

The information requested below is required for you to receive the Services (defined below). These Services are provided free of charge as a support resource to you. Please carefully read and complete this form. If you have any questions or need assistance in completing this form, please contact the phone number listed above.

ENROLL TO RECEIVE SERVICES (REQUIRED. CHECK THE BOX BELOW)

- I agree to enroll in the Services, as defined in the Health Information Authorization, below. I agree that Puma Biotechnology and its representatives and service providers may collect, use, and disclose my health data and my personal information as necessary to facilitate my participation in the Services, which includes receiving educational and promotional materials about the Services, NERLYNX® (neratinib) tablets, and other Puma Biotechnology products and services. My health data and personal information may otherwise be collected, used, and disclosed as described in the Health Information Authorization, below, and Puma's privacy policy, available here: <https://www.pumabiotechnology.com/privacy-policy.html>. I also agree that Puma may contact me at the contact information I have provided on this form, including by calling, texting, or emailing, for purposes related to participation in the Services.

HEALTHCARE PROVIDER INFORMATION

Name _____

Address _____

Phone number _____

PATIENT INFORMATION

Name (First & Last) _____ Email Address _____

Address _____ DOB (MM/DD/YYYY) _____

City _____ Cell Phone Number _____

State _____ Zip Code _____ Alternate Phone Number _____

Gender Male Female Can Text? Yes No Work Home

Preferred language _____

COMMUNICATION CONSENT (REQUIRED. CHECK THE BOX BELOW)

- I agree to receive phone calls and texts from Puma Biotechnology and its representatives and service providers at the above phone number to facilitate my participation in the Services and send me educational and promotional materials about NERLYNX® (neratinib) tablets and other Puma Biotechnology products and services. I understand that calls and texts may be sent by autodialer, SMS, and prerecorded, artificial voice, or AI-generated messages and that my consent to receive promotional messages via these technologies is not required to receive products or services. I may opt out at any time by texting STOP to any text or contacting Puma Biotechnology at info@pumabiotechnology.com. Message and data rates may apply.

HEALTH INFORMATION AUTHORIZATION (REQUIRED)

I hereby authorize my healthcare providers, my health insurance company, and my pharmacy and their respective representatives and service providers (collectively “My Providers”) to disclose my protected health information (PHI) including, my name, address, telephone numbers, medical records (including my medical conditions, treatments, and medications), health insurance coverage, and financial information to each other and Puma Biotechnology and its representatives and service providers (collectively “Puma”) to facilitate my participation in the Puma Patient Lynx Services (“Services”), which includes:

- Contacting my insurance company on my behalf to verify my coverage or assisting with other coverage related issues including, prior authorization or appeals support for NERLYNX® (neratinib) tablets
- Determining my eligibility for, and enrolling me in the Commercial Copay/Coinsurance Assistance Program
- Determining my eligibility for, and enrolling me in QuickStart or Bridge Program to connect me with additional coverage options, as needed
- Determining my eligibility for, and enrolling me in the Puma Patient Lynx Patient Assistance Program (PAP), including verifying my financial information and accessing my credit information derived from public and other sources, including information from a consumer reporting agency (credit bureau)
- Identifying third-party resources for financial assistance or alternate sources of funding or coverage that may be available to provide assistance with out-of-pocket expenses
- Supporting or coordinating my treatment with my Providers
- Sending me educational and product information about the Puma Patient Lynx program, or other information that may be of interest to me.

I understand that Puma may offer ongoing or additional patient support programs through Puma Patient Lynx and may contact me in the future regarding the program, its services and actual or potential offerings.

I understand that the information provided by me, my authorized legal representative, and My Providers may be used to send marketing materials to me. I further understand that my pharmacy(ies) may receive remuneration (payment) from Puma in exchange for providing me with certain Services based on my enrollment and sending me Services- or product-related information.

Once my information has been disclosed to Puma, I understand that certain state or federal privacy laws may no longer protect the information and the information may be subject to re-disclosure. However, I understand that Puma agrees to protect my information by using and disclosing it only for purposes authorized in this authorization or as required by law. I understand that refusing to sign this authorization will have no impact on the treatment I receive from my healthcare provider(s), nor will it affect my payment for treatment, or enrollment or eligibility for insurance benefits that I am otherwise entitled to.

I understand that this authorization is voluntary. However, if I refuse to sign, or revoke my authorization, Puma will not be able to provide the Services, as the information used and disclosed described in this authorization is necessary to receive the Services.

I understand that I may request a copy of this authorization and revoke this authorization at any time by mailing a letter to Puma Patient Lynx at: Puma Patient Lynx, PO Box 5490, Louisville KY 40255.

This authorization expires five (5) years from the day that I sign it as indicated by the date next to my signature, unless otherwise revoked as set forth above or unless a shorter period is mandated by state law. I understand that revoking this authorization will not apply to any information already used or disclosed in reliance on my authorization. Cancellation of this authorization will be valid when received by Puma. I certify that I have read and understand this Authorization. I understand that I am entitled to receive a signed copy of this form and can do so by calling Puma Patient Lynx at 855-816-5421 or by mailing a request to the address above.

I have read and agree to the Health Information Authorization as described in this form.

Print Patient or Patient Legal
Representative Name

Signature of Patient or Patient
Legal Representative

Date (MM/DD/YYYY)

If signed by Patient Legal Representative, please provide your relationship to the patient and you must also indicate below the authority to act on behalf of the patient.

- Relationship to Patient _____
- Power of Attorney, including authority to make healthcare decisions
- Court Order
- Parent or Guardian
- Other (please describe) _____



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