# Prescription 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. Rubraca Connections can help determine eligibility and coordinate the financial assistance process, and answer any questions you may have.

| | IOD PHARMACY | SPECIALTY PHARMACY |
|---|---|---|
| 1 | Submit a Rubraca prescription to your IOD pharmacy. 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. | Fill out entire Rubraca Prescription Form. |
| 2 | If your patient only requires financial support, fill out all sections of the form except G and **fax** it to Rubraca Connections at **1-844-779-7717** or submit online at **RubracaConnections.com**. | Fax the completed form to a network specialty pharmacy of your choice. If you would like assistance identifying a network pharmacy accepted by your patient's insurance, contact Rubraca Connections.<br>**Avella** (Fax: 877-546-5780)<br>**Biologics** (Fax: 800-823-4506)<br>**CVS Specialty** (Fax: 855-296-0210)<br>**US Bioservices** (Fax: 888-899-0067)<br>The specialty pharmacy will coordinate with Rubraca Connections if financial support is required. |

Rubraca® (rucaparib) tablets | connections

**If you need further financial or reimbursement support, contact Rubraca Connections:**

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

Visit **RubracaConnections.com**

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## PATIENT PAGE

### 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 _____

Health plan policy # _____ Group # _____ ◯ No insurance

Insurance company phone _____ Fax _____

Primary card holder _____ Primary card holder date of birth _____

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

Prescription benefit insurance _____

Prescription benefit insurance phone _____ Rx BIN # _____

Primary card holder _____ Primary card holder date of birth _____

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

### C PATIENT PROGRAM CONSENT – *All patients must read the following and provide a signature to use Rubraca Connections.*

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.*

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## HEALTHCARE PROVIDER PAGE

### D 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 _____

### E DIAGNOSIS INFORMATION

ICD-10 _____ Diagnosis _____

Patient is *BRCA*+ ◯ Yes ◯ No ◯ Other _____

### F 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*

◉ IOD pharmacy (name) _____ Phone _____

Preferred shipment location ◯ Prescriber office ◯ Patient home

### G PRESCRIPTION – *Complete the Rubraca prescription in the space provided below or attach separately.*

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

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.

### H COVERAGE LINK PRESCRIPTION – *Complete for patients who experience an insurance delay of 5 business days or more.*

The Rubraca Connections Coverage Link program provides the first 15 days of treatment at no cost, up to 5 refills, to patients experiencing insurance delays in their Rubraca coverage. Patients must meet diagnosis and coverage criteria to be eligible. Visit www.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 (5 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.

# Checklist

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## Rubraca Prescription Form checklist

☐ Required fields populated

**IOD pharmacy**

- ✓ Entire form complete
  *If submitting form as prescription*
- ✓ All sections complete except section G
  *If only Rubraca Connections financial assistance is needed*

**Specialty pharmacy**

- ✓ Entire form complete

☐ Required signatures obtained

- ✓ From patient
  *For consent to enroll in Rubraca Connections*
- ✓ From healthcare provider
  *If using form as a prescription or if enrolling patient in Rubraca Connections Coverage Link*

☐ Pharmacy benefit card attached

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

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