ORGOVYX™
(relugolix) 120 mg tablets

ORGOVYX SUPPORT PROGRAM

Patient Consent Form

If your patient has been prescribed ORGOVYX and would like to enroll in the ORGOVYX Support Program, please have them read and sign the Patient Certification and Consent below and the Patient Consent on the following page.

Fax completed forms to 1-844-826-8875

If you have any 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 P.O. Box 2211, Columbus, OH 43216.

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

☐ 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 eligibility standards of the PAP program.

☐ I have read and agree to the Terms and Conditions for participation in the Copay Assistance Program.

*For full terms and conditions for the Bridge Program, Copay Assistance Program, and Free Trial Program, please visit OrgovyxHCP.com.

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

Guardian Signature (If Applicable) _____ **Date** _____

ORGOVYX™ (relugolix) 120 mg tablets

ORGOVYX SUPPORT PROGRAM
PATIENT CONSENT

To join the ORGOVYX Support Program, please read the consent form and sign below.

PATIENT AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION (PHI):
By signing below, I give consent to my healthcare team (my physicians, pharmacists, specialty pharmacies, and other healthcare providers, and my health insurers) to disclose information related to my medical condition and treatment, financial information, coverage information, and contact information (my "protected health information" or "PHI") to Myovant Sciences, Inc. (including its agents and contractors) to use for the following purposes:

- Enroll me in and contact me about the ORGOVYX Support Program
- Provide 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
    - Providing me with financial assistance resources if I'm eligible, including copay assistance or free drug programs
    - Sending me an ORGOVYX Welcome Kit (where appropriate)
    - Enrolling me in the ORGOVYX Nurse Support Program
    - Communicating with my healthcare providers about ORGOVYX and Patient Support 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
    - Communicating with me through telephone or electronically 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 one year 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 P.O. Box 2211, Columbus, OH 43216
- I may refuse to sign this consent
- My healthcare treatment and eligibility for and receipt of health care 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 a right to receive a copy of this authorization consent once I have signed it

OPTIONAL CONSENT TO RECEIVE CERTAIN CALLS AND TEXT MESSAGES

☐ I consent to receive marketing calls and texts from and on behalf of Myovant Sciences, made with an autodialer or prerecorded voice, at the cell phone number for me (the patient) provided on this form. I understand that I do not need to provide this consent in order to purchase any Myovant Sciences products. I understand that text message and data rates may apply.

First Name _____ Last Name _____ Date of Birth _____

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

Guardian Signature (If Applicable) _____ **Date** _____