MIRATI&Me

Program Enrollment Form

KRAZATI® (adagrasib) 200 mg TABLETS

What is required to receive support?

Please see the required information below for each requested type of support. These requirements apply only for support through the Mirati & Me Patient Support Program and are not intended to limit any treatment, payment, or benefit activities with your pharmacy or other healthcare providers.

Support Requested* (check all that apply)

☐ **Benefits Verification**
- Complete sections **1 2 4 5 6**
- Fax copies of the health insurance and prescription drug coverage cards

☐ **Co-Pay Assistance**
- Complete sections **1 2 4 5 6 7**
- Prescriber signature required

☐ **Free Product Assistance**
- Complete sections **1 2 3 4 5 7 8**
- Prescriber and patient signatures required

☐ **Quick Start/Bridge Supply**
- Complete sections **1 2 4 5 6 7 8**
- Prescriber and patient signatures required

☐ **Patient/Caregiver Support**
- Complete sections **1 2 4 5 6**

For any questions, call 1-844-647-2842

*Certain eligibility criteria and restrictions apply.

SECTION 1: Patient Information

Patient First Name _____ Patient Last Name _____

Date of Birth _____

Gender: ☐ Male ☐ Female

Street Address _____

City _____ State _____ ZIP Code _____

Email Address _____

Primary Phone _____
☐ Mobile ☐ Home ☐ Work

Alternate Phone _____
☐ Mobile ☐ Home ☐ Work

Consent to leave voice messages at primary or alternative contact: ☐ Yes ☐ No

Consent to receive text messages†: ☐ Yes (Mobile number is required) ☐ No

†Message and data rates may apply.

Diagnosis

Diagnosis Code (ICD-10 Code) _____

Results of KRAS G12C Mutation Testing
☐ Positive ☐ Negative ☐ Not Performed ☐ Pending Results

Type of KRAS Test Used
☐ NGS Test ☐ Single Gene Test

Concurrent Therapy (check all that apply)
☐ Chemotherapy ☐ Immunotherapy ☐ Radiation Therapy
☐ Targeted Therapy ☐ Other

Prior Therapy (check all that apply)
☐ Chemotherapy ☐ Immunotherapy ☐ Radiation Therapy
☐ Targeted Therapy ☐ Other

SECTION 2: Insurance Information

Do you have health insurance?

☐ Yes ☐ No

If you answered Yes to having health insurance, **please provide the following information along with a copy of the front and back of your insurance card**. If you answered No, you attest you are uninsured and may skip this section.

Do you have prescription insurance?

☐ Yes ☐ No

If you answered Yes to having prescription insurance, **please provide the following information along with a copy of the front and back of your insurance card**. If you answered No, you may skip this section.

Prescription Insurance:

Insurance Name | Insurance Phone

Rx ID # | Rx Group #

Rx PCN | Rx BIN #

Primary Insurance:

Insurance Name | Policy ID Number

Insurance Phone | Group Number

Cardholder Name | Cardholder Date of Birth

Patient's relationship to cardholder: ☐ Self ☐ Spouse ☐ Other

Secondary Insurance:

Insurance Name | Policy ID Number

Insurance Phone | Group Number

Cardholder Name | Cardholder Date of Birth

Patient's relationship to cardholder: ☐ Self ☐ Spouse ☐ Other

SECTION 3: Financial Information (needed if requesting Free Product Assistance)

Total Annual Household Gross Income: _____

Total Number of People Within Household (including applicant): _____

US Resident (including US Territories): ☐ Yes ☐ No

SECTION 4: Prescriber Information

Prescriber First Name | Prescriber Last Name

Site/Facility Name | Phone | Fax

Prescriber NPI # | DEA # | State License #

Office Contact Name | Title | Office Contact Phone

Office Contact Fax | Email

Office Street Address | City | State | ZIP Code

SECTION 5: Prescription

Patient First Name | Patient Last Name | Date of Birth

☐ KRAZATI® (adagrasib) 200 mg Quantity _____ Refills _____

Directions

☐ Dispense as written

☐ Quick Start Rx (new to therapy):
KRAZATI® (adagrasib) 200 mg (max. 15-day supply) Quantity _____

■ Bridge Rx (currently on therapy):
KRAZATI® (adagrasib) 200 mg (max. 30-day supply) Quantity _____

Directions

SECTION 6: Pharmacy Information

☐ Onco360 ☐ Biologics ☐ In-office Dispensing Pharmacy

Pharmacy Name | Pharmacy NPI # | Phone

Unless the patient requests otherwise or the patient's insurance provider requires the patient to use a specific pharmacy, the prescription will be directed to the authorized pharmacy providing the lowest cost sharing for the patient under the patient's insurance plan.

Prescriber Signature | Date

No stamp signatures allowed.

SECTION 7: Prescriber Authorization*

By signing below, I certify that I am the physician, or a designated agent of the healthcare provider/practice, who has prescribed KRAZATI® (adagrasib) (the "Product"), which is medically necessary for this patient and the information provided on this form is accurate to the best of my knowledge. I have obtained the patient's authorization as required by the Health Insurance Portability and Accountability Act ("HIPAA") to use and disclose the patient's personally identifiable health information ("PHI") on this form to the patient's other healthcare providers (including pharmacies and Mirati), health insurers, and other designees that are involved in the patient's treatment for the purposes of preliminary insurance verification and to assess the patient's eligibility for participation in Mirati & Me. I agree that Mirati may contact me for additional information relating to Mirati & Me or the patient's therapy. I understand that any Product provided at no charge to the patient is provided on a complimentary basis. I will not submit or cause to be submitted any claims for payment of such Product to any third-party payer, including, without limitation, a federal healthcare program. If I am or become in possession of such Product, I will not resell or attempt to resell the Product. I agree to comply with Mirati & Me guidelines and understand that Mirati reserves the right to modify or discontinue Mirati & Me at any time.

Prescriber Signature _____ Date _____

Designated Agent Name _____ Title _____ Date _____

No stamp signatures allowed.

*Prescriber shall comply with applicable state prescribing requirements, such as e-prescribing, state-specific prescription form(s), fax language, etc. Noncompliance with applicable state prescribing requirements could result in additional communications from Mirati & Me or other contractors to the prescriber.

SECTION 8: Patient Authorization and Consent*

Authorization to enroll in the Mirati & Me Patient Support Program

I certify that the information provided is accurate to the best of my knowledge. All plans and programs through which I obtain healthcare coverage are listed above. I further certify that I am not insured for (or am rendered uninsured through the payer denial of KRAZATI® (adagrasib) (the "Product") and that I am a resident of the United States. Completion of this form and the provision of requested documentation does not guarantee that I will be approved to participate in Mirati & Me ("the Program"). Mirati & Me reserves the right to make an independent determination of my financial need. If I am eligible to participate in the Program, there is no purchase requirement associated with such assistance. The cost of the Product provided under the Program will not count toward any Medicare true out-of-pocket ("TrOOP") costs. Mirati reserves the right at any time, and without notice, to modify or discontinue Mirati & Me and any assistance provided to me. I will not submit or cause to be submitted any claims for payment or reimbursement from any third-party payer, including any federal healthcare program, or any private insurance plan, or from any other entity for a free supply of the Product, regardless of whether a payer subsequently determines that it will cover such supply of the Product. I will not sell, trade, or distribute or otherwise transfer the Product supplied under the Program. I agree to notify Mirati & Me if I obtain coverage through another source, no longer meet the income criteria for the Program, or if I find any errors in this application form. If I am approved, as required by my insurance or other benefit provider, I will notify such provider of my receipt of any free Product received through the Program. I understand that I must reapply for the Program annually and there is no guarantee I will qualify at this time or in future periods. This Authorization will expire in one (1) year from the date this Authorization is signed below, unless a shorter period is required by the law of my state of residence, or Authorization is revoked.

SECTION 8: Patient Authorization and Consent* (cont'd)

Consent to disclose personal health information

I authorize my healthcare providers and staff (e.g., physicians, pharmacies) and my insurance company to disclose in electronic or other form, personal health information to Mirati, its affiliates, agents, contractors and representatives, and Mirati & Me for purposes of providing education, information on Mirati products and support services to me related to the therapy, gathering feedback on my therapy and/or disease state, contacting me for any of the above purposes, creating information that does not identify me personally for use for other legitimate purposes. I understand that my healthcare providers, pharmacy, insurance company and Mirati contractors may receive remuneration from Mirati for processing my PHI for services provided through Mirati & Me, including prescription assistance, financial assistance and/or for providing me with access to the support services described in this form. 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 Mirati to others, but I also understand that Mirati will make reasonable efforts to keep my PHI private and to disclose it only for purposes set forth in this authorization. I understand that I may cancel this Authorization at any time by sending a written request with my name and address to Mirati at PO Box 5490, Louisville, KY 40255 or support@miratiandme.com. Once the cancellation is processed, the applicable parties may no longer share my PHI. Cancellation will not affect prior uses or disclosures of PHI.

Consent to credit check (for Free Product Assistance Only)

I also understand that Mirati & Me may request documentation from me, my employer, my healthcare provider, or my insurance company to verify my financial information. Mirati may obtain information from my credit profile from TransUnion for the purpose of verifying my income eligibility for Mirati & Me. I understand that I am providing "written instructions" to Mirati, under the Fair Credit Reporting Act ("FCRA"), authorizing Mirati to obtain information from my credit profile or other information from TransUnion solely for the purpose of determining financial qualifications for Mirati & Me and on an ongoing basis as needed for the duration of my participation in Mirati & Me. I understand that I am entitled to a copy of this Authorization upon request.

Patient Signature _____ Date _____

Legal Representative Signature _____

Legal Representative Printed _____ Date _____

*By signing on behalf of the patient, as representative or guardian, I attest that I am legally able to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient may be requested such as power of attorney or legal court order.

Please fax completed forms to 1-844-647-2844

MIRATI THERAPEUTICS