EMD Serono
Oncology Navigation Center™ (ONC)
Phone: 844-662-3631
(844-ONC-EMD1)
Fax: 1-844-501-0062
OncNavigationCenter.com

Please complete and fax signed enrollment form and prescription(s) to 1-844-501-0062.

The patient is requesting assistance with the following services for TEPMETKO® (tepotinib) (select all that apply):

____ Verification of Insurance Benefits/Drug Coverage
____ Quick Start/Bridge Program for Eligible Patients
____ Prior Authorization Assistance/Guidance
____ Apply for Co-Pay Assistance (for privately insured patients only)
____ Patient Assistance Program: Please apply if uninsured or you are unsure if you have insurance coverage for TEPMETKO.*
Complete a prescription on page 2 for the patient if applying for Patient Assistance Program
____ Appeals Assistance ____ Other ____________________

PATIENT INFORMATION

First Name:	Last Name:	Date of Birth:	Home Phone #:
Street Address (No PO Box):			Work Phone #:
City:	State:	ZIP:	Email:	Cell Phone #:
Gross Annual Household Income*: $	Number of People in Household:	Is patient a U.S. citizen or U.S. resident? ☐ **YES** / ☐ **NO**	

INSURANCE INFORMATION - Please provide copies of all pharmacy and medical insurance cards (front and back)

Does the patient have pharmacy and/or medical benefits through any private or government health insurer/payer/program? ☐ **YES** / ☐ **NO**
If "YES", please check applicable boxes and complete all that apply below.

Government Health Insurers/Payers/Programs

☐ Medicare Part C (Medicare Advantage) ☐ Medicare Part A ☐ Medicaid ☐ Veterans Affairs
☐ Medicare Part D - Drug Plan ☐ Medicare Part B ☐ TRICARE ☐ Other: ____________
List Medicare Beneficiary Identifier: ____________________

	Name of Insurer/Plan:	*Policy ID #:*	*Group #:*	*Insurer /PBM Phone #:*	*Policy Holder Name*
☐ **Private** - Pharmacy Benefits Manager **RxBIN:** ____________ **RxPCN:** ____________ **RxGrp:** ____________					
☐ **Private Insurance** - Medical (Primary) Is this an ACA Qualified Health Plan? ☐ **YES** / ☐ **NO**					
☐ **Private Insurance** - Medical (Secondary) Is this an ACA Qualified Health Plan? ☐ **YES** / ☐ **NO**					

PATIENT SIGNATURE – By signing below, I confirm that I have read and understand the *Patient Authorization for Use* and *Disclosure of Health* and *Personal Information* and the *Patient Consent for EMD Serono Oncology Navigation Center* and agree to the terms on pages 3 and 4.

Patient Name (print) ____________________ Patient Signature (required) ____________________ Date ________
Legal Representative/Guardian Signature (If applicable) ____________________ Relationship to Patient ____________________ Date ________

PHYSICIAN INFORMATION

Prescribing Physician Name:		Physician Email:	
State License #:	NPI:	Physician Tax ID #:	PTAN:
Facility Name:	Street Address (No PO Box):		
City:	State:	ZIP:	
Office Contact Name:	Phone:	Office Contact Email:	Fax:
PATIENT MEDICAL INFORMATION: Primary ICD-10-CM code: Secondary ICD-10-CM code:		List Treatment Start Date:	
Does the patient have a *MET*ex14 skipping alteration? ☐ **YES** / ☐ **NO**	List Previous Therapies:		
Is the patient's primary cancer metastatic? ☐ **YES** / ☐ **NO**			

PHYSICIAN SIGNATURE – By signing below, I confirm that I have read and understand the *Treating Physician Certification for EMD Serono Oncology Navigation Center* and agree to the terms on Page 4.

Physician Name (print) ____________________ Physician Signature (required) ____________________ Date ________

*For patients applying to the Patient Assistance Program, include before-tax wages, Social Security benefits, and any other source of household income.
NOTE: Please include income documentation if applying for the Patient Assistance Program.

Rx SECTION FOR PHYSICIAN – PLEASE COMPLETE AND SIGN ONE OR BOTH OF THE PRESCRIPTIONS FOR YOUR PATIENT BASED ON SPECIFIC PATIENT NEEDS

PRESCRIPTION FOR ELIGIBLE PATIENTS WHO WISH TO PARTICIPATE IN THE ONCOLOGY NAVIGATION CENTER™ FOR TEMPORARY QUICK START/BRIDGE PROGRAM. THIS SHOULD BE USED ONLY FOR PATIENTS WHO HAVE EXPERIENCED AN INSURANCE DELAY AND MEET THE ELIGIBILITY CRITERIA FOR THE QUICK START/BRIDGE PROGRAM

Patient Name:	Date of Birth:	Drug Name: TEPMETKO® (tepotinib)	225 mg tablets
Directions: Take_______ tablet(s) by mouth _______ times a day		Quantity: 15-day No Refills (unless authorized by program)	

Physician Prescription Signature – I certify that TEPMETKO® (tepotinib) is medically necessary for the patient above, and that it is prescribed in accordance with the FDA-approved prescribing information and this information is accurate to the best of my knowledge. I authorize EMD Serono, and its affiliates, business partners, and agents, to transmit this prescription to the designated pharmacy to dispense TEPMETKO® (tepotinib) to the patient.

Prescriber Name: ____________________

Prescriber Signature: ____________________ Date: _______

PRESCRIPTION FOR INSURED PATIENTS, OR FOR USE WITH EMD SERONO ONC PATIENT ASSISTANCE PROGRAM FOR ELIGIBLE PATIENTS

Patient Name:	Date of Birth:	Drug Name: TEPMETKO® (tepotinib)	225 mg tablets
Directions: Take_______ tablet(s) by mouth _______ times a day		Quantity: _______ Refills (up to 12): _______	

Physician Prescription Signature – I certify that TEPMETKO® (tepotinib) is medically necessary for the patient above, and this information is accurate to the best of my knowledge. I authorize EMD Serono, and its affiliates, business partners, and agents, to transmit this prescription to the designated pharmacy to dispense TEPMETKO® (tepotinib) to the patient.

Prescriber Name: ____________________

Prescriber Signature: ____________________ Date: _______

Patient Authorization for Use and Disclosure of Health and Personal Information

By signing the EMD Serono ONC Enrollment Form, I agree to the following:

- I authorize the disclosure and use, as described below, of my financial information, insurance information, contact information, medical information, including personally identifiable protected health information, to the Oncology Navigation Center™ program, EMD Serono, Inc. and individuals and companies working with EMD Serono, for the purpose of allowing the Oncology Navigation Center to provide me with reimbursement support services, Quick Start/Bridge Program services, patient assistance program services, and/or co-pay assistance, and/or to evaluate me for eligibility in the Oncology Navigation Center.
- I also authorize my physician(s), pharmacist(s), other healthcare providers, patient advocacy organizations, and insurance companies to disclose to the Oncology Navigation Center, and the companies that help administer the Oncology Navigation Center, information about my medical condition, treatments, financial information, insurance status, and protected health information for the purpose of providing Oncology Navigation Center services and assistance.
- Once my information has been disclosed pursuant to this authorization, I understand that federal privacy laws may no longer protect that information. I understand I may revoke this authorization by giving written notice of my revocation to the Oncology Navigation Center. After revocation of this authorization, the Oncology Navigation Center will stop using and disclosing my information, but the revocation will not affect prior use or disclosure of my information.
- I understand that this authorization will remain in effect for three years, or such shorter period as may be required by state law, from the date of my signature, unless I revoke this authorization earlier.
- I understand that my refusal to sign this authorization will not affect my ability to receive TEPMETKO® (tepotinib), my treatment, payment for treatment, eligibility for or enrollment in health benefits; however, such refusal will limit my ability to receive support services for TEPMETKO through the Oncology Navigation Center.
- I understand that I have the right to receive a copy of this authorization.

Patient Consent for the EMD Serono Oncology Navigation Center™

By signing the Oncology Navigation Center Enrollment Form, I agree and certify the following:

- I confirm that all financial and insurance information is complete and accurate. Additionally, during participation in the Oncology Navigation Center, and while I am receiving treatment with TEPMETKO® (tepotinib), I agree to immediately notify the Oncology Navigation Center if my health insurance status changes in the future, if I obtain any new health insurance plan, or if I become entitled to, or enroll in a government health insurance program/payer (i.e. Medicare, or Medicaid).
- I understand that the Oncology Navigation Center reserves the right to modify, change, or terminate the Oncology Navigation Center program at any time with or without notice.
- I understand that non-identifiable information from all Oncology Navigation Center program participants may be summarized for statistical or other purposes.

- **I understand that EMD Serono, through the Oncology Navigation Center, is collecting patients' relevant financial income and personal health information, including information relating to medical conditions, treatment, care management, prescriptions, and health insurance, for the purpose of determining the patients' eligibility for the Oncology Navigation Center and subsequently administering the program benefits or related services.**

Treating Physician Certification for the EMD Serono Oncology Navigation Center

By signing the Oncology Navigation Center Enrollment Form, I agree to and certify the following:

- TEPMETKO is medically appropriate for the patient identified above and that I, or a physician in my Practice, will be supervising the patient's treatment.
- The Oncology Navigation Center is a patient access program available to assist patients, and that program participation is voluntary, and that patient eligibility for services is not connected to or contingent on any past or future purchase of TEPMETKO.
- If the patient applies for and is eligible for donated product through the Oncology Navigation Center Patient Assistance Program or Quick Start/Bridge Program, I will not seek reimbursement for such donated product from any insurance company or program, including federal healthcare programs, such as Medicare and Medicaid. Additionally, I agree to notify the Oncology Navigation Center immediately if the patient is no longer receiving TEPMETKO through the Patient Assistance Program, and agree to return unused donated Patient Assistance Program product to the Oncology Navigation Center.
- I understand that information concerning program participants may be summarized for statistical or other purposes and provided to EMD Serono.
- The information provided on the enrollment form is complete and accurate to the best of my knowledge.
- The Oncology Navigation Center reserves the right to modify, change, or terminate the Oncology Navigation Center program at any time with or without notice.

- **I understand that EMD Serono is collecting physicians' relevant personal information to document that it has obtained the required certifications and authorizations to administer the Oncology Navigation Center.**

EMD Serono, Inc. does not guarantee coverage or reimbursement for TEPMETKO.
Coverage and reimbursement decisions are made by insurance companies following the receipt of claims.
EMD Serono's Privacy Policy can be found here: https://www.emdserono.com/us-en/privacy-policy.html.

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