Immunomedics PATIENT ASSISTANCE PROGRAM

With the Immunomedics Patient Assistance Program (PAP), patients who are uninsured or underinsured may be eligible to obtain access to **TRODELVY™ (sacituzumab govitecan-hziy) 180 mg for injection** at no cost.

To determine eligibility:

✔ Fax completed form to **1-833-851-4344** or mail to

TRODELVY ACCESS SERVICES
2730 S. Edmonds Ln,
Suite 300
Lewisville, TX 75067

✔ Please make sure that both the **healthcare provider** (page 1) and **patient** (page 2) sign and date the application

A Case Manager will contact your office with determination of patient eligibility. Should you have any questions about the services offered through the PAP, please contact **TRODELVY ACCESS SERVICES** at 1-844-TRODELVY (876-3358), Monday through Friday, 9 AM–7 PM ET.

ADMINISTERING PROVIDER INFORMATION

Administering Provider Name:			
Facility Name:		Facility Address:	
City/State/ZIP Code:			
Primary Contact Name:		Title:	
Phone:		Extension:	Fax:
Tax ID #:	NPI #:	State License #:	Expiration:

DIRECT-TO-HEALTHCARE PROVIDER DISTRIBUTION

(Complete only if the shipping address is different from the Administering Provider Address)

Site:	Contact Name for Shipment:	
Address:		
City/State/ZIP Code:		
Business Hours:	Phone:	Fax:

PRESCRIPTION AND HEALTHCARE PROVIDER CERTIFICATION: TRODELVY™ (sacituzumab govitecan-hziy) 180 mg for injection

Patient Name:	Patient DOB:
Patient Address:	
Patient weight (lbs/kg):	
TRODELVY (sacituzumab govitecan-hziy) for injection for intravenous use, lyophilized powder in single-use vials containing 180 mg per vial	
Dosage and Directions: _____mg (10 mg/kg) once weekly on Days 1 and 8 of continuous 21-day treatment cycles.	
Quantity (Number of Vials) to be dispensed:	
Number of Treatment Cycles/Number of Refills:	
I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed TRODELVY based on my professional judgment of medical necessity and for an FDA approved indication for TRODELVY. I certify that, to the best of my knowledge, the patient does not have any other insurance coverage for TRODELVY. I authorize Immunomedics, including its agents, administrators, and service providers, to forward this prescription to a dispensing pharmacy on behalf of myself and my patient.	
Healthcare Provider Signature: X _____ *If you are requesting access to TRODELVY and you are a New York State Prescriber, attach your order for TRODELVY on your NYS official prescription form.*	Date: _____

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The patient must sign the authorization below and submit it with the rest of the application. If approved, the patient's TRODELVY™ (sacituzumab govitecan-hziy) 180 mg for injection will be sent to their treating facility.

PATIENT INFORMATION

Patient Name:		Patient DOB:
Patient Address:		
City/State/ZIP Code:		Legal US Resident: ○Y ○N
Patient Phone:	Patient E-mail:	OK to Contact? ○Y ○N
Insurance Status: ☐ Uninsured ☐ Insured		
If insured, please provide the reason for this application:		
Primary Insurance:	Policy #:	Phone:

PATIENT FINANCIAL INFORMATION (TO BE PROVIDED BY THE PATIENT)

Annual household income: $_____

Number of people in the household dependent on said income: _____

Income documentation may be required to assess Immunomedics PAP eligibility for uninsured patients. Acceptable forms of documentation include the most recent copy of US federal tax return, Social Security income statements, recent pay stubs, etc.

PATIENT AUTHORIZATION FOR PAP

By providing my signature below, I authorize Immunomedics, including its agents, administrators, and service providers, to use and disclose the information on this form to permit Immunomedics to assess my eligibility for this program and contact me. I verify that the information provided in this application form is current, complete, and accurate, and understand that it will be reviewed and relied upon to determine my eligibility for product assistance. I understand that I may not, and agree that I will not, seek reimbursement from any private insurance or public assistance program for any TRODELVY made available to me under the Immunomedics PAP. I understand that any product assistance is contingent upon my ability to meet the eligibility criteria, and Immunomedics reserves the right to make an independent determination of financial and medical need. I also understand that Immunomedics reserves the right, at any time and without notice, to modify or discontinue this program with respect to any patient or in its entirety. I authorize Immunomedics to use and obtain information from my healthcare provider, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this application in order to provide assistance. If I experience an adverse event or a product technical complaint, I understand that it will be shared with Immunomedics, and that Immunomedics may contact my healthcare provider or myself to learn more about the event. I acknowledge that I am a legal resident of the United States.

I am providing "written instructions" under the Fair Credit Reporting Act to Immunomedics, including its agents, administrators, and service providers, authorizing Immunomedics to obtain information from my credit profile and/or other information from Experian Health. I authorize Immunomedics, including its agents, administrators, and service providers, to obtain such information solely to determine my eligibility for the Immunomedics PAP.

I may refuse to sign this authorization without any effect on my care or treatment from my healthcare provider. However, if I refuse to sign this form, I acknowledge that I will not be eligible to receive free product through the Immunomedics PAP. I can cancel this authorization at any time by mailing a written request to TRODELVY ACCESS SERVICES 2730 S. Edmonds Ln, Suite 300, Lewisville, TX 75067 or by calling 1-844-TRODELVY. This cancellation will not affect any use or disclosure of my information made prior to receiving notice of cancellation.

Patient's or Patient Representative's Name:	Date:
Patient or Patient Representative's Signature: X _____	Date:
If signed by the patient's representative, include a description of the representative's relationship to the patient and such person's authority to act for the patient (eg, parent, guardian, etc).	

Click here for the full Prescribing Information, including boxed Warning, and Patient Information.

Immunomedics