whom I designate on this form or at another time as my “caregiver,” and to my healthcare provider(s), healthcare entities, pharmacies, and health plan(s) for the purposes of providing the following services:

- Contacting my health plan to understand coverage for the medication prescribed for me
- Determining my eligibility for financial assistance and other support services
- Coordinating delivery of my prescribed medication either via a pharmacy or a specialty distributor
- Providing me with education and treatment reminders
- Conducting quality assurance and other internal business activities and asking me for feedback related to the services or my treatment

I understand that once my PHI is transmitted to Genmab as permitted by this Authorization, the PHI may no longer be protected under federal privacy law and could be redisclosed to others not referred to above. However, I also understand that Genmab has no intention to disclose my PHI for purposes other than those stated above.

I understand that I may choose not to sign this Authorization and, although that will mean Genmab cannot provide the services listed above, it will not affect my rights to obtain healthcare treatment or payment to cover my healthcare treatment. I understand that I may cancel this Authorization at any time by sending a notice of cancellation to Genmab at PO Box #375, Berkeley Heights, NJ 07922, and I also understand that if I do cancel the Authorization, that will not invalidate any uses or disclosures of my PHI made in reliance on the Authorization before the date when Genmab receives my notice of cancellation.

I understand that I have a right to receive a copy of this authorization after it is signed.

This Authorization expires two (2) years from the date signed in Step 3B, or at such earlier time as may be required under the law of the state in which I reside.

SECTION B Additional Consents

SECTION B1 - MyNavCare by Genmab Co-pay Assistance Program

I understand the *MyNavCare* Co-pay Assistance Program is for individuals who have medications paid for by commercial insurance (eg, private insurance company) and that eligibility into this program will be evaluated once my benefits are verified. I understand that I am not eligible to participate in the Co-pay Assistance Program if I am enrolled or otherwise participate in any government healthcare program (eg, Medicare, Medicaid, VA, DoD, Tricare, etc.). I understand that if I receive any assistance from the Co-pay Assistance Program, I will not seek reimbursement for the assistance I receive under the program from anyone else, including an insurance provider, a government healthcare provider, an independent charity, or from a health savings or flexible spending account. I also understand that Genmab's co-pay assistance may be discontinued at any time and that if my insurance coverage changes, I must notify Genmab at 1-866-628-2271 immediately so Genmab may determine if I remain eligible for the program. I understand that additional terms and conditions of the Co-pay Assistance Program, including co-pay savings limits, are accessible to me at 1-866-628-2271.

SECTION B2 - Genmab Patient Assistance Program (GPAP)

I understand that if I qualify for and receive free medication from Genmab under Genmab's Patient Assistance Program (PAP), I agree to comply with the program rules; I will not seek reimbursement for the assistance I receive from anyone else, including an insurance provider, a government healthcare program, an independent charity, a health savings account, a flexible spending account, or other health reimbursement account. If I have Medicare Part D, I will not count any free medication that I receive from the Genmab PAP toward my true out-of-pocket costs (TrOOP). I understand that the Genmab PAP provides medication on a calendar-year basis, and I must reapply every year. I understand that I may not be eligible for assistance in subsequent years if I do not meet the then-current eligibility criteria. I agree to immediately contact the PAP administrator at 1-866-628-2271 if my insurance, treatment, or financial situation changes in any way. I understand that Genmab may discontinue the PAP at any time or change the terms, conditions, and eligibility criteria for the PAP at any time, without prior notice.

SECTION B3 - Electronic Income Verification

I understand that if I seek to be evaluated for eligibility for the Patient Assistance Program, proof of my income must be provided to Genmab. I understand that by selecting the "I agree" box in Step 3A, I am providing written instructions to Genmab and/or its agents to obtain information from my personal credit profile or other information from Experian. I understand that if I do not wish to provide such instructions, I should check "I do not agree" in Step 3A and, in that case, Genmab will request additional financial documents from me, such as tax returns, Social Security income, bank statements, etc., to verify my income as a criterion for eligibility into the Patient Assistance Program.

SECTION B4 - Ongoing Support and Education by Phone and Text

I would like to enroll in phone support from *MyNavCare*, an optional program that could help me stay on track with my treatment plan by providing me with a Patient Engagement Liaison to provide information and education about my disease and provide other patient support resources. I understand that this program is not intended to take the place of regular communications with my treating physician and that I may opt out of the program at any time by contacting *MyNavCare* at 1-866-628-2271 or by writing to the following address: Genmab US, Inc., PO Box #375, Berkeley Heights, NJ 07922. I understand that by checking the box in Step 3A, I agree to receive calls and texts at the phone number provided and that they may be autodialed or prerecorded and are not a condition of purchase.

For more information, go to genmab.com. To review the privacy policy, visit genmab.com/privacy.