THE MYFEMBREE® SUPPORT PROGRAM

PATIENT START FORM

The Myfembree Support Program offers eligible patients:

Reimbursement support

Financial assistance

Patient Assistance Program

Educational support

Use the **PATIENT START FORM** to request:

Reimbursement support (eg, benefits investigation, prior authorization, or appeal assistance)

AND

Financial assistance evaluation

SUBMISSION INSTRUCTIONS FOR COMPLETING THIS START FORM

Before submitting the Start Form, it is important to:

1. Complete pages 1–4 of this form
2. Confirm signatures from **Patient** and **Prescriber** are provided; confirm all fields are completed
3. **Fax** completed form to **1-877-328-0138**

Quick Tips:

» Patient signatures **are required** to begin enrollment

» **Remind patients** they may receive a call from the Myfembree Support Program (1-833-693-3627). The Myfembree Support Program will contact patients who receive free medication to schedule shipment

Patient Consent for Enrollment and Sharing Protected Health Information

Here are the **three ways** that patients can provide their consent:

Read the consent information on pages 3 and 5. **Then, sign on page 3.**

OR

Text e-consent to 833-MYFEMBREE (833-693-3627) and follow prompts to complete patient consent.

OR

Scan or click to provide your e-consent and begin enrollment today.*

*Enrollment in the Myfembree Support Program will occur only after the healthcare provider has prescribed Myfembree and completed the Myfembree Support Program Enrollment Form.

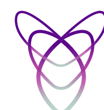
Fax the completed Patient Start Form with all required signatures to the Myfembree Support Program at **1-877-328-0138**

Myfembree Support Program
2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560

Hours of operation:
Monday–Friday, 8 AM–8 PM ET

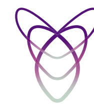
www.Myfembreehcp.com

Phone: 1-833-MYFEMBREE (1-833-693-3627)


Myfembree®
(relugolix, estradiol, and norethindrone acetate) tablets
40 mg, 1 mg, 0.5 mg

Please see full Prescribing Information, including BOXED WARNING, and Patient Information.

THE MYFEMBREE® SUPPORT PROGRAM
PATIENT INFORMATION AND INSURANCE



Myfembree®
(relugolix, estradiol, and norethindrone acetate) tablets
40 mg, 1 mg, 0.5 mg

- Complete the form accurately and include all necessary information
- **Ensure signatures are present** for the patient (if consent given) and prescriber (required)
  - Patient e-consent is also available at www.Myfembreehcp.com
- Fax the completed form to **1-877-328-0138**

1 Reimbursement Services*

☐ Benefits Investigation ☐ Prior Authorization Assistance ☐ Appeal Assistance

Will Prescriber communicate Reimbursement Services results to Patient?

☐ **Yes, Prescriber has Patient's permission and will communicate results to Patient.**

(If no preference indicated, the Myfembree Support Program will provide results to both Prescriber and Patient.)

Financial Assistance*

Evaluate Patient for:

☐ Copay Assistance Program (for commercially insured patients)†

☐ Myovant Sciences Patient Assistance Program†

The Myfembree Support Program will complete a benefits investigation for the Patient Assistance Program unless your office submits a benefits investigation completed within the last 30 days.

*Full reimbursement services and financial assistance are provided, if no selection is made.
†For full terms and conditions, please see page 6.

2 Patient Details

☐ Patient's demographics printout from the electronic medical record (EMR) is included. See attachment.

Last Name: First Name: Date of Birth:

Street: City: State: ZIP:

Preferred Language: Email:

Home Phone: Cell Phone: Work Phone:

Okay to contact patient? ☐ Yes ☐ No Leave Message? ☐ Yes ☐ No

Alternate Contact's Name‡: Alternate Contact's Phone‡:

‡If applicable.

3 Insurance Details *(Fax/include a photocopy of the patient's insurance card along with this enrollment form* ***OR*** *complete the fields below.)*

☐ Patient does not have insurance. ☐ I have supplied front and back copies of the insurance card.

Beneficiary/Subscriber Name:

Medical Insurance: Phone:

Policy ID #: Group #:

Pharmacy/Prescription Insurance: Phone:

Policy ID #: Rx Group #: Rx Bin #:

PATIENT CONSENT

4 Patient Consent and Signatures (*Both patient signatures are required for enrollment.*)

Authorization to Share and Use Protected Health Information

I have read and understand the PATIENT AUTHORIZATION TO SHARE AND USE PROTECTED HEALTH INFORMATION on page 5 of this form and I am granting such authorization by signing below.

Optional Promotional Communications

☐ By checking this box and signing my name, I additionally grant my authorization for Myovant Sciences to use my PHI to communicate with me about the benefits of Myovant Sciences products and services, as described in the PATIENT AUTHORIZATION TO SHARE AND USE PROTECTED HEALTH INFORMATION on page 5 of this form. I specifically consent to receive autodialed marketing texts from Myovant Sciences and its service providers regarding Myovant Sciences products and services at the cell phone number provided on page 2 of this form. I understand that providing this consent is not required or a condition of purchasing any products or services. I understand that I can opt out at any time.

Patient/Authorized Representative Signature:

Date:

Printed Name of Authorized Representative:

Authorized Representative's Relationship to Patient:

Other Consents Related to Participation in the Myfembree Support Program

Credit Check Consent and PAP Terms and Conditions Consent (*Required for Myovant Sciences Patient Assistance Program)*

☐ By checking this box and signing below, I confirm that I have read, understand, and accept the terms and conditions on pages 5 and 6 for participating in the Myovant Sciences Patient Assistance Program, and I grant permission to EvinceMed to provide the Myfembree Support Program with information from my credit/consumer profile for the sole purpose of determining if my income meets the eligibility standards of the Myovant Sciences Patient Assistance Program.

Copay Assistance Program Terms and Conditions Consent (*Required for Myfembree Copay Assistance Program)*

☐ By checking this box and signing below, I confirm that I have read, understand, and accept the terms and conditions on pages 5 and 6 for participating in the Myfembree Copay Assistance Program.

Patient/Authorized Representative Signature:

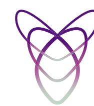
Date:

Printed Name of Authorized Representative:

Authorized Representative's Relationship to Patient:

Please see full Prescribing Information, including BOXED WARNING, and Patient Information.

THE MYFEMBREE® SUPPORT PROGRAM
PRESCRIBER, PRESCRIPTION, AND PHARMACY



Myfembree®
(relugolix, estradiol, and norethindrone acetate) tablets
40 mg, 1 mg, 0.5 mg

5 Prescriber Details

Last Name:	First Name:	Specialty:	
NPI #:	Tax ID #:		
Practice/Facility Name:			
Street:	City:	State:	ZIP:
Office Contact Name:	Preferred Primary Method of Contact:	☐ Phone ☐ Email	☐ Fax
Phone:	Email:	Fax:	

The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

6 Clinical Information

Diagnosis description/ICD-10-CM Code:	Anticipated treatment start date:

7 Prescription *(See pages 5 and 6 for program terms and conditions.)*

Drug Name (NDC: 72974-415-01)	Dosing	Quantity	Refills
Myfembree® (relugolix, estradiol, and norethindrone acetate)		28 tablets	________ (indicate number of refills)

☐ Patient Assistance Program (for patients with no insurance or insurance denials to receive free medication.)

Prescriber Declaration

By signing this form, I certify that this medication is medically necessary for the patient. I further certify that the information provided in this form is accurate to the best of my knowledge and that the patient meets the eligibility requirements of any Myfembree® Support Program selected above, including without limitation, the requirement that the patient be prescribed Myfembree for an FDA-approved indication. I acknowledge and agree that I may not bill for medication dispensed under the Myovant Sciences Patient Assistance Program to any private or government payer or other third party and that I will adhere to the terms and conditions of the Myfembree Support Program.

Prescriber Signature: ______________________________
Wet signature is required.

☐ Dispense as written
Date: ____________

8 Retail/Mail-Order Pharmacy Details

Name:			
Street:	City:	State:	ZIP:
Phone:	Submission: ☐ eRx	☐ Fax:	
Date of eRx or fax to pharmacy:			

Please see full Prescribing Information, including BOXED WARNING, and Patient Information.

PATIENT AUTHORIZATION TO SHARE AND USE PROTECTED HEALTH INFORMATION (PHI):

By signing below, I give consent to my healthcare team (my physicians, pharmacies, other healthcare providers, and my health insurers) to provide information related to my medical condition and treatment, financial information, insurance coverage information, and contact information (my "protected health information" or "PHI") to Myovant Sciences, Inc. (including its agents and contractors) for Myovant Sciences to use and to share with my healthcare team for the following purposes:

- Enrolling me in and contacting me about the Myfembree® Support Program and other Myfembree-related support programs
- Providing me with Myfembree Support Program services, which may include the following (also referred to as "Patient Support Services"):
  - Providing benefits investigation and reimbursement support, including help with prior authorization requirements or appealing a denied claim
  - Sending my prescription to the in-network specialty pharmacy that dispenses Myfembree
  - Providing me with financial assistance resources if I'm eligible, including copay assistance or free drug programs
  - Communicating with my healthcare team about Myfembree and Patient Support Services
  - Providing me with disease management and other educational materials
  - Contacting me to ask me questions or sending me surveys about my experience with Myfembree and Myfembree-related programs to help Myovant Sciences evaluate, improve, and develop products, services, materials, and programs related to my condition or treatment
  - Communicating with me via telephone, email, the Internet, and/or text message (data rates may apply) to assist with adherence to my medication routine, and to provide community resources and referrals
- By checking the "Optional Promotional Communications" box above my signature for this authorization on page 3 of this form, I additionally authorize Myovant Sciences to use my PHI to communicate with me by mail, email, phone, or text message (using the contact information provided on this form) to inform me about the benefits of Myovant Sciences products and services. For phone and text messaging, I understand that data rates may apply.

I understand that:

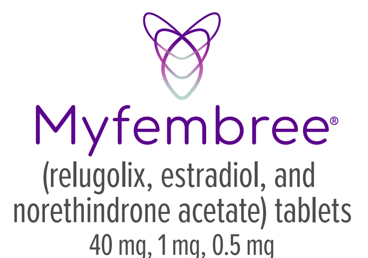
- This authorization is valid for five years from the date I sign it, unless a shorter period is required by state law or unless I cancel it before then
- I can cancel this consent at any time by writing to 2250 Perimeter Park Dr, Suite 300, Morrisville, NC 27560
- I may refuse to sign this authorization; my healthcare treatment and eligibility for and receipt of healthcare benefits are not conditioned on my signing this authorization, but I will not be able to enroll in the Myfembree Support Program unless I sign the authorization
- My healthcare treatment and eligibility for and receipt of healthcare benefits are not conditioned on my signing this consent
- Once my PHI is disclosed to Myovant Sciences, federal privacy law may not protect it from disclosure to others, but Myovant Sciences intends to use or disclose my information only for the purposes stated above [or as otherwise permitted by law]
- I have the right to receive a copy of this authorization consent once I have signed it

PATIENT CERTIFICATION AND CONSENT TO PROGRAM TERMS:

I understand the following statements:

- The personal information that I provide to Myovant Sciences is true and complete, and I agree that, at any time during my participation in the Myfembree Support Program, Myovant Sciences may request additional documentation to verify my personal information
- I am not charged to enroll or participate in the Myfembree Support Program or required to purchase any Myovant Sciences product
- The Myfembree Support Program may change or end at any time, without notice
- If I qualify for, and receive, copay assistance or free medication from Myovant Sciences, I agree to comply with the program rules and agree that I will not seek or receive reimbursement for the assistance I receive from any third party, including from an insurance program, a health savings, flexible spending, or other health reimbursement account. If I have Medicare Part D, I will also not count any free medication I receive towards my true out-of-pocket costs (TrOOP)
- I understand that assistance may be temporary and I may be required to reapply as described in the program rules
- I will contact the Myfembree Support Program if my insurance changes or I am no longer prescribed Myfembree
- I understand that completing and signing the Patient Assistance Program (PAP) portion of this form does not guarantee my eligibility for the Myovant Sciences Patient Assistance Program

Please see full Prescribing Information, including BOXED WARNING, and Patient Information.



Myfembree Copay Assistance Program: Terms and Conditions

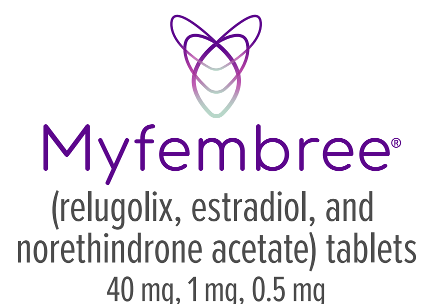
The Myfembree Copay Assistance Program ("Copay Program") is for eligible patients with commercial prescription insurance for Myfembree. With this Copay Program, eligible patients may pay as little as $5 per monthly Myfembree prescription (or $15 for a 90-day prescription); subject to calendar year maximum on Copay Program assistance of $5,000 per calendar year. After the calendar year maximum for Copay Program assistance is reached, patient will be responsible for the remaining out-of-pocket costs for Myfembree. This Copay Program may not be redeemed more than once every 21 days. The Copay Program is not valid for patients whose prescription claims are reimbursed, in whole or in part, by any state or federal government program, including, but not limited to, Medicaid, Medicare, Medigap, Department of Defense (DoD), Veterans Affairs (VA), TRICARE, Puerto Rico Government Insurance, or any state patient or pharmaceutical assistance program. Offer is not valid for cash-paying patients. Patient must be a resident of the U.S., Puerto Rico, or U.S. Territories. This Copay Program is void where prohibited by state law and on the date an AB rated generic equivalent for Myfembree becomes available. Certain rules and restrictions apply. This offer is not insurance. This offer cannot be combined with any other coupon, free trial, discount, prescription savings card, or other offer. This offer is not conditioned on any past or future purchase, including refills. Patient and participating pharmacists agree not to seek reimbursement for all, or any part of the benefit received by the patient through this Copay Program. Patient and participating pharmacists agree to report the receipt of Copay Program benefits to any insurer or other third party who pays for or reimburses any part of the prescription filled using the Copay Program, as may be required by such insurer or third party. Myovant Sciences reserves the right to revoke, rescind, or amend this offer without notice.

Myovant Sciences Patient Assistance Program: Terms and Conditions

The Myovant Sciences Patient Assistance Program ("Program") provides Myfembree; at no cost to eligible patients who are prescribed Myfembree for an FDA-approved indication. Patients and prescribers must complete the Myfembree Support Program enrollment form, and prescribers must provide a Patient Assistance Program prescription. To qualify, patients must meet Program eligibility requirements, which include, but are not limited to: (1) having no insurance or inadequate coverage for Myfembree; (2) meeting income guidelines and undergoing income evaluation; and (3) residing in the United States or US Territories. Patients may be required to apply to, and provide proof of denial from, various alternate funding sources in order to be eligible for Program enrollment. Program requires annual re-evaluation and re-enrollment for continued participation. Patient and participating prescribers agree not to seek reimbursement for all, or any part of, the free product received by the patient through this Program. Patients may not count the free product received from the Myfembree Support Program as an expense incurred for purposes of determining out-of-pocket costs for any plan, including true out-of-pocket costs ("TrOOP") for purposes of calculating the out-of-pocket threshold for Medicare Part D plans. Government health insured patients who meet the Program eligibility criteria are eligible to receive free product for the entire coverage year, and Myovant Sciences will notify patients' government health insurance plans that the patient is enrolled in the Program. Patients who are not enrolled in government health insurance plans who qualify for Program assistance may be eligible for 12 months of free Myfembree at a time, as long as they continue to meet the Program eligibility requirements. No purchase necessary. Program is not health insurance, nor is participation a guarantee of insurance coverage. Other limitations may apply. Myovant Sciences reserves the right to rescind, revoke, or amend the Program and discontinue support at any time without notice.

Please see full Prescribing Information, including BOXED WARNING, and Patient Information.

Confidentiality Notice: This letter contains personally identifiable information and may include individual protected health information (PHI). The information is intended only for use by the individual or entity addressed on this letter. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or the taking of action in reliance on the contents of this letter is strictly prohibited. If you have received this letter in error, please notify the sender immediately so that we can arrange for the return of the original documents to us at no cost to you.



Myfembree® and its associated logo are registered trademarks of Myovant Sciences GmbH.
All other trademarks are the property of their respective owners.
©2023 Myovant Sciences GmbH and Pfizer Inc.
All rights reserved. PP-US-REL-CT-2300142 08/23