Enrollment Form

Prosigna Patient Support

Fax: 877-515-8968
Phone: 855-4PROSIGNA

prosigna® patient support

www.prosigna.com

PATIENT INFORMATION

Patient name: _____

Patient DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home phone: _____

Work/cell phone: _____

Annual household income: _____

Number of people in your household:

U.S. Resident: ☐ Yes ☐ No

HEALTH INSURANCE INFORMATION

(you may also attach copies of insurance cards)

Primary insurance name: _____

Policy/Group #: _____

Phone: _____

Policy holder's name: _____

DOB: _____ Relationship: _____

Payer/provider ID #: _____

Secondary insurance name: _____

Policy/Group #: _____

Phone: _____

Policy holder's name: _____

DOB: _____ Relationship: _____

Payer/provider ID #: _____

Tertiary insurance name: _____

Policy/Group #: _____

Phone: _____

Policy holder's name: _____

DOB: _____ Relationship: _____

Payer/provider ID #: _____

PATIENT MEDICAL INFORMATION

Please provide the ICD9 diagnostic code: _____

Indicate patient's therapy (check all that apply):

☐ None ☐ Hormone therapy ☐ Radiation
☐ Surgery ☐ Other _____

Has treatment started?

☐ No ☐ Yes — Start date: _____

Previous treatment:

☐ None ☐ Hormone therapy ☐ Radiation
☐ Surgery ☐ Other _____

Clinical TNM stage:

☐ 0 ☐ I* ☐ IIA* ☐ IIB* ☐ IIIA
☐ IIIB ☐ IIIC ☐ IV

HER2 positive? ☐ Yes ☐ No*

ER/PR status? ☐ Positive* ☐ Negative

Nodal status? ☐ Positive* ☐ Negative*

Menopausal status: ☐ Pre ☐ Peri ☐ Post*

PHYSICIAN/PROVIDER INFORMATION

Physician name: _____

State Lic #: _____ DEA #: _____

PTAN: _____

Name of group/hospital: _____

Tax ID #: _____ NPI: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Preferred laboratory for Prosigna testing: _____

Address (if known): _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

INSTRUCTIONS FOR USE

The enrollment form should be completed and submitted for all insured and uninsured patients who may need assistance.

Insurance information: Please provide patient's insurance information

Patient medical information: The diagnosis and treatment information must be provided

Preferred laboratory information: Indicate the name of the preferred laboratory that will provide Prosigna Testing

Please attach the following:

- A front and back copy of the patient's insurance card
- If your claim or prior authorization submission has been denied, include copies of the claims or prior authorization requests and denials of such claims and appeals

Income verification documents: Following initial review of this application, the patient may be requested to submit copies of the most recent federal tax returns for income earners in the patient's household

PROVIDER'S CERTIFICATION

By signing below, I certify that:
(a) the Prosigna Assay is medically necessary; **(b)** I have received any necessary authorization to release the information in this form and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA] and implementing regulations) to the Nanostring Technologies, Inc. Prosigna Patient Support Program (the "Program") and contractors administering the Program for the purpose of seeking reimbursement and assisting in initiating the evaluation of the patient's eligibility for the Program; **(c)** I have not received, and will not in the future seek, any payment from the patient or any third party payor for the free Prosigna test that is being provided for use for this patient or being replaced under the Program; and **(d)** I appoint the Program to convey on my behalf to the laboratory chosen by the above-named patient the prescription described herein.

I agree to comply with the program guidelines as established by NanoString and understand that NanoString, at its sole and absolute discretion, reserves the right to modify or discontinue the Program at any time and to verify the accuracy of the information submitted.

PROVIDER'S SIGNATURE

(Signature required; this form cannot be processed without an original or stamped signature.)

Last name: _____ First name: _____ Date: _____

Signature: _____

PATIENT'S CERTIFICATION

By signing below, I certify that the information about me provided in this form is true and correct to the best of my knowledge. I understand that the Prosigna Patient Support Program (the "Program") includes programs and services, some of which are available only to patients who do not have insurance coverage for Prosigna. I understand that if I do not have insurance coverage I may need to enroll in the Patient Assistance or Product Replacement Programs and may be required to submit income verification documents to the Program for my household for purposes of determining my eligibility for the Program or to verbally confirm by phone to a Program representative the income information provided in this application.

PATIENT'S SIGNATURE

(Signature required; this form cannot be processed without an original signature.)

Last name: _____ First name: _____ Date: _____

Signature: _____

The Prosigna Breast Cancer Prognostic Gene Signature Assay Intended Use*

In the U.S., the Prosigna Assay is indicated in female breast cancer patients who have undergone surgery in conjunction with loco-regional treatment consistent with standard of care, either as:

(1) a prognostic indicator for distant recurrence-free survival at 10 years in postmenopausal women with HR+, lymph node-negative, Stage I or II breast cancer to be treated with adjuvant endocrine therapy alone, when used in conjunction with other clinicopathological factors or **(2)** a prognostic indicator for distant recurrence-free survival at 10 years in postmenopausal women with HR+, lymph node-positive (1-3 nodes), Stage II breast cancer to be treated with adjuvant endocrine therapy alone, when used in conjunction with other clinicopathological factors. The device is not intended for patients with 4 or more positive nodes. Special conditions for use: The Prosigna Assay is not intended for diagnosis, to predict or detect response to therapy, or to help select the optimal therapy for patients.