rigel onecare®
ACCESS. SUPPORT. CARE.

REZLIDHIA Enrollment Form

Please fax completed form to:
833-397-4435 (833-FXrigel)

REZLIDHIA™ (olutasidenib) 150 mg capsules

Questions? Call RIGEL ONECARE Monday to Friday, 8am to 8pm EST at **833-744-3562 (833-RigelOC)**

RIGEL ONECARE PROGRAMS*

Nurse Navigator

- Will identify the applicable support resources for patients taking REZLIDHIA
- Will provide patients taking REZLIDHIA with adherence and product education calls that are personalized to their desired frequency
- Will assist with access needs for REZLIDHIA such as benefit investigations, prior authorizations, and appeal processes, if needed

Patient Assistance Program (PAP)

- ≤ 500% of federal poverty level
- On-label indications only
- Any patient, 18 years or older, is eligible if criteria are met

Copay or Coinsurance Assistance

- Pay as little as $15 per prescription fill
- Annual benefit of $25,000
- Must have commercial insurance (no Medicaid, Medicare, or other government programs)

Free Drug Supply

- For insurance coverage delays longer than 5 business days
- Up to 60 days supply and/or insurance coverage determination
- On-label indications only
- Any patient, 18 years or older, is eligible if criteria are met

**All RIGEL ONECARE programs are subject to eligibility requirements and changes. Criteria above do not represent all criteria for each program. Must be U.S. resident or U.S. territory resident. Restrictions apply.*

PATIENT INFORMATION

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

Sex: ❒ Male ❒ Female ❒ Other

Street Address _____ City _____ State _____ Zip _____

Home Phone # _____ Mobile Phone # _____ Email Address _____

PATIENT INSURANCE AND PHARMACY PREFERENCE

Please copy both sides of the patient's insurance card(s) and include with fax.

Primary Health Insurance	Prescription Drug Insurance	Secondary Insurance
Plan Name _____	Plan Name _____	Plan Name _____
Phone # _____	Phone # _____	Phone # _____
Policy ID # _____	Policy ID # _____	Policy ID # _____
Group # _____	Group # _____	Group # _____
_____ Policy Holder Name *(if other than patient)*	Rx BIN _____	
DOB _____ (mm/dd/yyyy)	PCN _____	

❒ Patient has no insurance

Preferred Pharmacy: ❒ IDN / IOD Pharmacy ❒ Biologics by McKesson ❒ Optime Care SP

IDN / IOD Pharmacy Name _____ Phone # _____ Fax # _____

 Click here or see REZLIDHIA.com for Full Prescribing Information including **Boxed WARNING**.

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

DIAGNOSIS AND CLINICAL INFORMATION

Data 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 _____

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

PRESCRIBER INFORMATION & PRESCRIPTION

Prescriber Name _____

Practice Name _____

Phone _____ Fax _____

Email _____

NPI # _____ DEA # _____

Prescriber Specialty _____

Practice Contact _____

Street Address _____

City _____ State _____ Zip _____

State License # _____

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 REZLIDHIA.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)**
Dispense as Written (DAW)

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

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

Contact RIGEL ONECARE for information regarding electronic prescriptions or other dosing instructions.

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

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.

PERSONAL INFORMATION FOR PATIENT SUPPORT I authorize my healthcare providers (including my doctor(s) and their staff), my pharmacies, my employer and my health insurer(s) to disclose my personal information, which may include any information related to healthcare insurance, benefits, coverage limits, appeals and health records related to my treatment or other relevant information in the RIGEL ONECARE program ("Personal Information") to Rigel Pharmaceuticals, Inc., its affiliated companies, business partners, contractors, and vendors (together "Rigel") so that Rigel can (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with REZLIDHIA, (ii) coordinate my receipt of REZLIDHIA, (iii) provide me with information about REZLIDHIA, (iv) contact me throughout therapy to discuss my therapy and provide clinical support, (v) conduct market research, surveys, quality assurance, and other internal business activities in connection with the RIGEL ONECARE program, and (vi) share such information with pharmacies, my insurer(s), healthcare provider (including my doctor(s) and their staff) and other third parties for the purposes described above. I understand and agree that Personal Information transmitted by email and cell phone cannot be secured against unauthorized access. If I qualify for the Rigel Patient Support Program, I understand that any assistance provided under this program is contingent upon my ability to meet the eligibility criteria for the program as determined by Rigel.

USE While Rigel will only use my Personal Information for the intended purposes described above, I understand that once my Personal Information is disclosed it may be re-disclosed by recipients and will no longer be protected by federal privacy law. I understand my Personal Information may be used by pharmacies to process my prescription. I understand that I may refuse to provide my authorization or in the future opt out of specific components or services of RIGEL ONECARE, and that my refusal will not affect my ability to receive treatment from my healthcare providers. I understand my pharmacy may receive payment from Rigel for disclosing and using my Personal Information in exchange for providing the services associated with the program or for marketing purpose.

TIMEFRAME, COPY, AND REVOCATION I understand that this Authorization will expire upon the earlier of (i) five (5) years from this date, (ii) my unenrollment from the Program, or (iii) as required by applicable law. I also understand that the RIGEL ONECARE program may change or end at any time without prior notification. I also understand that I can obtain a copy of my signed Authorization upon request and that I can revoke this Authorization at any time by calling Rigel at 833-rigelOC (833-744-3562) or 650-449-8646 or by writing to RIGEL ONECARE, 4060 Wedgeway Ct, Earth City, MO 63045. I also understand any revocation will only apply to my healthcare provider(s), pharmacies, and health insurer(s) once they receive notification of my revocation.

Patient Name _____ Representative Name _____
(print) *(print, if applicable)*

Patient/Representative Signature _____ Date _____
(mm/dd/yyyy)

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.

 Click here or see REZLIDHIA.com for Full Prescribing Information including **Boxed WARNING**.

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

PATIENT ASSISTANCE PROGRAM

Patient to complete this section if applying for long-term free drug supply via the Patient Assistance Program (PAP).

Total number of people in your home (including yourself): ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6+

Are you a Veteran? ❒ Yes ❒ No

U.S. Resident: ❒ Yes ❒ No

Disabled: ❒ Yes ❒ No

Total Gross Monthly Household Income $ _____

Last four digits of Social Security Number: _____

I hereby certify that I am not insured for (or am rendered uninsured through the payer denials of) REZLIDHIA. In order to qualify for free product, I must meet the program criteria. I understand that my income will be validated through Experian® based on the information I provided. I understand that RIGEL ONECARE could ask me for a copy of my IRS 1040 form or other proof of income for the purpose of an audit. I agree to provide my financial documentation in a timely manner, if so requested. RIGEL ONECARE reserves the right to make an independent determination of my financial and medical need.

RIGEL ONECARE reserves the right at any time, and without notice, to modify or discontinue this program and any assistance provided to me. I represent and certify that I am a legal resident of the United States (and U.S. territories) and verify that the information provided in this enrollment form is current, complete, and accurate. I agree that I, my healthcare provider, my healthcare provider's institution, or any other person, must not seek payment or accept reimbursement from any third-party payer, including any federal healthcare program such as Medicare or Medicaid, or any private or other insurance plan, or from any other person or entity for any free supply of REZLIDHIA tablets supplied under this program, regardless of whether a payer subsequently determines that it will cover the product. I agree to be responsible for notifying RIGEL ONECARE if (i) I obtain coverage through another source, state, or private program, (ii) I no longer meet the income criteria for the program, or (iii) I find any errors in my application.

Any changes in insurance coverage and/or financial circumstances while enrolled in the program may affect your ability to continue to receive free product via the PAP program. You must reapply for program eligibility at the end of each calendar year. RIGEL ONECARE will reach out to you and your healthcare provider at that time to help with the reenrollment process.

My signature below certifies that I have received, read, understood, and agree to the Patient Assistance Program.

Patient Name _____ Representative Name _____
(print) *(print, if applicable)*

Patient/Representative Signature _____ Date _____
(mm/dd/yyyy)

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