SHORLA SOLUTIONS

QUICK START PROGRAM

Print and fax completed form to:

Shorla Solutions:
1 (866) 779-6296

Program Inquiries:
1 (844) 9SHORLA (974-6752) Option #5

QUICK START PROGRAM INFORMATION & PRESCRIPTION FORM

As part of our commitment to patients and health care providers, the Shorla Solutions Quick Start Program provides a 30-day supply of IMKELDI (imatinib) Oral Solution for eligible*, NEW patients when the prior authorization has not been approved by the insurance company within 3 business days.

SECTION 1: THE PATIENT INFORMATION

Patient's First Name: _____ Patient's Last Name: _____

Address Line 1: _____

Address Line 2 (Apartment/Unit Number): _____

City: _____ State: _____ Zip: _____

Date of Birth: MM/DD/YYYY _____ Gender: ☐ Male ☐ Female

Email: _____

Mobile Phone: _____ Home Phone: _____

1. Are you a resident in the United States? ☐ Yes ☐ No
2. Are you a NEW patient to IMKELDI (imatinib) Oral Solution? ☐ Yes ☐ No
3. Do you have insurance coverage for prescription medications? ☐ Yes ☐ No
4. Do you have a delay in obtaining prior authorization from your insurance that exceeds 3 business days? ☐ Yes ☐ No

SECTION 2: INSURANCE INFORMATION *Please attach copies (front and back) of all insurance cards

Primary Medical Insurance: _____ Primary Rx Insurance: _____

Insurance Phone: _____ Rx Insurance Phone: _____

Policy ID : _____ Policy ID: _____

Patient's First Name: _____ Group #: _____

Policy Holder First/Last Name: _____ RxBin #: _____

Relationship to Patient: _____ RxPCN #: _____

SECTION 3: PRESCRIBER INFORMATION

Prescriber's First Name: _____ Prescriber's Last Name: _____

Prescriber NPI: _____ Group Tax ID# _____

Office Contact Name: _____ Office Contact Email: _____

Phone: _____ Fax: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

Specialty: _____

*Patient eligibility limited to a single Quick Start fill as a new patient start when a prior authorization has not been approved by the insurance company within 3 business days. By definition, an unresolved prior authorization could be either an initial prior authorization or a prior authorization denial that has been submitted for an appeal and insurance approval is still pending after 3 business days. Patient eligibility may be re-evaluated under certain extenuating circumstances.

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Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: MM/DD/YYYY _____

SECTION 4: PRESCRIPTION INFORMATION

QUICK START PROGRAM

Medication Name	Strength	Directions	Quantity	Refills
Imkeldi (imatinib) Oral Solution	80mg/mL	Take _____mL(s) by mouth _____ time(s) per day	_____ (1 bottle is 140 mL)	☐ 1 Year ☐ Other:_____

Allergies: _____ ICD 10 Code: _____

Diagnosis: _____

Patient's Current Medication(s): _____

I acknowledge by signing this form that I have obtained authorization to release the patient's personal health information and the information on this form and any prescription to Shorla Oncology (together with its affiliates) for the purpose of providing product support services. I am certifying treatment with IMKELDI indicated above is medically necessary for this patient. I understand that this medication is being provided for free to the named patient by Shorla Oncology and agree that neither I or the patient will bill an insurer or any government healthcare program for the cost of this medication. This program is only available to eligible* new patients who have insurance, in which an insurance prior authorization has not been reached within 3 business days. I certify that the information on this form is complete and accurate to the best of my knowledge. I certify that I will comply with my state-specific prescription requirements, such as e-prescribing, state-specific prescription forms and fax language.

Prescriber Signature: ORIGINAL SIGNATURE _____ **Dispensed As Written** ☐ **Date:** MM/DD/YYYY _____

SECTION 5: PATIENT AUTHORIZATION AND CONSENT

Shorla Oncology Quick Start Program provides the first 30 days of drug at no cost to new patients who have a delay of 3 business days or more in obtaining prior authorization to receive IMKELDI (imatinib) Oral Solution and meet all eligible* requirements of the IMKELDI Quick Start Program. I acknowledge that no free product received as part of this program may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded or distributed for sale. I understand that this program is not meant to induce a physician to use or prescribe IMKELDI. Shorla Solutions reserves the right to review patient profiles, grant requests based on patient need and to change program guidelines or terminate the program at any time without notification.

By signing this program authorization and consent, I authorize Shorla Oncology and its Agents to use and share with my healthcare providers, and insurers information about me for the purpose of coordinating my enrollment and participation in the Shorla Oncology Quick Start Program. My information includes my prescription-related health records, information about my health care plan benefits, and any other information to verify treatment and eligibility for this program. I also authorize Shorla Oncology and its Agents to contact me by mail, phone or email in connection with the Shorla Oncology Quick Start program.

Printed Patient First/Last Name: _____

Patient Signature: _____ **Date:** MM/DD/YYYY _____

An incomplete form will result in a processing delay | Program Inquiries: 1 (844) 9SHORLA (974-6752) Option #5

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