Nuvalent PATIENT SUPPORT

Enrollment Form

To enroll in Nuvalent Patient Support, healthcare providers and patients must fill out this enrollment form and can submit by fax to (430) 205-4468, email to PatientSupport@nuvalent.com, or mail to Nuvalent Patient Support, 11800 Weston Parkway, Cary, NC 27513. **You can also enroll by completing and submitting the form online at www.NuvalentPatientSupport.com.**

Nuvalent Patient Support
(844) 688-5333

1 PATIENT INFORMATION (*Required field)

*First name:	Middle initial:	*Last name:
*Date of birth (MM/DD/YYYY):		*Gender: ☐ Male ☐ Female ☐ Other:
*Primary phone:		Secondary phone:
*Home address:		*City: *State: *ZIP:
Email:		Preferred language: ☐ English ☐ Other:

NOTICE: Applicable state and other law may provide you with certain rights regarding your information. This may include information about the categories of personal information that Nuvalent, Inc. collects and uses, described in more detail in Nuvalent's Privacy Policy. The Nuvalent Privacy Policy also describes how to contact Nuvalent with questions or to exercise your rights.

Authorization to Use & Disclose Health Information

☐ ***I have read and agree to the Authorization to Use & Disclose Health Information located on page 3 of this form in order to participate in the Nuvalent Patient Support program.**

*Name and Signature

_____
Print full name

X_____
Signature

*Date (MM/DD/YYYY): _____

*Relationship to Patient: ☐ Self ☐ Legal Representative

By signing on behalf of the patient, as representative or guardian, I attest that I am legally authorized to sign such documents on the patient's behalf

Marketing Consent: ☐ I have read and agree to the Marketing Consent on page 4 (Optional).

2 INSURANCE INFORMATION

Provide a copy of each side of the insurance card(s) by fax: (430) 205-4468 or email: PatientSupport@nuvalent.com, or complete the chart below.

*What type of health insurance does the patient have? (Check all that apply)

☐ Commercial ☐ Government (Medicare, Medicaid, TRICARE) ☐ Uninsured (Complete page 4 in full, if applicable) ☐ Other: _____

Please fill out the following fields with the insurance information.	Primary Pharmacy Insurance	Secondary Pharmacy Insurance
BIN		
PCN		
Group #		
Policy #		
Insurance Phone		
Insurance Plan		
Plan Holder Name (if different than patient)		
Planholder DOB		

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*Patient name: _____

*Patient date of birth (MM/DD/YYYY): _____

3 PATIENT CLINICAL INFORMATION

*Primary ICD-10 diagnosis code:	Secondary ICD-10 diagnosis code:

Please do not submit copies of your patients medical records.

4 PRESCRIBER INFORMATION (*Required field)

*Prescriber first name:	*Prescriber last name:		
Facility name:		*NPI #:	
*Mailing address:	*City:	*State:	*ZIP:
*Office phone:	*Office fax:		
Office contact full name:	Office contact title:		
Office contact email:	Office contact phone:		

5 BENEFITS VERIFICATION AND FINANCIAL ASSISTANCE PROGRAMS

☐ Check here if your patient would only like support with benefits verification to understand their coverage. Otherwise, please select below which financial support program(s) the patient would like to apply to.

Please note that programs and support are subject to specific restrictions, terms and conditions, and eligibility criteria.

☐ Quick Start Program†	☐ Bridge Program†	☐ Patient Assistance Program (PAP)†
For eligible patients who are new to therapy and are experiencing an insurance delay (100 mg tablets only)	For eligible patients who are already on therapy and are experiencing a gap in coverage	For eligible patients, medication is provided monthly at no cost. If your patient is applying for PAP, please have them complete page 4

†Note: For eligible patients participating in one of our financial support programs, the selected prescription must be dispensed through Biologics by McKesson. After completion of the temporary supply from the Quick Start or Bridge Programs, the patient's prescription may be sent back to the prescriber's office for in-office dispensing, if patient continues on therapy. **If the patient is eligible, Nuvalent Patient Support can notify the medically integrated dispensing team to obtain the prescription from the healthcare provider.**

6 PRESCRIPTION INFORMATION

JIDEYTRO™ (zidesamtinib) tablets ☐ 25 mg ☐ 100 mg	Take ___ tablet(s) by mouth once daily	Quantity:	Refills:

PROVIDER ATTESTATION: By signing this form, I certify that therapy with the above listed medication is medically necessary for the patient identified in this application ("Patient"). I have reviewed the current Prescribing Information for such medication and will be supervising Patient's treatment. I authorize Nuvalent Patient Support to transmit this prescription to the appropriate pharmacy designated by me, Patient, or Patient's plan. I understand that I am under no obligation to prescribe this medication or any other product manufactured by Nuvalent, and I certify I have received nothing of value from Nuvalent or its agents or representatives for prescribing a Nuvalent product.

I have received from Patient, or his/her legal representative, the necessary authorization to release, in accordance with applicable federal and state law and regulations, medical and/or other patient information relating to treatment with the above listed medication to Nuvalent, its agents or contractors, for the purposes of processing the Patient Support program application and/or assisting in continuing the Patient's treatment with the Nuvalent medication. In addition, for any free drug provided through any Nuvalent program, I will not seek payment from the patient or any third party, and I agree to comply with all program rules and applicable laws.

Prescriber signature: X _____ ☐ *Dispense as written* Date: _____

Prescriber first name: _____ Prescriber last name: _____ Prescriber NPI #: _____

Supervising Physician first name: _____ *If applicable* Supervising Physician last name: _____ *If applicable*

☐ I confirm that I have read, understood, and agreed to be bound by the Provider Attestation. In lieu of signature provided above, a prescription will be submitted separately.

Send a prescription (Biologics by McKesson: NCPDP: 3430369 | NPI: 1487640314 | Phone: (800) 850-4306 | Fax: (800) 823-4506 11800 Weston Parkway Cary, NC 27513) as required by your state's law for dispensing.

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Nuvalent Patient Support Consent for Authorization to Use & Disclose Health Information, Financial Support, and Marketing

Patients should read the Nuvalent Patient Support HIPAA Authorization, financial consent, and marketing consent information and complete the acknowledgment section on page 1.

Authorization to Use & Disclose Health Information

By signing this authorization, I authorize any health insurance plan, physician, healthcare professional, hospital, clinic, pharmacy, or other healthcare provider (collectively, "Providers") to disclose my protected health information, including information relating to my medical diagnosis and condition (such as lab test results, genetic and biomarker test results, treatment or care management), prescription information, health insurance, and my personal information including personal identifiers such as my name, mailing and email addresses, telephone number and date of birth, as well as all information provided on this form ("Information"), to Nuvalent Inc, its affiliates and their respective employees, agents, representatives, service providers, and contractors (collectively, the "Company") for the following purposes: (i) to fulfill my prescription; (ii) to enroll me in Nuvalent Patient Support; (iii) to provide products, supplies, or services and to administer Nuvalent Patient Support; (iv) to determine eligibility for and provide patient support services including but not limited to prior authorization support, patient assistance programs, free drug or other financial assistance services, and other related programs; (v) to communicate with me or my Providers; (vi) to communicate with me by mail, email, telephone, or if agreed to in this form, by automated phone calls and text communications; (vii) to provide me with information about Company products, services and programs for educational and other purposes; (viii) to provide me with other therapy support services such as adherence reminders and disease education; (ix) to conduct market research and data analysis; and (x) to de-identify my Information for use in improving, developing, analyzing, and evaluating products, services, and programs, or in conducting other legitimate business and/or compliance activities.

I understand that certain parties, such as my pharmacy provider, may receive remuneration (payment) from Company for activities described in this authorization.

I understand that once disclosed to the Company, my Information disclosed under this authorization may be redisclosed by the recipient and no longer be protected by applicable law, including HIPAA. I further understand that I may refuse to sign this authorization and that my treatment, payment, insurance enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I also understand that if I do not sign this authorization or if I later cancel it, I will not be able to receive Nuvalent Patient Support services.

I understand that I am entitled to a copy of this authorization and can access additional copies or a digital version of the signed authorization by calling Nuvalent Patient Support at (844) 688-5333. I understand that I may revoke this authorization at any time by sending written notice of revocation to Nuvalent Patient Support at 11800 Weston Parkway Cary, NC 27513. I understand that such revocation will not apply to any Information already used or disclosed through this authorization and that revoking my authorization will end my participation in Nuvalent Patient Support.

This Authorization will remain in effect for five (5) years from the date next to my signature, or a shorter period if provided for by applicable law, unless revoked sooner.

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Complete this section only if you are interested in applying for the Patient Assistance Program (PAP).

Patient Certification and Financial Consent for Patient Assistance Program (PAP)

☐ By signing below, I confirm that I have read, understood, and agree to the Patient Certification and Financial Consent.

Relationship to Patient: ☐ Self ☐ Legal Representative Date (MM/DD/YYYY):_____

Signature:

_____ X_____

Print full name *Signature*

Patient Certification

I certify that:

The information I have provided in this application is true, correct, current and complete. I cannot afford the medication requested and (1) I do not have insurance or (2) I do not have insurance coverage for the medication, or (3) I have insurance coverage but cannot afford the deductible, co-pay, co-insurance, or other cost sharing requirement of my insurance plan. I have tried and been unable to access alternate sources of coverage or financial support for the medication. I understand that I may be required to provide proof of ineligibility for certain other prescription drug coverage programs in order to meet the eligibility requirements for the Patient Assistance Program. I will not make any claim for reimbursement from any third-party payor, including any health plan or prescription drug plan, for any medicine provided to me through Nuvalent Patient Support. I will not sell, trade, or otherwise transfer the medicine supplied through this program. If I am a member of a Medicare Part D plan, I will not seek to have any costs for my prescription counted as part of my out-of-pocket cost for prescription drugs. I will notify Nuvalent Patient Support immediately if anything changes with my prescription, income, or my insurance coverage. I authorize Nuvalent Patient Support and its vendors to obtain, use, and disclose my information as necessary to determine eligibility and operate the program, consistent with applicable privacy laws and any separate consent/authorization signed by me. I understand that I must confirm my eligibility annually to continue participating in the PAP. I meet the eligibility requirements and agree to the terms and conditions listed above. In addition, I understand that eligibility under the Program is subject to approval by Nuvalent and that application to the Patient Assistance Program does not guarantee that I will be able to participate in the Program. I understand that documentation may be required by me to verify the information provided in this application for purposes of determining my eligibility for assistance to verify the information provided herein.

Financial Consent

I understand that I am providing "written instructions" authorizing the Nuvalent Patient Assistance Program ("PAP"), Nuvalent and its vendors, under the Fair Credit Reporting Act ("FCRA"), to obtain information from my credit profile or other information from credit reporting and verification agencies, for the purpose of determining financial qualifications for the PAP. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I promise that any information, including financial and insurance information that I provide, is complete and true. If my income or health coverage changes, I will call Nuvalent Patient Support at (844) 688-5333. If eligible, I would like to be considered for programs administered by Nuvalent Patient Support. This information will only be used to determine eligibility for PAP. I understand that any free product provided to me through PAP is contingent upon my meeting eligibility criteria and that income limits apply. PAP applicants may be required to submit verification for all sources of household income. No party may seek reimbursement for any free drug provided to the patient under PAP. If my income cannot be verified from credit reporting and verification agencies, Nuvalent Patient Support will request documentation from me such as my IRS 1040 form or other proof of income to verify my financial information. I agree to provide such information in a timely manner. This consent is valid for as long as the patient remains enrolled in the PAP.

Review this section if you are interested in opting into the marketing communications on page 1.

Marketing Consent

I consent to receiving communications by mail, email, or telephone, or if agreed to in this form for marketing purposes or to provide me with information about Nuvalent's products, services, and programs or other topics of interest. I authorize Nuvalent to contact me to conduct market research or otherwise ask me about my or my loved one's experience with or thoughts about such topics of interest. I understand and agree that any information that I provide may be used by Nuvalent to help develop new products, services, and programs. I understand that this Marketing Authorization is not required to enroll in Nuvalent Patient Support and is not required as a condition of purchasing any goods or services.
I understand that Nuvalent will not sell or transfer my personal information to any third party for marketing purposes without my express permission.

I may opt out of marketing-related emails by clicking the "Unsubscribe" link at the bottom of each such email. To stop receiving other communications from Nuvalent, please contact Nuvalent at (844) 688-5333 with your request.

This Marketing Authorization expires after three (3) years, or such shorter time frame required by applicable law unless otherwise canceled earlier.

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