Patient Authorization for Enrolling in IncyteCARES

IncyteCARES is a program that helps patients with access and support for their prescribed Incyte medicine. To complete your program enrollment, please complete and sign this form.

All fields are required unless noted.

I authorize my Healthcare Professional (eg, physicians, pharmacies) and my insurance company to disclose personal health information about me, including information related to my medical condition and treatment, my health insurance coverage, and my address, email address, and telephone number (collectively, my "PHI") to Incyte, its agents, and the IncyteCARES Program (collectively, "Incyte") so that Incyte may use the information for purposes of: (i) assisting in my enrollment in IncyteCARES; (ii) assessing my eligibility for savings program or free drug or referring me to other programs or sources of funding and financial support; (iii) coordinating delivery of my prescribed Incyte medicine to me or my Healthcare Professional; (iv) providing education, information on Incyte products and services, and ongoing support services to me; (v) gathering feedback on my therapy and/or disease state; (vi) contacting me by mail, email, phone, or fax for any of the above purposes; and (vii) creating information that does not identify me personally for use for other legitimate purposes. I understand that my pharmacy providers may receive remuneration for making such disclosures. I also authorize my Healthcare Professionals and my insurance company to use my PHI to communicate with me about Incyte products and services and I understand that they may receive remuneration for making such communications. I understand that, once disclosed pursuant to this authorization, my PHI may no longer be protected under federal or state law and could be disclosed by Incyte to others, but I understand that Incyte will make reasonable efforts to keep it private and to disclose it only for the purposes set forth in this authorization.

I understand that I do not have to sign this authorization to obtain healthcare treatment or benefits; however, in order to receive the services and communications described above, I must sign the authorization. I understand that I may cancel my

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authorization at any time by contacting IncyteCARES at 1-855-452-5234 or by mail at PO Box 221798, Charlotte, NC 28222-1798. My cancellation of this authorization will be effective when my Healthcare Professionals and insurance companies are notified of its receipt by Incyte, but will not apply to PHI already used or disclosed in reliance upon this authorization.

I understand that I have a right to receive a copy of this authorization.

This authorization expires one year after the date below unless I cancel it before then.

Patient's Full Name _____

Address _____

City _____ State ____ ZIP Code _____

Phone Number _____ Date of Birth ____ /____ /____

Signature _____ Date ____ /____ /____

Doctor's Name *(Optional)* _____

Patient's Legal Representative *(Optional)* _____

Signature _____ Date ____ /____ /____

Relationship with patient _____

To Submit Your Signed Form

Fax to: 1-855-525-7207

or

Mail to: IncyteCARES Patient Assistance Program
PO Box 221798
Charlotte, NC 28222-1798