SUPPORT PROGRAM PATIENT CONSENT FORM

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

The Myfembree® Support Program is designed to help patients throughout their treatment journey. We offer financial assistance options, dedicated support staff, and other helpful resources once patients have been prescribed Myfembree®. Patients must complete this consent form before the Support Program staff can assist with any reimbursement or coverage issues.*

If assistance is required during the enrollment process, call the Myfembree Support Program at 1-833-MYFEMBREE (1-833-693-3627), 8 AM – 8 PM ET, Monday – Friday

Patient Consent for Enrollment and Sharing Protected Health Information

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

1 – Fax these completed forms to: 1-877-328-0138

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

Patient Consent to Participate in the Myfembree Support Program

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 2 of this form.

PATIENT CERTIFICATION AND CONSENT TO PROGRAM 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 Myovant Sciences to obtain information from my credit profile or other information from Experian Health. I give consent to Myovant Sciences 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: _____

*Visit www.Myfembree.com for full terms and conditions.

Please see full Prescribing Information, including BOXED WARNING.

Please see Myovant Sciences Privacy Policy and Terms of Use.

MYOVANT SCIENCES | Pfizer

SUPPORT PROGRAM PATIENT CONSENT FORM (cont'd)

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

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 (data rates may apply) 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 Myovant Sciences 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/**

Patient First Name: _____ Patient Last Name: _____ Date of Birth: _____

SIGN HERE Patient Signature: _____ Date: _____

Guardian Signature (If Applicable): _____ Date: _____

Please see full Prescribing Information, including BOXED WARNING.