ORGOVYX™
(relugolix) 120 mg tablets

ENROLLING YOUR PATIENTS IN THE ORGOVYX SUPPORT PROGRAM

We are dedicated to providing your patients ongoing support to help them start and continue taking ORGOVYX as prescribed. We know how important it is for patients to stay on track while on treatment. We're here to help.

The ORGOVYX Support Program offers eligible patients:
• Reimbursement support • ORGOVYX Free Trial Program • Financial assistance
• ORGOVYX Bridge Program • Nurse support • ORGOVYX education

STEPS FOR PATIENTS

1. **Provide information and sign**
Ensure patients provide their information at the top of the Patient Start Form. Patients must also read the consent information on pages 1 and 2, provide their consent, and sign

2. **Provide insurance information**
The patient must provide their medical and pharmacy insurance information. They can either provide copies of their **medical** and **pharmacy benefit** insurance cards to be faxed with the form or provide the information directly on the form

3. **Answer pharmacy call**
Remind patients to look out for a call from the dispensing pharmacy to confirm their prescription

Patients may opt out of this program at any time by calling 1-833-ORGOVYX (1-833-674-6899) or submitting a written opt-out to P.O. Box 2211, Columbus, OH 43216.

STEPS FOR PRESCRIBERS

1. **Fill out patient insurance and practice information**
Ensure that the patient's insurance information is either filled out on the form or that copies of their **medical** and **pharmacy benefit** cards are faxed. Fill out the practice information on page 3, including state license and NPI numbers

2. **Fill out the appropriate prescription type for your patient:**
   - Free trial prescription
   - ORGOVYX prescription to send to your preferred specialty pharmacy
   - Bridge prescription

3. **Sign to indicate prescriber certification**
Review prescriber consent information and sign to authorize prescription

4. **Fax completed forms to the ORGOVYX Support Program at 1-844-826-8875**
Only pages 1, 2, and 3 of this document need to be faxed

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
P.O. Box 2211, Columbus, OH 43216

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

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ORGOVYX SUPPORT PROGRAM
START FORM

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 information

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

Preferred Language ☐ English ☐ Spanish ☐ Other _____ Email _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Method of Contact ☐ Home ☐ Work ☐ Cell

Best Time to Contact ☐ Morning ☐ Afternoon ☐ Evening
(You can select more than 1 option.)

OK to leave confidential message? ☐ Y ☐ N

Alternate Contact: Name _____ Relationship to Patient _____ Phone _____

Medical and pharmacy benefit insurance information

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

Medical Insurance Name _____ Member Name _____

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

Member ID# & Group ID# _____

Prescription Insurance Name _____

Member Name _____ Group # _____ Prescription Insurance Phone _____

Member ID# _____ PCN# _____ BIN# _____

Patient consents: To join the ORGOVYX 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

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 on page 4 of this form.

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

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

PATIENT AUTHORIZATION: FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Patients, keep this page for your records.

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.

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

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

ORGOVYX™ (relugolix) 120 mg tablets

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START FORM

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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

Prescriber information: Fill out your information and NPI numbers.

☐ Clinic Pharmacy/In-Office Dispensing Pharmacy _____

Pharmacy Phone _____ Practice Name _____

Prescriber Name _____ Specialty _____

Office Address _____ Office Phone _____

Office Fax _____ Contact Name _____ Phone _____

Office Contact Email _____ NPI# _____

Supervising/Collaborating Physician Name _____

Prescription type: Fill out the prescription 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 _____

Free Trial Prescription

Prescription Type	Drug Name (NDC: 72974-120-01)	Directions*	Quantity	Refills
Free Trial Prescription of ORGOVYX Diagnosis/ICD-10 Code: _____	**ORGOVYX™ (relugolix) 120 mg tablets**	**Loading dose:** Take 3 tablets (360 mg) by mouth on the first day of treatment. **Maintenance dose:** Take 1 tablet (120 mg) by mouth once daily around the same time each day.	**30 tablets**	**1**

SIGN HERE **Prescriber's Signature** _____ **Date** _____

(Dispense as written)

ORGOVYX Prescription

Prescription Type	Drug Name (NDC: 72974-120-01)	Directions*	Quantity	Refills
ORGOVYX Prescription Diagnosis/ICD-10 Code: _____	**ORGOVYX™ (relugolix) 120 mg tablets**	**Loading dose:** Take 3 tablets (360 mg) by mouth on the first day of treatment. **Maintenance dose:** Take 1 tablet (120 mg) by mouth once daily around the same time each day. **OR:** _____ (Prescriber to specify any alternative or additional dosing instructions here.)	**30 tablets**	_____ (indicate number of refills)

Preferred Specialty Pharmacy: ☐ Biologics SP **OR** ☐ US Bioservices SP

SIGN HERE **Prescriber's Signature** _____ **Date** _____

(Dispense as written)

Bridge Prescription

Prescription Type	Drug Name (NDC: 72974-120-01)	Directions*	Quantity	Refills†
Bridge Prescription of ORGOVYX Diagnosis/ICD-10 Code: _____	**ORGOVYX™ (relugolix) 120 mg tablets**	**Maintenance dose:** Take 1 tablet (120 mg) by mouth once daily around the same time each day.	**30 tablets**	**3**

†Bridge Program provides up to a 4-month supply as indicated in terms and conditions on page 4.

SIGN HERE **Prescriber's Signature** _____ **Date** _____

(Dispense as written)

*Please see dosage and administration section of the full Prescribing Information.

HEALTHCARE PROVIDER CONSENT

By my signature, I certify that I have obtained any and all consents from the patient or the patient's authorized personal 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 I have obtained consent from the patient or the patient's legal representative to be contacted by Myovant Sciences, ORGOVYX, and/or parties acting on their behalf using an autodialer or prerecorded voice at the patient telephone number(s) provided on this form regarding the purposes described above and for other marketing and non-marketing purposes. I also give my permission to receive calls related to these services from Myovant Sciences, ORGOVYX, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at my telephone number(s) provided on this form.

For SP 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 FREE TRIAL PROGRAM TERMS AND CONDITIONS

The ORGOVYX Free Trial Program (FTP) provides an up to 2-month supply of ORGOVYX at no cost to patients who meet FTP eligibility requirements and who agree to the FTP terms and conditions by submitting a signed FTP enrollment form. (i) FTP is a free trial offer, intended solely to allow new patients to try ORGOVYX and to determine with their healthcare provider whether ORGOVYX is right for them. There is no obligation to continue use of ORGOVYX after the free trial has been completed; (ii) to be eligible, patient must: (1) reside in the United States or Puerto Rico and (2) be a new patient not currently using ORGOVYX or who previously received ORGOVYX through the FTP; (iii) ORGOVYX supplied through the FTP will be dispensed only through a pharmacy designated by Myovant Sciences up to the limits above; (iv) product may only be delivered to the patient's home address (no P.O. boxes) or the prescribing healthcare provider's office; (v) it is unlawful for any person to sell, purchase, trade, barter or export ORGOVYX supplied through the FTP or make an offer to do so; (vi) ORGOVYX supplied through the FTP may not be billed (in whole or part, directly or indirectly) to any patient or third-party payer, including Medicare, Medicaid and commercial insurance plans; (vii) Myovant Sciences reserves the right to change or discontinue the FTP at any time without notice; (viii) the FTP is not health insurance; (ix) the FTP is not a discount, rebate, coupon, cost-sharing program or other form of financial assistance and no portion of the value of the FTP product may count as a patient out-of-pocket expense under any health insurance program; (x) ORGOVYX supplied free of charge through the FTP is not contingent on continued use of ORGOVYX. To continue a patient on therapy, a separate prescription must be written by the healthcare provider; (xi) the FTP is void where prohibited by law and where use is prohibited by the patient's insurance provider.

ORGOVYX COPAY ASSISTANCE PROGRAM TERMS AND CONDITIONS

The ORGOVYX Copay Assistance Program ("Program") is for eligible patients with commercial prescription insurance for ORGOVYX. 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. Patient must be a resident of the U.S., Puerto Rico, or U.S. Territories. This Program is void where prohibited by state law. 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. 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. ORGOVYX Support Program has no control over the decisions made by, and does not guarantee support from, independent third parties.

ORGOVYX BRIDGE PROGRAM TERMS AND CONDITIONS

The ORGOVYX Bridge Program ("Program") provides ORGOVYX at no cost for a limited period (up to 4 months) to eligible, commercially-insured patients whose insurance coverage is delayed or who experience a temporary lapse in coverage. 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. Prescribers must complete the Bridge prescription on the start form. By participating, patient acknowledges intent to pursue insurance coverage for ORGOVYX with their health care provider. Program requires the submission of a request for coverage within 9 months post-Program initiation in order to remain eligible. Patients will receive their maintenance drug supply each month for up to 12 months or until they receive insurance coverage approval, whichever occurs earlier. Program is not available to patients who are uninsured or where prohibited by law. 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 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.