rigel onecare®
ACCESS. SUPPORT. CARE.

REZLIDHIA Prescription and Enrollment Form

Phone: 833-744-3562 Fax: 833-397-4435
Email: support@RigelONECARE.com

REZLIDHIA® (olutasidenib) 150 mg capsules

RIGEL ONECARE SUPPORT OPTIONS:

Insurance Verification
❒ Benefits Investigation, Prior Authorization, Appeal Assistance

Financial Assistance
❒ Patient Assistance Program
❒ Copay Assistance

Temporary Supply
❒ Quick Start Program
❒ Bridge Program

PATIENT INFORMATION

First Name* _____ Last Name* _____ DOB* _____ (mm/dd/yyyy)
Sex:* Male ❒ Female ❒ Other ❒ Patient Preferred Language _____
Street Address* _____ City* _____ State* _____ Zip* _____
Home Phone #* _____ Mobile Phone #* _____ Email Address _____

CAREGIVER INFORMATION

Relationship to Patient _____ First Name _____ Last Name _____
Mobile Phone # _____ Email Address _____

PATIENT INSURANCE **Provide copies of the front and back of the insurance card.**

Primary Health Insurance
Name _____
Phone # _____
Policy ID # _____
Group # _____
Policy Holder Name _____ *(if other than patient)*
Policy Holder DOB (mm/dd/yyyy) _____

Primary Prescription Insurance
Name _____
Phone # _____
Policy ID # _____
Rx Group # _____
Rx BIN _____
Rx PCN _____

Secondary Health Insurance
Name _____
Phone # _____
Policy ID # _____
Group # _____
Policy Holder Name _____ *(if other than patient)*
Policy Holder DOB (mm/dd/yyyy) _____

DIAGNOSIS AND CLINICAL INFORMATION

Date of Initial AML Diagnosis _____ (mm/dd/yyyy)

❒ ICD-10-CM C92.00 *Acute myeloblastic leukemia, not having achieved remission*
❒ ICD-10-CM C92.01 *Acute myeloblastic leukemia, in remission*
❒ ICD-10-CM C92.02 *Acute myeloblastic leukemia, in relapse*
❒ Other ICD-10-CM _____

Prior Medications/Treatments for AML

❒ Chemotherapy agents:
❒ Cytarabine ❒ Idarubicin ❒ Daunorubicin ❒ Fludarabine
❒ Azacytidine ❒ Other agent(s) _____

❒ Venclexta (venetoclax) ❒ in combo with HMA ❒ in combo with other _____
❒ Tibsovo (ivosidenib) ❒ in combo with HMA ❒ in combo with other _____
❒ HSCT ❒ Radiation ❒ Other approved AML therapies _____
❒ Investigational compounds _____

Prior (last or current) AML therapy outcome: ❒ Refractory ❒ Relapsed ❒ Neither ❒ No prior treatment (newly diagnosed)

___ Number of treatment regimens (including current) for AML (excluding pending initiation of REZLIDHIA)

❒ YES ❒ NO Does patient have comorbidities or other reasons that preclude the use of intensive chemotherapy?

❒ YES ❒ NO Was the patient tested for IDH1 mutation?
If yes, date _____ (mm/dd/yyyy)

❒ YES ❒ NO ❒ UNKNOWN Is the test FDA approved?

❒ YES ❒ NO Was the result positive for IDH1 mutation?

❒ Primary or ❒ Secondary AML

Transfusion dependency status:
❒ YES ❒ NO Red blood cells
❒ YES ❒ NO Platelets

Most recent lab values:
___ % of bone marrow blasts
___ % of peripheral blood blasts
___ x 10^9 White blood cells
___ x 10^9 Absolute neutrophil count

SPECIALTY PHARMACY

❒ Biologics by McKesson ❒ Onco360 ❒ In-office Dispensing Site _____

* Required

Patient First Name _____ **Last Name** _____ **DOB** _____ **(mm/dd/yyyy)**

PRESCRIPTION AND PRESCRIPTION AUTHORIZATION

Prescriber First Name* _____ Prescriber Last Name* _____

NPI #* _____ State License #* _____ DEA # _____

Practice/Institutional Name _____ Office Contact Name _____

Office Address _____ City _____ State _____ Zip _____

Office Phone #* _____ Office Fax # _____ Office Contact Email _____

Select your preferred method of contact: ❒ Phone ❒ Fax ❒ Email

By signing below, I, as the treating healthcare practitioner, state: (i) This prescription is medically appropriate for this patient and I will be supervising this patient's treatment; (ii) all information supplied to Rigel or its agents ("Rigel") relating to this enrollment form is accurate, and has been obtained pursuant to a separate, valid patient authorization that allows Rigel to contact this patient to provide services relating to (1) treatment and (2) benefit verification and/or pre-authorization. Further, I understand that: (a) any free product provided is for the use of this patient only and shall not be sold or transferred to anyone else, or returned for credit; (b) free product may not be counted toward Medicare Part D out-of-pocket costs, nor claimed for reimbursement from any third-party payer (private or government); (c) I am under no obligation to prescribe any Rigel drug and I have not received and will not receive any benefit from Rigel for prescribing a Rigel drug; and (d) Rigel may revise, change, or terminate programs at any time without notice. I authorize Specialty Pharmacy to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

REZLIDHIA See Full Prescribing Information including **Boxed WARNING** at REZLIDHIAhcp.com for detailed product and dosage information.

Sig: Take 1 (one) capsule (150mg) by mouth twice daily Qty _____ Refills _____

_____/_____ **OR** _____/_____

Prescriber's Signature (no stamp) **Date (mm/dd/yyyy)** Prescriber's Signature (no stamp) Date (mm/dd/yyyy)

Dispense as Written (DAW) Substitution Allowed

If this section does not comply with your state's prescription laws, please provide us with a compliant prescription.

RIGEL'S PRIVACY NOTICE, PATIENT AUTHORIZATION, AND RELEASE

Rigel has programs available to support patients and we will use the information provided to see which program, based on its criteria, you may qualify for. Please read the following carefully, then sign and date.

AUTHORIZATION REGARDING PERSONAL INFORMATION FOR PATIENT SUPPORT

By signing below, I authorize my healthcare providers (including my doctor(s) and their staff), my pharmacies, and my health insurer(s) (my "Health Team") to disclose to Rigel Pharmaceuticals, Inc., its affiliated companies, business partners, contractors, and vendors (together "Rigel") my personal information as needed for my participation in the RIGEL ONECARE program (the "Program"), including my contact information, information related to my healthcare insurance, health records related to the medicine indicated at the top of this form (the "Product"), and my treatment for related conditions (collectively, my "Personal Information"). I authorize Rigel to use my Personal Information to: (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with the Product, (ii) coordinate my receipt of the Product, (iii) provide me with information about the Product, (iv) contact me throughout my treatment with the Product to discuss my treatment and provide related support, and (v) conduct program improvement and other internal business activities in connection with the Program (including market research, surveys, quality assurance), and I authorize Rigel to share my Personal Information with my Health Team for the same purposes. I understand and agree that Personal Information transmitted by email and cell phone cannot be secured against unauthorized access.

I understand that:

- While Rigel intends to use my Personal Information only as described above, once my Personal Information is disclosed pursuant to this authorization, it may no longer be protected by certain federal privacy regulations and might be disclosed to others.
- Rigel (i) will not use my Personal Information for promotional marketing purposes unrelated to the Program, (ii) uses reasonable administrative, technical, and physical safeguards to protect Personal Information, and (iii) has an applicable Privacy Policy at https://www.rigel.com/privacy-policy.
- I may refuse to sign this authorization or, in the future, withdraw it by writing to Rigel at RIGEL ONECARE, 11800 Weston Pkwy, Cary, NC 27513, and that providing the authorization is not a condition for me to receive treatment (including with the Product) or health insurance coverage, but that I may not participate in the Program unless I provide this authorization.
- If I do withdraw the authorization, that will not invalidate any uses or disclosures made in reliance on the authorization before my written notice of withdrawal is received by Rigel.
- My pharmacy may receive payment from Rigel for disclosing and using my Personal Information in exchange for providing program-related administrative or patient support services, including education related to my therapy.
- This authorization will expire 5 years after I sign it below, unless I withdraw it earlier or state law requires an earlier expiration date.
- I am entitled to receive a copy of this authorization after I have signed it below.

❒ I authorize Rigel to communicate with me via unencrypted email and text.

Patient Name* (print) _____ Representative Name (print) _____

Patient/Representative Signature* (If signed by a representative, I certify that I am legally authorized to act on behalf of the patient and am describing my relationship to the patient below) _____ Date* (mm/dd/yyyy) _____

Relationship to Patient _____

ADDITIONAL COMMUNICATION RELEASE

❒ I understand Rigel may call, email, text message, and mail materials from Rigel at the telephone number(s) and addresses (physical and email) provided on the enrollment form. I understand that my cell phone carrier's standard rates may apply for calls and texts to my cell phone.

Please see REZLIDHIAhcp.com for Full Prescribing Information including Boxed WARNING.

* Required

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