SyndAccess™

Patient Enrollment Form

Be sure to fill out all sections of this form. All fields are required.
Incomplete fields may cause processing delays.

1-888-567-SYND (1-888-567-7963)
Monday-Friday 9 AM-6 PM ET

Once complete, please fax all pages to 1-888-567-3299

Support@SyndAccess.com

1. SyndAccess Services Requested* *(select all that apply)*

- ○ Insurance Verification (Benefit Investigation, Prior Authorization and Appeal Assistance)
- ○ Financial Assistance (Information on potential financial assistance programs, including Revuforj® (revumenib) commercial copay screening)
- ○ Patient Assistance Program (PAP)
- ○ Bridge or Quick Start Programs
- ○ Assistance with all services

*All programs and support are subject to eligibility requirements and limitations

2. Healthcare Professional/Facility Information

Prescriber Name (first, last): _____ Office Contact Name: _____

NPI #: _____ Office Contact Email: _____

Tax ID #: _____ Office Phone: _____ Fax: _____

Facility Name: _____ Preferred Contact Method: ○ Phone ○ Fax ○ Email

Street Address: _____

City: _____ State: _____ Zip: _____

3. Patient/Caregiver Information

Patient Name (first, last): _____ Gender at birth: ○ Male ○ Female Date of Birth: _____

Street Address: _____ Home Phone: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Email: _____

Caregiver/Alternate Contact Name (required for patients under age 18): Primary Language: _____

_____ Preferred Contact Method: ○ Home Phone ○ Mobile Phone ○ Email

Relationship to Patient: _____ Best Time to Contact: ○ Day (8 AM–5 PM ET) ○ Evening (after 5 PM ET)

Contact Caregiver/Alternate Contact Instead of Patient? ○ Yes ○ No Caregiver/Alternate Contact Phone: _____

4. Insurance Information (if possible, please include a copy of both sides of patient's insurance cards)

Does the patient have insurance? ○ Yes ○ No If 'Yes', what type of insurance? (select all that apply)

○ Commercial/Private Insurance ○ Medicare ○ Medicaid ○ Other _____

Has a Prior Authorization been submitted for the patient? ○ Yes ○ No Date Submitted: _____ Reference #: _____

Primary Insurance

Insurance Name: _____

Insurance Phone Number: _____

Cardholder Name: _____

Relationship to Patient: _____

Member ID/Policy #: _____

Group #: _____

Other (State Medicaid): _____

Prescription Insurance

Insurance Name: _____

Insurance Phone Number: _____

Cardholder Name: _____

Relationship to Patient: _____

Member ID/Policy #: _____

Group #: _____

Rx BIN #: _____ *Rx PCN #:* _____

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5. Clinical Information

Patient Diagnosis: _____

ICD-10 Code(s): _____ Is the patient new to therapy? ○ Yes ○ No

Has the patient received a transplant? ○ Yes ○ No Date of Procedure: _____

Concurrent Medications: _____

_____

Previous Therapies (Induction, Consolidation): _____

Allergies: _____

6. Pharmacy and Shipping Preferences

Preferred Specialty Pharmacy (select one):

○ Biologics ○ ONCO360 ○ Other _____

If 'other', Pharmacy Name: _____

Phone: _____

Has a prescription already been sent to the pharmacy? ○ Yes ○ No

Preferred Shipping Location (select one):

○ Patient ○ Provider ○ Other _____

If 'other', Street Address: _____

City: _____ State: _____ Zip: _____

7. Prescription Information (select one of the dosing options below)

Patient Assistance Program Rx for Revuforj® (revumenib)

Please refer to the Prescribing Information for dosing, including dose modifications for CYP3A4 inhibitors
(Please submit a separate prescription with this form, and provide additional information, if required by your state)

Please complete for all patients. Date of recorded weight measurement: _____

Patient's BSA (m^2): _____ **Height (cm):** _____ **Weight (kg):** _____

Dose for ≥40 kg patients*	Quantity (30-day supply)
○ 270 mg twice daily (as tablets)	160 mg x 60 tablets + 110 mg x 60 tablets
○ 160 mg twice daily (as tablets)	160 mg x 60 tablets
○ 110 mg twice daily (as tablets)	110 mg x 60 tablets

*Dosing for <40 kg patients requires BSA dosing, which may utilize 25 mg tablets. The 25 mg tablets are not currently available for use. Contact SyndAccess for further questions.

Additional instructions: _____

_____

_____

Prescriber Name (print): _____ Signature: _____

Date: _____ NPI#: _____

Please see Full Prescribing Information, including BOXED WARNING.

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Patient Name (first, last): _____ Date of Birth: _____

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8. Quick Start Prescription (optional) (select one of the dosing options below)

Quick Start Rx for Revuforj® (revumenib)

Please refer to the Prescribing Information for dosing, including dose modifications for CYP3A4 inhibitors
(Please submit a separate prescription with this form, and provide additional information, if required by your state)

Please complete for all patients. Date of recorded weight measurement: _____

Patient's BSA (m^2): _____ **Height (cm):** _____ **Weight (kg):** _____

Dose for ≥40 kg patients*	Quantity (15-day supply)
○ 270 mg twice daily (as tablets)	160 mg x 30 tablets + 110 mg x 30 tablets
○ 160 mg twice daily (as tablets)	160 mg x 30 tablets
○ 110 mg twice daily (as tablets)	110 mg x 30 tablets

*Dosing for <40 kg patients requires BSA dosing, which may utilize 25 mg tablets. The 25 mg tablets are not currently available for use. Contact SyndAccess for further questions.

Additional instructions: _____

Prescriber Name (print): _____ Signature: _____

Date: _____ NPI#: _____

9. Copay Support Program Terms and Conditions

- Revuforj® (revumenib) Copay Support Program is available to eligible commercially insured patients who are US residents. Pay as little as $0 out of pocket for each prescription. Maximum benefit and eligibility: Depending on the insurance plan, patients could have additional financial responsibility for any amounts over Syndax's maximum liability above annual cap. Patients must be a US resident and have a valid prescription for Revuforj® (revumenib) for an FDA-approved indication. Not available to cash paying patients or uninsured. Not available to patients enrolled in state or federal health care programs, including Medicare, Medicaid, Medigap, VA, DoD, or TRICARE. Offer only available to patients with private commercial insurance. This offer is limited to one (1) per person during this offering period and is not transferrable.
- This offer may not be combined with any other rebate/coupon, free trial, or similar offer for the specified prescription. Syndax has the right to modify, alter, or cancel the Copay Support Program for Revuforj® (revumenib) at any time without prior notification.
- This offer is not conditioned on any past, present, or future purchases, including refills. Patients must have a valid prescription for an FDA-approved indication.

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Patient Name (first, last): _____ Date of Birth: _____

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10. Healthcare Professional Certification (signature required for processing)

By signing below, I agree to participate in the SyndAccess Patient Assistance Program (PAP) for the patient named on this form and hereby represent, covenant, and certify as follows:

1) The above therapy (or medicine) is medically necessary, and the patient's diagnosis is consistent with the product's label;

2) I have obtained from my patient his or her consent and any required written authorization as required by HIPAA and other federal or state laws to release to SyndAccess (Syndax Patient Access and Support Services) and its representatives/agents all patient information needed for this application, including, without limitation, my patient's financial and medical information;

3) I understand that SyndAccess and its representatives/agents will only use this information to assess the patient's eligibility and participation in the SyndAccess PAP;

4) I have not received, nor will I seek or accept reimbursement from any federal, state, or private payers for any drug provided for my patient by the SyndAccess PAP;

5) I have not received, nor will I seek or accept payment from my patient for any co-insurance amount paid for by the Revuforj® (revumenib) Copay Support Program;

6) I have not received, nor will I seek or accept payment from my patient or any payer for services performed by SyndAccess or for any amounts already paid for under this program;

7) I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible under this program and I will notify SyndAccess if I become aware of any such changes;

8) I understand that I am under no obligation to prescribe any Syndax medication and I have not received and will not receive any benefit from Syndax for prescribing a Syndax medication;

9) I understand that the information contained in this form is complete and accurate to the best of my knowledge;

10) I understand that I am agreeing to be contacted by SyndAccess for the purposes of this program; and

11) I will notify SyndAccess of any errors regarding the foregoing and will make every effort to correct those errors.

Prescriber Name (print): _____ Signature: _____

Date: _____

Syndax Pharmaceuticals does not assume responsibility for, nor does it guarantee the availability, scope of quality of the services offered under SyndAccess. Healthcare Professionals, not Syndax, are responsible for the services they provide. The SyndAccess PAP services have no value apart from the product. Verification of insurance coverage is ultimately the responsibility of the Healthcare Provider. Syndax and our service providers do not represent or guarantee that payer reimbursement or any other payment or reimbursement of any kind will be made. Syndax and our service providers do not reimburse for claims denied by payers. Information provided as a result of the benefit investigation is provided for general reference and informational purposes only. Our service providers make every effort to be accurate in the information provided; however, no representations or warranties are expressed or implied by our service providers and Syndax regarding the accuracy or reliability of the information. Our service providers or Syndax, or its agents or employees shall not be liable legally, financially, or otherwise, for damages of any kind as a result of or related to these services. Our service providers and other users of this information resulting from benefit investigation services accept full responsibility for use of the service.

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Patient Name (first, last): _____ Date of Birth: _____

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11. Patient Consent and Authorization to Use/Disclose Health Information

I hereby authorize my healthcare professionals, my health insurance company, and my pharmacy to disclose my protected health information (PHI) including, but not limited to, my name, address, telephone number, medical records, health insurance coverage, and financial information to SyndAccess and its agents. I understand that once my health information has been disclosed to SyndAccess, it could be subject to redisclosure and that federal and state privacy laws may no longer protect the information.

I hereby authorize SyndAccess and its agents (1) to contact me, or the person legally authorized to sign on my behalf, by phone, text, email, or mail for the purposes of the program (2) to contact my insurance company on my behalf to verify my coverage for Revuforj® (revumenib), (3) to determine my eligibility for enrollment in the Revuforj® (revumenib) Copay Program and for enrollment in the Patient Assistance Program (PAP), Quick Start or Bridge Programs including verification of my financial information, (4) to provide me with information regarding any independent third-party foundation or alternate sources of funding or coverage that may be available to provide assistance with out-of-pocket expenses, (5) to coordinate my treatment with my healthcare professionals and specialty pharmacy, and (6) to send me materials regarding products, services, or other information that may be of interest to me.

I understand that if my insurance or financial status changes, I need to notify SyndAccess of any changes and that this may affect my participation in the Patient Assistance Program. Eligibility for the program will need to be renewed every calendar year, and may change if the patient no longer meets the requirements as stated.

I understand that patients with insurance plans or employers participating in an alternate funding program (also sometimes referred to as patient advocacy programs, among other names) requiring them to apply to a manufacturer's patient assistance program or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of relevant Syndax products, or that otherwise denies, restricts, eliminates, delays, alters, or withholds any insurance benefits or coverage contingent upon application to, or denial of eligibility for, specialty drug prescription coverage through the alternate funding program are not eligible for the Syndax Patient Assistance Program.

I understand that if I refuse to sign this authorization, it will not affect my treatment by my healthcare professionals, or my payment, enrollment, or eligibility for benefits from my health plan. However, if I refuse to sign this authorization, or sign and then withdraw my authorization at a later date, it may affect my ability to participate in SyndAccess. If I do not withdraw authorization, it will remain valid for 3 years (or at such lesser time as state law may require). I understand I am entitled to receive a copy of this authorization.

I understand that I may revoke (cancel) this authorization at any time in writing by mailing a letter to: SyndAccess Program, 150 Hilton Dr, Jefferson, IN 47130. My withdrawal goes into effect once received by the program. Cancelling this authorization will not affect the ability of SyndAccess to use and disclose PHI that it has received prior to receipt of the cancellation of my authorization. I also understand that by withdrawing my authorization, I may not receive or may stop receiving the services provided under this program.

SyndAccess reserves the right to modify, change, or remove eligibility criteria, program offerings, or available support at any time for any or no reason.

Patient Name (print): _____ Patient or Legal Representative Signature: _____

Date: _____

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12. Patient Financial Consent (only required if applying for Patient Assistance Program)

Gross Annual Household Income: _____ Number of Members in Household: _____

Source(s) of Income (check all that apply): ○ Job ○ Family ○ Public Assistance ○ SSI/SSD ○ Other _____

SyndAccess may require additional documentation to assess program eligibility (i.e., 1040 Tax Return, SSA-1099, W-2 Form)

Patient Acknowledgment

I understand that completing this form does not ensure my enrollment in the Patient Assistance Program ("PAP").

By signing below, I certify that the information provided is complete and accurate. I authorize Syndax and its service providers administering the PAP (collectively, "SyndAccess") to obtain financial information from my credit profile or other financial information electronically. I understand that SyndAccess needs, and I agree that SyndAccess may use, this financial information to determine my financial eligibility to participate in SyndAccess's Patient Assistance Program. I also agree to provide additional financial documentation in a timely manner, if so requested.

Patient Name (print): _____ Patient or Legal Representative Signature: _____

Date: _____

Please see Full Prescribing Information, including BOXED WARNING.