Madrigal Patient Support

Patient Enrollment Form

SCAN Enroll Online

- Call 1-877-219-7770 or visit madrigalpatientsupport.com
- Submit via fax at 1-844-411-1177 or submit online at madrigalenrollmentHCP.com

Support needed ❑ BI ❑ PA ❑ Appeal/Denial ❑ Copay ❑ PAP ❑ SP Triage ❑ Enrollment only (Rx sent to SP)

1 Patient Information — *Asterisk indicates required information.

First name* _____ Last name* _____
Date of birth* (MM/DD/YYYY) ___/___/_____ Gender* ❍ M ❍ F
Address* _____ Apt # _____
City* _____ State* _____ ZIP* _____
Phone* _____ ❍ Mobile ❍ Home OK to leave detailed message? ❍ Y ❍ N OK to text? ❍ Y ❍ N
Caregiver name _____ Caregiver phone _____

2 Patient Insurance Information — Attach a copy of insurance card(s).

SELECT 1 ❍ Patient has pharmacy benefit ❍ Patient does not have pharmacy benefit SELECT 1 ❍ Commercial insurance ❍ Medicare ❍ Medicaid ❍ Other

Insurance name:	Policy #:
Subscriber name: DOB: / /	Rx BIN #:
Rx Group #:	Rx PCN #:

3 Prescriber Information — *Asterisk indicates required information.

First name* _____ Last name* _____
Specialty* _____ NPI #* _____
Address* _____ City* _____ State* _____ ZIP* _____
Phone* _____ Ext _____ Fax* _____ Email _____
Primary office contact name* _____
Phone _____ Ext _____ Fax _____ Email _____

4 Diagnosis

❑ This patient is being prescribed Rezdiffra™ (resmetirom) for an FDA-approved indication.
ICD-10: ❑ K75.81 ❑ Other: _____

❑ Is consistent with F2. ❑ Is consistent with F3.
NITs: ❑ FibroScan ❑ ELF ❑ Other: _____

5 Prescription Information — *Asterisk indicates required information.

Rezdiffra		Bridge (for coverage delay only)
Strength*	❍ 100-mg tablets ❍ 80-mg tablets ❍ 60-mg tablets	❍ 100-mg tablets ❍ 80-mg tablets ❍ 60-mg tablets
Prescribing directions		
Quantity*	❍ 30-day supply *Other*:	15-day supply
Refills*		3x
❑ NKDA	Food/Drug allergies:	

❑ I authorize the dispensing of a limited supply of Rezdiffra as indicated on this form to my commercially insured patient if they experience an insurance coverage delay and otherwise meet eligibility criteria. I authorize Madrigal Patient Support to forward this prescription to the pharmacy dispensing free product under the Madrigal Bridge Program to the patient named on this form. I agree to assist in efforts to secure access to Rezdiffra for my commercially insured patient in the event of a coverage delay. *For full eligibility criteria of the Madrigal Bridge Program, please contact Madrigal Patient Support.*

Prescription Signature (REQUIRED)

X _____ ___/___/_____ X _____ ___/___/_____

Prescriber signature*: Dispense as written Date* **Prescriber signature: Substitution permitted** Date

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.

6 Preferred Specialty Pharmacy

❍ Accredo	❍ Amber	❍ Centerwell	❍ CVS Specialty Pharmacy	❍ Maxor	❍ Optum	❍ Walgreens

7 Prescriber Attestation — *Asterisk indicates required information.

Madrigal Patient Support Enrollment: Prescriber Attestation (REQUIRED)

Prescriber name* _____

X _____ ___/___/_____
Prescriber signature* Date*

By submitting this form, I certify to the best of my knowledge that: (a) the person named on this form is my patient and that the information submitted is complete and accurate; (b) the above therapy is medically necessary for this patient and for an FDA-approved indication; (c) I have received the written authorization in accordance with applicable state and federal law (including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ["HIPAA"]), to provide the health information regarding the patient on this form to Madrigal Patient Support, the contracted dispensing pharmacy, or other third-party contractors working on behalf of Madrigal Patient Support for the purpose of requesting reimbursement support, assisting in initiating or continuing therapy, to facilitate the filling of my patient's prescription, and to assess, if applicable, the patient's eligibility for patient assistance or other support programs; (d) the support requested on behalf of the patient may include benefits investigation (BI), prior authorization (PA), appeals support, SP Triage, Madrigal Patient Assistance Program, and/or copay information.

If applicable, I authorize Madrigal Patient Support to conduct a benefits investigation for my patient and to act on my behalf for the limited purpose of transmitting this prescription to the appropriate pharmacy designated by the patient per their benefit plan provided that, if this prescription is not so designated, Madrigal Patient Support is authorized to transmit this prescription to a network pharmacy it selects or to the pharmacy otherwise indicated.

I understand that any free product distributed through Madrigal Patient Support is not contingent on any purchase obligations. I also understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale. I consent to Madrigal Patient Support contacting me by fax, mail, or email to provide additional information to Madrigal Patient Support and understand that Madrigal Patient Support may revise, change, or terminate any program services at any time without notice to me.

I certify that I have reviewed the additional terms available at https://hcpverify.com/terms, which are specifically incorporated herein by reference, and acknowledge and consent to their application and enforceability in regards to this certification.

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8 Patient Information & Authorizations — *Asterisk indicates required information.*

Patient last name* _____ First name* _____ DOB* ___/___/___

Email _____

Mobile phone _____ ☐ *I have read the **Text Messaging Consent** in section 10 and expressly consent to receive text messages from Madrigal.*

Patient Authorization for Access Support (REQUIRED FOR MPS SUPPORT) *(See section 9 for details of authorization.)*

Patient or authorized representative signature X _____ Date* ___/___/___

Print authorized representative: First name _____ Last name _____

Relationship to patient _____ Representative phone _____ Date ___/___/___

Patient Certifications *(See section 10 for details of consent.)*

Patient or authorized representative signature X _____ Date* **(REQUIRED IF SIGNED)** ___/___/___

Annual household income _____ Household size _____

9 Patient Authorization for Access Support

(HIPAA) Patient Authorization for Access Support:

I authorize my physician(s) and their staff (together, "Healthcare Providers"), my health insurer, health plan or programs that provide me healthcare benefits (together, "Health Insurers"), and any specialty pharmacies ("Specialty Pharmacies") that dispense my medication, to disclose my personal or other health information, which may include contact information, demographic information, financial information, and information related to my medical condition, treatments, and health insurance and benefits, to Madrigal Patient Support, and their respective partners, affiliates, subcontractors, and agents (together, "Madrigal"). I authorize Madrigal to receive, use, and share my information in order to provide me with access to the product, services, and programs described on this form, which may include the following:

- Working with my health insurance plan to understand or verify coverage for Madrigal products
- Enrolling in the Madrigal Patient Assistance Program (MPAP)
- Determining my eligibility for and facilitating enrollment into financial assistance services if I'm eligible, including copay assistance
- Coordinating my prescription through a pharmacy. This includes contacting me to discuss my coverage, costs and eligibility for assistance and other program administration purposes
- Facilitating my access to Madrigal products through prior authorization for coverage and assistance with appeals of denied claims for coverage
- Ensuring quality and safety and improving our products and services

I understand that Madrigal may de-identify my information and use it in performing research, education, business analytics, marketing studies, or for other commercial purposes, including linkage with other de-identified information Madrigal receives from other sources. I understand that Madrigal may share my information, including identifiable health information, in order to de-identify it for these purposes and as needed to communicate with me by mail, telephone, or email, or, if I indicate my agreement and consent, by text.

Once disclosed to Madrigal, my personal information released under this authorization may no longer be protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA). However, Madrigal will only use and share my personal information for the purposes stated on this authorization or as otherwise permitted by law.

I understand that I do not have to sign this Authorization, but Madrigal will not be able to provide the services to me without it and I will not be able to enroll in Madrigal Patient Support. A decision by me not to sign this Authorization will not affect my ability to obtain medical treatment, payment for treatment, insurance coverage, access to health benefits or Madrigal products. However, I understand that my pharmacy may receive payment or other remuneration for disclosing my personal information and distributing marketing material pursuant to this authorization.

This authorization is valid for 18 months from the date support is last provided, or until my local state law requires expiration, or I revoke it earlier. I have the right to revoke (cancel) this authorization at any time by submitting a written notice to: Madrigal Patient Support, P.O. Box 7613, Overland Park, KS 66207. If I revoke this authorization, I will no longer be eligible for the services described. If a healthcare provider, health insurer, or specialty pharmacy is disclosing my personal information to Madrigal on an authorized, ongoing basis, my revocation will be effective with respect to such disclosing party when they receive notice of my revocation. My revocation will not impact uses and disclosures of my personal information that have already occurred in reliance on this authorization.

More information on my privacy rights, including specific rights I may have as a resident of certain states can be found in Madrigal's privacy policy (www.madrigalpharma.com/privacy).

I have a right to request a copy of this authorization.

10 Patient Certifications

I am enrolling in the Madrigal Patient Support Program ("MPS") and authorize Madrigal Pharmaceuticals, Inc., its affiliates, agents and service providers ("Madrigal") to provide support under MPS, as described in this Enrollment Form and as may be added in the future. Such support includes medication and adherence communications and support, medication dispensing support, coverage and financial assistance support, disease and medication education, and other support services.

If I sign up for Madrigal copay support, I understand that copay card information will be sent to my designated specialty pharmacy along with my prescription, and any assistance with my applicable cost-sharing or copayment for Rezdiffra™ (resmetirom) will be made in accordance with the MPS terms and conditions.

I authorize Madrigal to verify my eligibility for the Madrigal Patient Assistance Program ("MPAP"), and I understand that such verification may include contacting me or my Healthcare Provider for additional information and/or reviewing additional financial, insurance, and/or medical information. I authorize Madrigal under the Fair Credit Reporting Act to use my demographic information to access reports on my individual credit history from consumer reporting agencies, and that such access will not impact my credit score. I further understand and authorize Madrigal to use any consumer reports about me and information collected from me, along with other information they obtain from public and other sources, to estimate my income in conjunction with the MPAP eligibility, if necessary.

I understand that Madrigal Patient Assistance Program (MPAP) provides free medicine to qualifying patients. Participation in MPAP is free and MPAP does not collect any fees from people seeking assistance. I understand that MPAP assistance is dependent on ability to meet the eligibility criteria for the program as determined by MPAP. MPAP does not have any obligation to provide the program services to me and is not liable in the provision of these services.

(continued)

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10 Patient Certifications (continued)

I understand that patients with insurance plans or employers participating in an alternate funding program (also sometimes referred to as patient advocacy programs, specialty networks, SHARx, Paydhealth, or Payer Matrix, among other names) requiring them to apply to a manufacturer's patient assistance program or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of relevant Madrigal products, or that otherwise denies, restricts, eliminates, delays, alters, or withholds any insurance benefits or coverage contingent upon application to, or denial of eligibility for, specialty drug prescription coverage through the alternate funding program are not eligible for the MPAP. I agree to inform MPAP if I am a member of such an insurance plan or if I am applying to MPAP on behalf of a patient who is a member of such an insurance plan. I further understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale. If approved for the MPAP I will not seek to have the value of any medication provided to me under this program counted toward my true-out-of-pocket (TrOOP) cost for prescription drugs for my Medicare Part D Plan. I will not seek reimbursement for any products dispensed under the program. I will notify the program if my insurance or financial situation changes. The program may be changed or discontinued without notice.

I acknowledge that by checking the Text Messaging Consent box in section 8, I expressly consent to receive text messages from or on behalf of Madrigal at the mobile telephone number(s) that I provide. I understand that my wireless service provider's message and data rates may apply. I understand that I can opt out of future text messages at any time by following the opt-out instructions contained in any text message communications, and that I can get help for text messages by texting HELP to the number provided in any text message communications. I also understand that additional text messaging terms and conditions may be provided to me in the future as part of an opt-in confirmation text message. Message and data rates may apply.

I agree to receive by mail, telephone or email, or, if I indicate my agreement and consent above, by text, marketing and promotional communications and other information from Madrigal including health-related resources and therapy information (the "Communications"). I understand that Madrigal respects my personal information. Madrigal or third parties working on its behalf will not sell my personal information. If, in the future, I no longer want to receive the Communications, I may opt out at any time by contacting Madrigal in writing at the address in section 9 or by unsubscribing from Communications.

I understand that I may be contacted by Madrigal in the event that I report an adverse event. I understand that I do not have to enroll in MPS to receive the Communications, and that I can still receive Rezdiffra™ (resmetirom) as prescribed by my Healthcare Provider. I may opt out of receiving Communications, individual support services offered by MPS, including any copay support, or opt out of MPS entirely at any time by notifying an MPS representative by telephone at 1-877-219-7770 or by sending a letter to the address in section 9. I also understand that support provided by MPS may be revised, changed, or terminated at any time.