Rubraca Prescription and Access Form

Rubraca® (rucaparib) tablets

Simple steps to getting Rubraca

You can send your patient's Rubraca 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.

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
- CuraScript SD
- McKESSON
- Oncology Supply (AmerisourceBergen)

SPECIALTY PHARMACY

Submit a Rubraca prescription to a network specialty pharmacy via fax.

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

Accredo	Phone: 877-732-3431
Avella	Phone: 877-546-5779
Biologics	Phone: 800-850-4306
CVS Specialty	Phone: 800-259-1783

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**

Rubraca Prescription and Access Form

Patient Information

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 _____

RxBIN _____ RxPCN _____

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 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. I certify that I will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program, including Medicare and Medicaid. I understand that I have the right to a copy of my authorization.

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.

Rubraca Prescription and Access Form

Healthcare Provider Information

Rubraca® (rucaparib) tablets

D PRESCRIBER INFORMATION

Prescriber name _____ Prescriber specialty _____

Practice/facility name _____

NPI prescriber license # _____ Site tax ID _____

Address _____ City _____ State _____ ZIP _____

Office contact _____ Preferred communication method ◉ Phone ○ Fax ○ E-mail

Phone _____ Fax _____ E-mail _____

○ BV Other special instructions _____

E 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 code _____ Diagnosis _____

Drug: Rubraca Dosage _____ Days' supply _____ Quantity _____ Refills _____

Directions for use _____

Prescriber signature X _____ (Dispense as written) Date _____

X _____ (Substitution permitted) 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.
Note: Stamped prescriber signatures will not be accepted.

F RUBRACA CONNECTIONS QUICKSTART PROGRAM – *Complete for patients in cases they experience a coverage determination delay of at least 5 business days or more, regardless of income or insurance type. Patients must meet diagnosis criteria to be eligible. Visit RubracaConnections.com for complete Terms and Conditions and eligibility criteria.*

Patients receive 15-day supplies of Rubraca for up to 60 days (2 months).

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

Drug: Rubraca Dosage _____ Days' supply 15 days Quantity _____ Refills (3 max) _____

Directions for use _____

Medication needed-by date _____

Prescriber signature X _____ (Dispense as written) Date _____

I have determined that Rubraca is medically appropriate for the treatment of the patient.
Note: Stamped prescriber signatures will not be accepted.

G DELIVERY – *If you have a preferred specialty pharmacy, please select one of the following. You may leave this section blank if you do not have a preference.*

○ Accredo ○ Avella ○ Biologics ○ CVS Specialty

Preferred shipment location ○ Prescriber office ○ Patient home

Complete and fax the form to Rubraca Connections at 1-844-779-7717.

Please click here for full Prescribing Information for Rubraca.

Rubraca Prescription and Access Form

Rubraca® (rucaparib) tablets

Required checklist

- ☐ All fields in each required section of the form are populated.
- ☐ Signatures obtained
  - ✓ Patient signature
  - ✓ Prescriber signature
- ☐ Attached copies of:
  - ✓ Patient health plan card (both sides)
  - ✓ Pharmacy benefit card (both sides)

Compile the completed Rubraca Prescription and Access Form with patient and prescriber signatures and copies of the patient's health insurance cards and fax this material to **Rubraca Connections** at **1-844-779-7717**.

To contact a **Rubraca Connections Access Specialist** by phone, please call **1-844-779-7707**.

Please click here for full Prescribing Information for Rubraca.

CLOVIS ONCOLOGY

© 2020 Clovis Oncology. PP-RUCA-US-1547 05/2020