SUPPORT PROGRAM
PATIENT ENROLLMENT

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

The Myfembree® Support Program is committed to helping patients who are prescribed Myfembree® obtain access to their medication, with the following support options:

Copay Assistance Program*: Patients with commercial insurance may pay as little as $5 per monthly prescription or $15 for a 90-day prescription, with a $2,000 annual cap

Free Medication Programs*:

- **Bridge Program**–Eligible patients with commercial insurance may qualify for up to 4 months of a free supply of Myfembree
- **Quick Start Program**–Eligible patients with federal insurance may qualify for up to 2 months of a free supply of Myfembree
- **Patient Assistance Program**–Eligible uninsured patients or those with insurance denials may qualify to receive their medication at no cost from the Myovant Sciences Patient Assistance Program

*Please see page 6 for full terms and conditions.

Please find the required form for a patient to be enrolled in the Myfembree Support Program on the following pages. Information is required from both the patient and the prescriber.

Patient

Patient Consent for Enrollment and Sharing Protected Health Information

Here are the two ways that patients can provide their consent:

1 – Complete patient e-consent at www.Myfembreehcp.com

2 – Read and sign pages 4 and 5 of this form

Prescriber

Insurance Details

☐ Verification of accurate patient information

☐ Photocopy or fax of insurance cards

☐ Patient's specific demographic information (patient's demographics printout from electronic medical record [EMR] is allowed)

Clinical Information

☐ Diagnosis description/ICD-10-CM code

Contact Information

☐ Standard contact information for the prescriber and patient

Prescription Details

☐ Myfembree prescription information

Pharmacy Details

☐ Retail or mail-order pharmacy information

Prescriber Declaration

☐ Confirmation of accuracy for provided information

When the form is completed and all required signatures are obtained, it should be faxed to the Myfembree Support Program at **1-877-328-0138**

Hours of operation: Monday – Friday, 8 AM – 8 PM ET
Phone: 1-833-MYFEMBREE (1-833-693-3627) **Fax:** 1-877-328-0138
www.Myfembreehcp.com

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

Please see full Prescribing Information, including BOXED WARNING.

SUPPORT PROGRAM
ENROLLMENT FORM

Myfembree®
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- 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**

Patient Details

☐ Patient's demographics printout from the EMR is included. See attachment.

Last Name:	First Name:	Date of Birth:	
Street:	City:	State:	ZIP:
Preferred Language:			
Preferred Phone #1:	☐ Mobile ☐ Home ☐ Work		
Preferred Phone #2:	☐ Mobile ☐ Home ☐ Work		
Okay to contact patient? ☐ Yes ☐ No	Leave Message? ☐ Yes ☐ No	Email:	
Alternate Contact's Name*:	Alternate Contact's Phone*:		

*If applicable.

Clinical Information

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

Insurance Details *(fax or include a photocopy of the patient's insurance card along with this enrollment form)*

☐ Patient does not have insurance.

Beneficiary/Subscriber Name:	
Medical Insurance:	Phone:
Policy ID #:	Group #:
Pharmacy/Prescription Insurance:	Phone:
Policy ID #:	Rx Group #:
Rx Bin #:	

Please see full Prescribing Information, including BOXED WARNING.

SUPPORT PROGRAM
ENROLLMENT FORM (cont'd)

Myfembree®
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Prescriber Details

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

Prescription *(See page 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)

Please see dosage and administration section of the full Prescribing Information, including BOXED WARNING.

☐ Bridge Program (For commercial insurance only, **up to a 4-month supply of free medication.**)

☐ Quick Start (For government insurance only, **up to a 2-month supply of free medication.**)

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

SIGN HERE Prescriber Signature: ☐ Dispense as written Date:

Wet signature is required.

Retail/Mail-Order Pharmacy Details

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

Prescriber Declaration

I certify that the information provided in this form is accurate to the best of my knowledge. I acknowledge that I may not bill for this medication to any private or government payer and that I will adhere to the terms and conditions of the Myfembree Support Program.

SIGN HERE Prescriber Signature: Date:

Wet signature is required.

Please see full Prescribing Information, including BOXED WARNING.

Patient Consent to Participate in the Myfembree® Support Program

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

Patient consents: To join the Myfembree Support Program, please read and, if you agree with the terms, check the boxes and sign the (i) Patient Certification and Consent below and the (ii) Patient Consent on page 5.

PATIENT CERTIFICATION AND CONSENT TO TERMS

By signing below, I attest to **the following statements:**

- The information that I provide to Myovant Sciences is true and complete.
- If, at any time during my participation in the Myfembree Support Program, Myovant Sciences requests additional documentation to verify the accuracy of information I have or am providing, I will need to provide such documentation in order to continue in the Program.
- I am aware that I will not be charged any fee, or required to purchase any Myovant Sciences product, in order to enroll and participate in the Myfembree Support Program.
- I understand that 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 will comply with the Program rules and I will not seek or receive payment for the assistance I receive from any third party, including from any insurance plan, whether a health savings, flexible spending, or other healthcare reimbursement account. If I have coverage under Medicare Part D, I will not count any free medication I receive towards my true out-of-pocket costs (TrOOP). I will contact the Myfembree Support Program if my insurance changes or I am no longer prescribed Myfembree.
- I understand that assistance under the Myfembree Support Program may be temporary, and I may be required to reapply as described in the Program rules.
- I understand that completing and signing this form does not guarantee my eligibility for copay assistance or free medication from Myovant Sciences.

☐ I grant permission for the Myfembree Support Program to obtain information from my credit profile or other information from Experian Health. I give consent to the Myfembree Support Program to obtain such information solely to determine if my income meets the eligibility standards of the Myovant Sciences Patient Assistance Program. *[Optional, only relevant if participating in the Myovant Sciences Patient Assistance Program].*

☐ I have read and agree to the Terms and Conditions for participation in the Myfembree Copay Assistance Program on this form. *[Optional, only if participating in the Myfembree Copay Assistance Program].*

SIGN HERE Patient Signature: Date:

Guardian Signature (If Applicable): Date:

Please see full Prescribing Information, including BOXED WARNING.

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Consent for Information Sharing

PATIENT AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION (PHI):

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

- Enroll me in and contact me about the Myfembree® Support Program.
- Provide me with Myfembree Support Program services, which may include the following (also referred to as "Patient Support Services"):
  - Checking my insurance benefits, including help with prior authorization requirements or appealing a denied claim.
  - Providing me with financial assistance resources if I'm eligible, including copay assistance or free drug programs.
  - Sending me a Myfembree Welcome Kit (where appropriate).
  - Communicating with my healthcare providers about Myfembree Support Program services.
  - Providing me with disease management and other educational materials.
  - Providing me with information about Myovant Sciences products, services, and programs, which may include sending me surveys about my experience with these programs.
  - Communicating with me through telephone, email, the Internet, or text message to assist with adherence to my medication routine, and work with third parties to provide community resources and referrals.

I understand that:

- This authorization expires 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 authorization at any time by writing to 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560 or calling the Myfembree Support Program at (1-833-MYFEMBREE); however, my cancellation will not invalidate any uses or disclosures of my PHI made in reliance on the authorization prior to the date the Myfembree Support Program receives my notice of cancellation.
- I may refuse to sign this authorization.
- My healthcare treatment and eligibility for and receipt of health care benefits are not conditioned on my signing this authorization.
- 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 without my authorization.
- I have the right to receive a copy of this authorization once I have signed it.

OPTIONAL AUTHORIZATION TO RECEIVE CERTAIN CALLS AND TEXT MESSAGES

☐ I authorize the Myfembree Support Program to contact me by phone or text message, including by using an auto dialer or pre-recorded voice, at the cell phone number for me provided on this form, to inform me about the benefits of Myovant Sciences products and services. I understand that I do not need to provide this authorization in order to purchase any Myovant Sciences product, and that text messages and data rates may apply. I have reviewed and agreed to the full terms and conditions located at www.Myfembree.com. **Frequency may vary. Reply STOP to cancel, HELP for help. View our privacy policy: https://www.myovant.com/privacy-policy/**

SIGN HERE Patient Signature: Date:

Guardian Signature (If Applicable): Date:

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Myfembree Copay Assistance Program: Terms and Conditions

The Myfembree Copay Assistance Program ("Program") is for eligible patients with commercial prescription insurance for Myfembree. With this Program, eligible patients will pay as little as $5 per monthly Myfembree prescription or $15 if they received a 90-day prescription; subject to a maximum of $2,000 per calendar year. After the annual maximum of $2,000 for Myfembree is reached, patient will be responsible for the remaining monthly out-of-pocket costs. Patient must enroll in the Program by visiting www.Myfembree.com or by calling 1-833-MYFEMBREE (833-693-3627). Card must be activated before use. This Program may not be redeemed more than once every 21 days. The 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 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 card 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 Program. Patient and participating pharmacists agree to report the receipt of Program benefits to any insurer or other third party who pays for or reimburses any part of the prescription filled using the Card, as may be required by such insurer or third party. Myovant Sciences reserves the right to revoke, rescind, or amend this offer without notice. The Myfembree Copay Assistance Program is good through December 31, 2022.

Myfembree Bridge Program: Terms and Conditions

The Myfembree Bridge Program ("Program") provides Myfembree at no cost for a limited period to eligible patients with commercial insurance who have been prescribed Myfembree for an FDA-approved indication, and whose insurance coverage is delayed or who experience a temporary lapse in coverage. Commercially insured patients are eligible for up to 4 months of free product. This 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. Patients and prescribers must complete the Myfembree Support Program enrollment form, and prescribers must provide a Myfembree Bridge prescription. Patients will receive their drug supply each month for up to 4 months or until they receive insurance coverage approval, whichever occurs earlier. Patients must be residents of the United States or US Territories. Program is not available to patients who are uninsured or where prohibited by law such as Massachusetts and Minnesota. Patients may be asked to reverify insurance coverage status during the course of the Program. Patients and participating prescribers agree not to seek reimbursement for all, or any part of the benefit received by the patient through this Program. 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.

Myfembree Quick Start Program: Terms and Conditions

The Myfembree Quick Start Program ("Program") provides a one-month supply of Myfembree at no cost to eligible patients with government insurance who are newly prescribed Myfembree for an FDA-approved indication, and whose insurance coverage is delayed 5 days or more. An additional one-month supply of Myfembree is available for such eligible patients who face a continued delay in insurance coverage. Patients and Prescribers must complete the Myfembree Support Program enrollment form, and prescribers must provide a Quick Start Program prescription. Patients must be residents of the United States and US Territories. Patients may be asked to reverify insurance coverage status during the course of the Program. Patients 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. 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.

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. Patients must meet Program eligibility requirements, which include, but are not limited to, lack of insurance coverage for Myfembree, financial criteria and income evaluation, and patients must be residents of the United States and US Territories. Program requires annual re-evaluation and re-enrollment for continued participation. Patients may be asked to reverify insurance coverage status during the course of the Program. 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. 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.

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