CoverOne®

TEPMETKO® (tepotinib) Enrollment Form

Fax 1-800-214-7295
Questions? 1-844-8COVER1 (844-826-8371)
CoverOne.com

∗ = to be completed by Prescribing Physician only

SERVICES REQUESTED

☐ Benefits Verification/Prior Authorization/Appeals Support

☐ Co-Pay Assistance Program (for commercially insured patients)
- Patients may also apply online at CoverOne.com

☐ Bridge Program (for eligible patients)

☐ Patient Assistance Program (for eligible uninsured or underinsured patients)

Additional Note(s) _____

1 Patient Information

First Name _____ Last Name _____
Address _____
City _____ State _____ Zip _____
DOB (mm/dd/yyyy) _____ Gender (optional) _____
Phone _____ ☐ Home ☐ Work ☐ Cell
Ok to leave voicemail? ☐ Yes ☐ No Preferred Language _____
Email _____
Preferred Method of Communication: ☐ Phone ☐ Email ☐ Text (opt-in below)

2 Patient Financial Information

(required if requesting Patient Assistance Program evaluation)

CoverOne Patient Assistance Program may provide TEPMETKO at no cost to eligible uninsured or underinsured patients. To apply for no-cost TEPMETKO, please complete the information below and include your most recent tax return (e.g., IRS Form 1040). Household income should include before-tax wages, Social Security benefits, and any other source of household income.

Household Size (no. of people) _____
Household Income _____ ☐ Yearly ☐ Monthly

3 Patient Authorization and Consent

3A. I have read and understand the ***Patient Authorization for Use and Disclosure of Health and Other Personal Information*** and the ***Patient Consent for CoverOne*** and agree to the terms on page 3.

SIGN HERE

_____ _____ _____
Patient or Personal Representative Signature | Date | Personal Representative Full Name (if applicable)

Authority/relationship of personal representative (if applicable): ☐ Legal Guardian ☐ Power of Attorney

3B. FOR CALIFORNIA PATIENTS ONLY

☐ By checking this box, I request that my Authorization to Use and Disclose Health and Other Personal Information and Marketing Consent (if selected below) remain valid for 10 years from the date of signature. If not, such consent will expire one (1) year from the date of signature.

3C. Marketing Consent (optional)

☐ By checking this box, I authorize EMD Serono and its affiliates to use my Health Information for marketing and market research purposes, including, but not limited to, providing educational and promotional materials, information, offers, and services related to my therapy or medical condition, and contacting me to participate in focus groups, surveys, or interviews funded or sent by EMD Serono, CoverOne or EMD Serono affiliates. I understand I may withdraw my consent as described in this form.

3D. Opt-In for Automated Text Messages (optional)

☐ By checking this box, I consent to receive text messages from EMD Serono and agree to the terms outlined below.

4 ∗Patient Insurance Information (Please include a copy of both sides of the insurance card)

Type of Insurance(s)

☐ Employer ☐ Medicaid
☐ Healthcare Exchange ☐ No Insurance
☐ Medicare
- If Part D, does patient receive Low-Income Subsidies (LIS)? ☐ Yes ☐ No

☐ Other

_____

Has a prior authorization (PA) been initiated? ☐ Yes ☐ No
- If "Yes", PA status? ☐ Approved ☐ Denied ☐ In Progress

Prescription Insurance Name _____
Cardholder (if different than patient) _____
RX ID # _____ RX Group # _____
RX BIN # _____ RX PCN # _____
Phone _____

Primary Medical Insurance Name _____
Cardholder (if different than patient) _____
ID # _____ Group # _____
Phone _____

5 *Prescribing Physician Information

First Name _____ Last Name _____
Address _____
City _____ State _____ Zip _____
NPI # _____ Tax ID # _____
State License # _____

Office/Clinic/Institution Name _____
Office Contact Name _____
Phone _____ (ext _____) Fax _____
Email _____

6 *Patient Medical Information

Primary ICD-10-CM Code _____
Secondary ICD-10-CM Code _____
List Previous Therapies _____

Planned TEPMETKO Treatment Start Date _____
Does the patient have a *MET*ex14 skipping alteration? ☐ Yes ☐ No
Is the patient's primary cancer metastatic? ☐ Yes ☐ No

7 *Prescribing Physician Authorization

SIGN HERE

By signing below, I confirm that I have read and understand the ***Prescribing Physician Certification for CoverOne*** and agree to the terms on page 4.

_____ Prescribing Physician Signature

_____ Prescribing Physician Name (print)

_____ Date

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TEPMETKO® (tepotinib) Prescription (Rx) Information

FOR PRESCRIBING PHYSICIAN USE ONLY

Please complete and sign one or both of the prescriptions for your patient based on specific patient needs.

Rx for CoverOne Bridge Program ONLY

This Rx should only be used for patients who have experienced an insurance delay and meet eligibility criteria for the CoverOne Bridge Program.

Patient Full Name_____ DOB (mm/dd/yyyy) _____

Drug Name TEPMETKO® (tepotinib) 225 mg tablets

Quantity 15-day No refills (unless authorized by program)

Directions Take ☐ 1 **OR** ☐ 2 225 mg tablet(s) by mouth once a day
(check only one box)

Prescribing Physician Prescription Signature

I certify that TEPMETKO® (tepotinib) is medically necessary for the patient above, and that it is prescribed in accordance with the FDA-approved prescribing information and this information is accurate to the best of my knowledge. I authorize EMD Serono, and its affiliates, business partners, and agents, to transmit this prescription to the designated pharmacy to dispense TEPMETKO® (tepotinib) to the patient.

SIGN HERE _____ Prescribing Physician Signature _____ Prescribing Physician Name (print) _____ Date

Rx for Insured Patients or CoverOne Patient Assistance Program Use

This should only be used for insured patients for fill through Biologics Specialty Pharmacy, or for use with eligible CoverOne Patient Assistance Program (PAP) patients.

Patient Full Name_____ DOB (mm/dd/yyyy) _____

Drug Name TEPMETKO® (tepotinib) 225 mg tablets

Quantity _____ Refills (up to 12): _____

Directions Take _____ 225 mg tablet(s) by mouth once a day

Prescribing Physician Prescription Signature

I certify that TEPMETKO® (tepotinib) is medically necessary for the patient above, and this information is accurate to the best of my knowledge. I authorize EMD Serono, and its affiliates, business partners, and agents, to transmit this prescription to the designated pharmacy to dispense TEPMETKO® (tepotinib) to the patient.

SIGN HERE _____ Prescribing Physician Signature _____ Prescribing Physician Name (print) _____ Date

Authorization to Use and Disclose Health and Other Personal Information

By signing section 3 of the CoverOne Enrollment Form, I agree to the following:

- I authorize my treating physician(s), pharmacy(ies), health insurance company(ies), prescription drug plan(s), and other parties providing me health care or paying for my health care (collectively, "My Health Care Providers and Plans") to disclose my personal and protected health information ("Health Information") to EMD Serono, Inc. and its agents and representatives (collectively "EMD Serono"). My Health Information may include, but is not limited to, information regarding my diagnosis of and treatment for the one or more conditions for which I may be or have been prescribed TEPMETKO® (tepotinib) information included in a Enrollment Form, and any other information deemed relevant by My Health Care Providers and Plans that may be considered sensitive or specially protected by law. EMD Serono may use and further disclose my Health Information to My Health Care Providers and Plans or other third parties in order to: (1) enroll me in and administer the CoverOne Program and contact me by mail, email, or by live call at the telephone number(s) listed above, or to any future telephone number(s) provided by me; (2) conduct a benefits investigation and coordinate my insurance coverage for any prescribed EMD Serono product(s); (3) facilitate the filling of my prescription for and the delivery and administration of that product(s); and (4) contact me regarding the CoverOne Support Program and conduct quality assurance, surveys, and other internal business activities or analyses in connection with the CoverOne Program.
- I understand that once my Health Information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws (*e.g.*, the Health Insurance Portability and Accountability Act (HIPAA)) and may be further disclosed to others.
- For more information on your privacy rights and choices, please see EMD Serono's privacy notice at https://www.emdserono. com/us-en/privacy-policy.html.
- I understand that I may refuse to sign this authorization and such refusal will not affect my eligibility to receive any EMD Serono product, my treatment, payment for treatment, or eligibility for or enrollment in health benefits, but it will limit my ability to receive CoverOne Support Program services. I understand and agree that this authorization will remain in effect for 10 years from the date of my signature (unless I am a California resident, in which case this authorization will remain in effect for 1 year, or for 10 years if I check the box in Section 3B above) unless I revoke it earlier by contacting EMD Serono in writing at EMD Serono & CoverOne 200 Pier 4 Boulevard, Boston, MA 02210 or by phone at 844-826-8371 If I revoke this authorization, My Health Care Providers and Plans will stop disclosing my Health Information to EMD Serono, and EMD Serono will stop using and disclosing this information, as soon as possible, but the revocation will not affect prior use or disclosure of my Health Information in reliance on this authorization.
- I also understand that I have the right to receive a signed copy of this authorization.

Patient Consent for the Patient CoverOne® Program, Terms, Conditions ("Consent")

By signing section 3 of the CoverOne Enrollment Form, I agree to the following:

- I confirm that all financial and insurance information is complete and accurate. Additionally, during participation in CoverOne, and while I am receiving treatment with BAVENCIO, I agree to immediately notify CoverOne if my health insurance status changes in the future, if I obtain any new health insurance plan, or if I become entitled to, or enroll in a government health insurance program (i.e., Medicare or Medicaid).
- If I apply and am eligible for no-cost product through the CoverOne Patient Assistance Program, I will not seek reimbursement for such no-cost product from any insurance company or program, including federal healthcare programs, such as Medicare or Medicaid. I understand that if I currently have Medicare coverage, my eligibility for the CoverOne Patient Assistance Program will automatically expire on December 31st of the current calendar year and it will be necessary for me to submit a new CoverOne Enrollment Form (along with any required income documentation) if I would like to request additional assistance through the CoverOne Patient Assistance Program. I understand that the CoverOne Patient Assistance Program reserves the right to request additional documentation from me to support my request for assistance based on my financial hardship including, for example, additional documents relating to my income.
- I understand that EMD Serono reserves the right to modify, change, or terminate the CoverOne program or any services at any time with or without notice.
- I understand that if I am a California resident I have certain rights with respect to my personal information that are described in the EMD Serono California Consumer Privacy Act Privacy Policy available at *https://www.emdserono.com/us-en/privacy-policy.html*.
- I understand that information from CoverOne program participants may be summarized for statistical or other purposes but such summaries will not contain information that identifies me personally.
- I understand that EMD Serono, through CoverOne, is collecting patients' relevant financial income and personal health information, including information relating to medical conditions, treatment, care management, prescriptions, and health insurance, for the purpose of determining the patients' eligibility for CoverOne and subsequently administering the program benefits or related services.

Patient Opt-In for Automated Marketing Text Messages

I authorize EMD Serono, Inc. (or its agents), to send text messages to the cell phone number I have provided on page 1 of this form (or to any future cell phone number(s)provided by me to EMD Serono, using an automatic telephone dialing system on a recurring basis regarding EMD Serono's programs or products. This opt-in also enables EMD Serono to contact me by text message to provide me with Program services, if applicable. Agreeing to this opt-in is not a condition of participating in the Program or purchasing products, goods, or services from EMD Serono. I understand that my cell phone service provider may charge me fees for texts sent to me and I agree that EMD Serono will have no liability for the cost of any such calls or texts. EMD Serono's Legal Statement and Privacy Policy apply. At any time, I may opt-out or withdraw my consent to receive text messages by replying "STOP" via return text message or contacting EMD Serono in writing at: EMD Serono, CoverOne, 200 Pier 4 Blvd., Boston, MA 02210.

To opt in in, please check the box in section 3D under Patient Authorization on page 1.

CERTIFICATION

Prescribing Physician Certification for CoverOne

By signing section 7 of the CoverOne Enrollment Form, I agree and certify to the following:

- TEPMETKO is medically appropriate for the patient identified above and that I, or a prescribing physician in my Practice, will be supervising the patient's treatment.
- I hereby certify that my office has obtained HIPAA-compliant authorization from the above-named patient to disclose medical and other protected health information necessary for EMD Serono to provide the services described in the Authorization on the previous page, including assisting the patient with obtaining insurance coverage for TEPMETKO.
- CoverOne is a patient assistance program available to assist patients, and that program participation is voluntary, and that patient eligibility for services is not connected to or contingent on any past or future purchase of TEPMETKO.
- If the patient applies for and is eligible for no-cost product through the CoverOne Patient Assistance Program or Quick Start/Bridge Program, I will not seek reimbursement for such no-cost product from any insurance company or program, including federal healthcare programs, such as Medicare or Medicaid. Additionally, I agree to notify CoverOne immediately if the patient is no longer receiving TEPMETKO through the Patient Assistance Program and agree to return unused no-cost Patient Assistance Program product to CoverOne.
- I understand that information concerning program participants may be summarized for statistical or other purposes and provided to EMD Serono.
- The information provided on the enrollment form is complete and accurate to the best of my knowledge.
- CoverOne reserves the right to modify, change, or terminate the CoverOne program at any time with or without notice.
- **I understand that EMD Serono is collecting physicians' relevant personal information to document that it has obtained the required certifications and authorizations to administer CoverOne.**

EMD Serono, Inc. does not guarantee coverage or reimbursement for TEPMETKO. Coverage and reimbursement decisions are made by insurance companies following the receipt of claims. EMD Serono's Privacy Policy can be found here: https://www.emdserono.com/us-en/privacy-policy.html

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