ORGOVYX® SUPPORT PROGRAM

PATIENT START FORM

The ORGOVYX Support Program offers eligible patients:
· Reimbursement support · Financial assistance · ORGOVYX Bridge Program
· Patient Assistance Program · Educational support

Submission instructions for completing this Start Form

Before submitting the Start Form, it is important to:

1. Complete pages 1, 2, and 3 of this form

2. Confirm signatures from **Patient** and **Prescriber** are provided; confirm all fields are completed

3. Fax completed form to **1-844-826-8875**

Quick Tips:

- Patient signatures are required to begin enrollment
- Remind patients they may receive a call from the ORGOVYX Support Program (1-833-674-6899).
  The ORGOVYX Support Program will contact patients who receive free medication to schedule shipment

Checklist for Bridge and PAP Enrollment Requests*

Bridge Program

The ORGOVYX Bridge Program can provide ORGOVYX for a limited period (up to 4 months) in a calendar year to eligible, commercially insured patients who experience a delay in coverage.

Bridge Program Eligibility Criteria

To qualify, patients must:

- ☐ Be prescribed ORGOVYX for advanced prostate cancer
- ☐ Be a resident of the US or US Territories
- ☐ Have commercial insurance
- ☐ Be experiencing a delay in coverage
- ☐ Be actively pursuing coverage

PAP Program

The Myovant Sciences Patient Assistance Program (PAP) provides ORGOVYX at no cost to eligible patients who have an unmet financial need.

PAP Eligibility Criteria

To qualify, patients must:

- ☐ Be prescribed ORGOVYX for advanced prostate cancer
- ☐ Be a resident of the US or US Territories
- ☐ Be uninsured or have inadequate coverage for ORGOVYX
- ☐ Meet income eligibility requirements for the Program (<400% of the Federal Poverty Level, adjusted for household size)
- ☐ Be unable to afford the cost of their medication
- ☐ Have no alternate sources of funding available
  Patients who may be eligible for Medicaid or Medicare's Extra Help (Low-Income Subsidy) will be required to submit documentation of denial

Questions? Call 1-833-ORGOVYX (1-833-674-6899), Monday–Friday, 8 AM–8 PM ET.

*Please see page 5 to view the full Terms and Conditions for the ORGOVYX Bridge Program and the Myovant Sciences Patient Assistance Program. Residents of Minnesota and Massachusetts are not eligible for the ORGOVYX Bridge Program.

Hours of operation: Monday–Friday, 8 AM–8 PM ET
Phone: 1-833-ORGOVYX (1-833-674-6899) **FAX: 1-844-826-8875**
OrgovyxHCP.com | 2250 Perimeter Park Dr, Suite 300, Morrisville, NC 27560

Please see full Prescribing Information and Patient Product Information for ORGOVYX® (relugolix).

ORGOVYX® (relugolix) 120 mg tablets

ORGOVYX® SUPPORT PROGRAM

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FAX completed forms to 1-844-826-8875

If you have questions or need more information, call 1-833-ORGOVYX (1-833-674-6899), Monday–Friday, 8 AM–8 PM ET, visit OrgovyxHCP.com, or write us at 2250 Perimeter Park Dr, Suite 300, Morrisville, NC 27560.

*Designates required fields.

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 ORGOVYX Support Program will provide results to both Prescriber and Patient).

Financial assistance†

Evaluate Patient for:

☐ Bridge Program (for commercially insured patients)‡

☐ Copay Assistance Program (for commercially insured patients)‡

☐ Myovant Sciences Patient Assistance Program‡

The ORGOVYX Support Program will complete a benefits investigation for the Bridge Program and 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 5.

Patient information

First Name* _____ Last Name* _____ Date of Birth* (MM/DD/YY) _____

Preferred Language ☐ English ☐ Spanish ☐ Other _____ Email _____

Address* _____ City* _____ State* _____ ZIP* _____

Home Phone* _____ Work Phone _____ Cell Phone* _____

Preferred Contact Phone Number ☐ Home ☐ Work ☐ Cell Best Time to Contact ☐ Morning ☐ Afternoon ☐ Evening
(You can select more than 1 option.)

OK to leave a message at your preferred contact phone number? ☐ Yes ☐ No

Alternate Contact: Name _____ Relationship to Patient _____ Phone _____

Pharmacy benefit and medical insurance information

☐ Patient does not have insurance (if checked, skip this section).

FOR THIS SECTION: Fill out the pharmacy and medical insurance information below **OR** fax copies of the patient's PHARMACY BENEFIT and MEDICAL insurance cards along with this form to 1-844-826-8875.

Prescription Insurance Name* _____

Member Name _____ Group# _____ Prescription Insurance Phone _____

Member ID# _____ PCN# _____ BIN# _____

Medical Insurance Name* _____ Member Name _____

Medical Insurance Type ☐ Private/Commercial ☐ Medicare ☐ Medicaid Insurance Phone _____

Member ID# _____ Group# _____ Effective date _____

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*Designates required fields.

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 4 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 4 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 1 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.

SIGN HERE **Patient Signature*:** _____ **Date*:** _____

If signed by legal representative of patient:

Legal Representative Signature: _____ **Date:** _____

Printed Name of Legal Representative: _____

Legal Representative's Relationship to Patient: _____

Other Consents Related to Participation in the ORGOVYX 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 4 and 5 for participating in the Myovant Sciences Patient Assistance Program, and I grant permission to EvinceMed to provide the ORGOVYX 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 ORGOVYX 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 4 and 5 for participating in the ORGOVYX Copay Assistance Program.

Bridge Program Terms and Conditions Consent *(Required for ORGOVYX Bridge Program)*

☐ By checking this box and signing below, I confirm that I have read, understand, and accept the terms and conditions on pages 4 and 5 for participating in the ORGOVYX Bridge Program.

SIGN HERE **Patient Signature*:** _____ **Date*:** _____

If signed by legal representative of patient:

Legal Representative Signature: _____ **Date:** _____

Printed Name of Legal Representative: _____

Legal Representative's Relationship to Patient: _____

ORGOVYX® SUPPORT PROGRAM

PATIENT START FORM

FAX completed forms to 1-844-826-8875

If you have questions or need more information, call 1-833-ORGOVYX (1-833-674-6899), Monday–Friday, 8 AM–8 PM ET, visit OrgovyxHCP.com, or write us at 2250 Perimeter Park Dr, Suite 300, Morrisville, NC 27560.

*Designates required fields.

Select preferred dispensing method*: Please select one only.

☐ In-Office/Clinic Dispensing Pharmacy or Hospital/Health System Dispensing Pharmacy _____

Pharmacy Contact Name _____ Office Phone _____

☐ Specialty Pharmacy (Please select specialty pharmacy below.)

☐ Biologics ☐ Onco360

Prescriber information: Fill out your information and NPI number.

Practice Name* _____ Prescriber Name* _____

Specialty _____ NPI#* _____

Supervising/Collaborating Physician Name _____

Office Address* _____ City* _____ State* ____ ZIP* _____

Primary Office Contact Name _____ Office Phone* _____

Office Contact Email _____ Office Fax* _____

Prescription: Fill out the prescription type that is relevant to your patient.

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.

Patient's DOB* (MM/DD/YY) _____ Patient's Full Name* _____

Anticipated ORGOVYX Start Date _____ Diagnosis/ICD-10-CM Code* _____

Drug Name (NDC: 72974-120-01)	Directions **Please check the box(es) that correspond(s) to the prescribed dose regimen indicated for the patient.** (Please see dosage and administration section of the full Prescribing Information.) (Bridge Program and PAP prescriptions will only be filled for advanced prostate cancer patients and must be consistent with the dosage recommendation in the full Prescribing Information.)	Quantity	Refills Indicate number of refills below.
ORGOVYX® (relugolix) 120 mg tablets	☐ **Loading dose followed by maintenance dose:** Take 3 tablets (360 mg) by mouth on the first day of treatment. After the first day, take 1 tablet (120 mg) by mouth once daily around the same time each day.	**30 tablets**	**NO REFILLS**
	☐ **Maintenance dose:** Take 1 tablet (120 mg) by mouth once daily around the same time each day.	**30 tablets**	_____
	☐ **Loading dose followed by dose modification for use with combined P-gp and strong CYP3A inducers that cannot be avoided (per full Prescribing Information):** Take 3 tablets (360 mg) by mouth on the first day of treatment. After the first day, take 2 tablets (240 mg) by mouth once daily around the same time each day.	**60 tablets**	**NO REFILLS**
	☐ **Dose modification for use with combined P-gp and strong CYP3A inducers that cannot be avoided (per full Prescribing Information):** Take 2 tablets (240 mg) by mouth once daily around the same time each day.	**60 tablets**	_____

Ship to*: ☐ Doctor's Office ☐ Patient's Home

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 ORGOVYX Support Program selected above, including without limitation, the requirement that the patient be prescribed ORGOVYX for an FDA-approved indication. I acknowledge and agree that I may not bill for medication dispensed under the ORGOVYX Bridge Program or 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 ORGOVYX Support Program.

SIGN HERE **Prescriber's Signature*:** _____ ☐ Dispense as Written

(Wet signature is required.)

Date*: _____

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 ORGOVYX Support Program and other ORGOVYX-related support programs
- Providing me with ORGOVYX 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 ORGOVYX
  - Providing me with financial assistance resources if I'm eligible, including copay assistance or free drug programs
  - Communicating with my healthcare team about ORGOVYX® 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 ORGOVYX and ORGOVYX-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 2 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 ORGOVYX 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 ORGOVYX Support Program, Myovant Sciences may request additional documentation to verify my personal information
- I am not charged to enroll or participate in the ORGOVYX Support Program or required to purchase any Myovant Sciences product
- The ORGOVYX 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 ORGOVYX Support Program if my insurance changes or I am no longer prescribed ORGOVYX
- 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

HEALTHCARE PROVIDER CERTIFICATION AND CONSENT

By signing on page 2 of this form, I certify that I have obtained any and all consents from the patient or the patient's legal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Myovant Sciences and its contractors and agents for purposes relating to Myovant Sciences, patient support programs, including, assisting the patient with benefits investigation, prior authorization/appeals assistance, financial assistance resources and information, such as copay support or free drug programs, for which the patient may be eligible, and other support for ORGOVYX® (relugolix).

I certify that the patient (or the patient's legal representative) has provided consent to be contacted, at the patient's phone number provided on this form, by Myovant Sciences and/or parties acting on its behalf, in relation to the patient's access to ORGOVYX.

For Specialty Pharmacy Triage: I give consent to Myovant Sciences to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. Transmission of this form shall be via fax or mail; verbal transmission does not constitute a valid prescription.

ORGOVYX COPAY ASSISTANCE PROGRAM: TERMS AND CONDITIONS

The ORGOVYX Copay Assistance Program ("Copay Program") is for eligible patients with commercial prescription insurance for ORGOVYX. With this Copay Program, eligible patients will pay as little as $10 per month, subject to a maximum of $10,000 per calendar year. After the annual maximum of $10,000 for ORGOVYX is reached, patient will be responsible for the remaining monthly out-of-pocket costs. This Copay Program may not be redeemed more than once per 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 generic equivalent for ORGOVYX 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, present, 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 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 ORGOVYX Copay Program is valid through December 31, 2024.

ORGOVYX BRIDGE PROGRAM: TERMS AND CONDITIONS

The ORGOVYX Bridge Program ("Bridge Program") provides ORGOVYX at no cost for a limited period (up to 4 months) in a calendar year to eligible, commercially-insured patients, who have been prescribed ORGOVYX for an FDA-approved indication, and whose insurance coverage is delayed or who experience a temporary lapse in coverage. Prescribers must complete the Bridge Program prescription on the start form. By participating, patient acknowledges intent to pursue insurance coverage for ORGOVYX with their healthcare provider. Patients will receive their maintenance drug supply each month for up to 4 months or until they receive insurance coverage approval, whichever occurs earlier. The Bridge Program is not available 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 must be residents of the United States or US Territories. The Bridge 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 Bridge Program. Patients and participating prescribers agree not to seek reimbursement for all, or any part of the benefit received by the patient through this Bridge Program. No purchase necessary. The Bridge 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 Bridge 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 ORGOVYX at no cost to eligible patients who are prescribed ORGOVYX for an FDA-approved indication. Patients and prescribers must complete the ORGOVYX 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 ORGOVYX; (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 ORGOVYX 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 ORGOVYX 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 and Patient Product Information for ORGOVYX® (relugolix).

ORGOVYX® (relugolix) 120 mg tablets