Prescription Form

Rubraca® (rucaparib) tablets

Simple steps to getting Rubraca

You can send your patient's Rubraca® (rucaparib) tablets prescription to either your practice's in-office dispensing (IOD) pharmacy or one of our Rubraca network specialty pharmacies. A Rubraca Connections Access Specialist is available, if needed, to help determine eligibility and coordinate the financial assistance process, and answer any questions you may have.

IOD PHARMACY

1 Submit a Rubraca prescription to your practice's IOD pharmacy via fax or online at RubracaConnections.com/iAssist.

2 Your IOD pharmacy can order Rubraca directly from one of our wholesalers. If your IOD pharmacy is not in-network, the pharmacist will forward to a network specialty pharmacy. Rubraca Connections can also assist with the triage process.

ASD Healthcare AmerisourceBergen

CardinalHealth

McKESSON

Oncology Supply AmerisourceBergen

SPECIALTY PHARMACY

Complete a Rubraca prescription and send to a network specialty pharmacy via fax or online at RubracaConnections.com/iAssist.

If you would like assistance identifying a network specialty pharmacy accepted by your patient's insurance, contact Rubraca Connections.

Avella
Phone: 877-546-5779 | **Fax: 877-546-5780**

Biologics
Phone: 800-850-4306 | **Fax: 800-823-4506**

CVS Specialty
Phone: 800-259-1783 | **Fax: 855-296-0210**

US Bioservices
Phone: 877-757-0667 | **Fax: 888-899-0067**

The specialty pharmacy will coordinate with Rubraca Connections if financial support is required.

Rubraca® (rucaparib) tablets | connections

For further financial or reimbursement support for your patients, contact Rubraca Connections:

Call **1-844-779-7707**
Monday through Friday 8 AM to 8 PM ET

Visit **RubracaConnections.com**

Prescription Form – Patient

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A PATIENT AND CAREGIVER INFORMATION

Patient name (first and last) _____ Date of birth _____ Gender ◯ M ◯ F

Address _____ City _____ State _____ ZIP _____

Home phone _____ Cell phone _____ E-mail _____

Social security number _____ Language assistance required? ◯ Yes (please specify language) _____ ◯ No

Caregiver name (first and last) _____ Caregiver phone _____

B INSURANCE INFORMATION – *Fill out or attach legible front/back copy of pharmacy benefit card.*

Primary insurance _____ Insurance company phone _____

Health plan policy # _____ Group # _____ ◯ No insurance

Primary card holder _____ Primary card holder date of birth _____

Relationship to card holder ◯ Self ◯ Other (please specify) _____

Prescription benefit insurance _____ Prescription benefit insurance phone _____

Primary card holder _____ Primary card holder date of birth _____

Relationship to card holder ◯ Self ◯ Other (please specify) _____

Would you like Rubraca Connections to contact your patient with an explanation of benefits? ◯ Yes ◯ No

Note: Your patient may be contacted about delivery of Rubraca® (rucaparib) tablets.

C RUBRACA CONNECTIONS PATIENT ASSISTANCE PROGRAM – *If patient is uninsured or rendered uninsured and would like to apply for the Rubraca Connections Patient Assistance Program, please complete below. Patient application may be subject to audit or request for additional information.*

Yearly gross household income _____ Household size (number of people who contribute to or are dependent on your household income) _____

Rubraca Connections policy prohibits prescribers from charging the patient any fee for enrollment or other activities associated with the patient's participation in the Rubraca Connections Patient Assistance Program. No claim may be made to any third-party payer: eg, Medicaid, Medicare, private insurance, etc.) for payment for product provided under the Rubraca Connections Patient Assistance Program. No purchase is necessary. Product may not be used for resale, returned for credit, or shared with other patients. Clovis reserves the right to rescind, revoke, or change the program at any time without notice. Visit RubracaConnections.com for complete Terms and Conditions and eligibility criteria.

Note: If patient does not provide signature below, consent will be acquired at a later stage for enrollment in the Rubraca Connections Patient Assistance Program.

D PATIENT PROGRAM CONSENT

I authorize my healthcare providers, health plans and pharmacies (collectively, "Healthcare Organizations") to use and share my personal and health information related to my medical condition and drug therapy (my "health information") with Clovis Oncology and its patient support programs (collectively, "Rubraca Connections") (i) for reimbursement assistance, (ii) for referral to and enrollment in patient support and/or financial assistance programs, (iii) for providing me with materials and information about my treatment or other programs related to my drug therapy and enrolling me in such programs as I request, (iv) to contact me for market research purposes about Rubraca and Rubraca Connections, (v) to improve Rubraca Connections quality of operations, or (vi) as required or permitted by law. I understand that, once disclosed pursuant to this authorization, my health information may no longer be protected under federal or state law and could be disclosed by Rubraca Connections to others, but I understand that Rubraca Connections will make reasonable efforts to keep it private and to disclose it only for the purposes set forth in this authorization. I understand that my pharmacy may receive payment from Clovis Oncology in connection with (i) the disclosure of my health information to Rubraca Connections for purposes allowed under this authorization, including but not limited to market research purposes and (ii) the use of my health information to communicate with me about Clovis Oncology products or services. I understand that my authorization is voluntary and my healthcare providers, health plans and pharmacies may not condition my treatment, payment for treatment, enrollment or eligibility for benefits on whether I sign this authorization. However, if I do not sign this authorization, it may affect my ability to enroll in Rubraca Connections. I understand that this authorization will remain valid for 5 years after the date of my signature or such earlier date as required by applicable law, unless I revoke it earlier by cancelling my enrollment, which I may do by writing to PO Box 220308, Charlotte, NC 28222-0308 at any time. I understand that my cancellation will not apply to any use or disclosure of my health information by my healthcare providers, health plans or pharmacies before they receive notice of my cancellation.

Patient signature X _____ Date _____

Print patient first and last name _____

Print legal representative first and last name (If patient is unable to sign) _____

If signed by someone other than the patient, please describe your legal authority/power of attorney to sign on behalf of the patient (eg, guardian, custodian, healthcare power of attorney). Please note that if you are the patient's prescriber, that alone does not give you legal authority to sign on behalf of the patient.

Prescription Form – Healthcare Provider

Rubraca® (rucaparib) tablets

E PRESCRIBER INFORMATION

Prescriber name _____ Prescriber specialty _____

Practice/facility name _____

DEA/NPI prescriber license # _____ Medicaid/Medicare provider # _____

Address _____ City _____ State _____ ZIP _____

Office contact _____ Preferred communication method ◯ Phone ◯ Fax ◯ E-mail

Phone _____ Fax _____ E-mail _____

F DIAGNOSIS AND PRESCRIPTION – *Complete the Rubraca® (rucaparib) tablets prescription in the space provided below or attach separately.*

Patient name (first and last) _____ Date of birth _____

ICD-10 _____ Diagnosis _____

Drug: Rubraca Dosage ◯ 200 mg ◯ 250 mg ◯ 300 mg Quantity (days) _____ Refills _____

Directions for use _____

The recommended starting dose and schedule for Rubraca is 600 mg taken twice daily. If your patient misses a dose of Rubraca, instruct them to take their next dose at their usual scheduled time. Your patient should not take an extra dose to make up for a missed dose.

Medication needed-by date _____

Prescriber signature X _____ Date _____

I have determined that Rubraca is medically appropriate for the treatment of the patient, and authorize Rubraca Connections to convey the attached prescription on my behalf to the selected specialty pharmacy and to receive information on the status and related matters.

G QUICKSTART PRESCRIPTION – *Complete for patients who experience an insurance delay of 5 business days or more.*

Patients with private/commercial or government insurance receive 15-day supplies of Rubraca for up to 60 days (2 months) during insurance coverage investigations. Patients must meet diagnosis and coverage criteria to be eligible. Visit RubracaConnections.com for complete Terms and Conditions and eligibility criteria.

Patient name (first and last) _____ Date of birth _____

Drug: Rubraca Dosage ◯ 200 mg ◯ 250 mg ◯ 300 mg Quantity 15 days Refills (3 max) _____

Directions for use _____

The recommended starting dose and schedule for Rubraca is 600 mg taken twice daily. If your patient misses a dose of Rubraca, instruct them to take their next dose at their usual scheduled time. Your patient should not take an extra dose to make up for a missed dose.

Medication needed-by date _____

Prescriber signature X _____ Date _____

I have determined that Rubraca is medically appropriate for the treatment of the patient.

H DELIVERY – *Choose one of the following options for ordering Rubraca.*

Specialty pharmacy (select one) – *If you have a question about selecting a specialty pharmacy, please contact Rubraca Connections at 1-844-779-7707.*

◯ Avella **(Fax: 877-546-5780)** ◯ Biologics **(Fax: 800-823-4506)** ◯ CVS Specialty **(Fax: 855-296-0210)** ◯ US Bioservices **(Fax: 888-899-0067)**

OR

◯ Your in-office dispensing (IOD) pharmacy (name) _____ Phone _____

Preferred shipment location ◯ Prescriber office ◯ Patient home

Checklist

Rubraca® (rucaparib) tablets

Rubraca Prescription Form checklist

☐ Required fields populated

Refer to the checklist below depending on your preferred delivery method:

IOD pharmacy

- ✓ Sections A, B, D, E, and H are always required
- ✓ If submitting the form as a prescription, please complete section F
- ✓ If you would like to enroll a patient in the Rubraca Connections QuickStart Program, please complete section G
- ✓ If you would like to determine a patient's eligibility to apply to the Rubraca Connections Patient Assistance Program, please complete section C

Specialty pharmacy

- ✓ Sections A, B, D, E, F, and H are always required
- ✓ If you would like to enroll a patient in the Rubraca Connections QuickStart Program, please complete section G
- ✓ If you would like to determine a patient's eligibility to apply to the Rubraca Connections Patient Assistance Program, please complete section C

☐ Signatures obtained

- ✓ From healthcare provider
  Required if using the form as a prescription or if enrolling a patient in the Rubraca Connections QuickStart Program
- ✓ From patient
  Recommended but not required in order to receive access support

☐ Pharmacy benefit card attached

Contact Rubraca Connections if you have any questions or would like more information

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