rigel onecare®
ACCESS. SUPPORT. CARE.

GAVRETO Enrollment and Patient Assistance Program Form

Please fax completed form to: 833-397-4435 (833-FXrigel)
For more information, please call RIGEL ONECARE at
833-744-3562 (833-rigelOC)
Monday – Friday, 8am – 8pm EST or visit **RigelONECARE.com**

GAVRETO® pralsetinib 100mg capsules

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 # _____

DIAGNOSIS

Data of Initial Diagnosis _____ (mm/dd/yyyy)

❒ ICD-10-CM C34.90
Malignant neoplasm of unspecified part of unspecified bronchus or lung.

❒ ICD-10-CM C73
Malignant neoplasm of thyroid gland.

❒ Other ICD-10 _____

CLINICAL INFORMATION

Has patient been on GAVRETO before? ❒ Yes ❒ No

Line of therapy: ❒ 1L ❒ 2L ❒ Other: _____

Smoking history: ❒ Current/former ❒ Never ❒ Unknown

Prior therapy type: ❒ Platinum-based chemotherapy ❒ Non-platinum-based chemotherapy
❒ Multikinase inhibitor ❒ PD-L1 inhibitor

Please click here or visit GAVRETO.com to see the full Prescribing Information and Patient Information for GAVRETO.

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

PRESCRIBER INFORMATION & PRESCRIPTION

Prescriber Name _____ Prescriber Specialty _____

Practice Name _____ Practice Contact _____

Phone _____ Fax _____ Street Address _____

Email _____ City _____ State ____ Zip _____

NPI # _____ DEA # _____ 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.

GAVRETO See full Prescribing Information at GAVRETO.com for detailed product and dosage information.

Sig: Take 4 (four) capsules (100 mg) by mouth once 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.

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

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 GAVRETO, (ii) coordinate my receipt of GAVRETO, (iii) provide me with information about GAVRETO, (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 purposes.

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.

My signature below certifies that I have received, read, understood, and agree to the Privacy Notice and Patient Authorization to release and use my personal health information. I also attest that I (the patient) am 18 years of age or older.

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

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.

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+

U.S. Resident: ❒ Yes ❒ No

Total gross monthly household income $ _____

I hereby certify that I am not insured for (or am rendered uninsured through the payer denial of) GAVRETO. 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 GAVRETO capsules 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. 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 *(print)* _____ Representative Name *(print)* _____

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

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