SpringWorks CareConnections™

GOMEKLI™ (mirdametinib) ENROLLMENT FORM

PLEASE COMPLETE THE ENTIRE FORM, SIGN, AND FAX IT TO 844-227-3747.
SpringWorks CareConnections will acknowledge receipt.
Access a digital enrollment form at springworkstxcares.com/gomekli/hcp, or e-prescribe directly to PharmaCord Pharmacy (NCPDP Number 1836191).

Scan with your mobile device to add SpringWorks CareConnections contact information

For assistance, please call SpringWorks CareConnections™ at 844-CARES-55 (844-227-3755), Monday - Friday, 8 AM - 10 PM ET.

PATIENT TO COMPLETE

SECTION 1 | Patient Information

Patient First and Last Name: _____ Date of Birth: ____/____/____ (MM/DD/YYYY) Gender ◯ M ◯ F

Street Address: _____ Apt: _____ City: _____

State: _____ ZIP: _____ Mobile Phone: (____) _____ ◯ Preferred # Alternate Phone: (____) _____ ◯ Preferred #

Email: _____ Primary Language: _____

Patient Height: _____ Date Last Checked: ____/____/____ (MM/DD/YYYY) Patient Weight: _____ Date Last Checked: ____/____/____ (MM/DD/YYYY)

Preferred Contact Method: ◯ Call ◯ Text ◯ Email Preferred Time of Day to Contact: ◯ Morning ◯ Afternoon ◯ Evening

Legal Representative Name: _____ Relationship to Patient: _____ Phone Number: (____) _____

SECTION 2 | Patient Financial Information (required to verify eligibility for Patient Assistance Program)

Number of Household Members (Including Patient): _____ Annual Gross Household Income: $ _____

SECTION 3 | Patient Consents

TEXT MESSAGING ◯ I authorize SpringWorks Therapeutics or others on its behalf to contact me by automated SMS/text message regarding any of the aforementioned services and/or my condition or treatment. I understand that I am not required to provide this consent as a condition of purchasing any goods or services. Message and data rates may apply. Terms & Conditions can be found at https://springworkstxcares.com/downloads/CareConnections-Mobile-Terms-and-Conditions.pdf. Privacy Policy can be found at https://springworkstx.com/privacy-policy.

SIGN HERE 1 of 2

Patient Authorization: I have read and received a copy of the consent language on **pages 3 and 4 in Section 10** and agree to the Authorization to Disclose/Use Health Information.

_____ ____/____/____ (MM/DD/YYYY)
Patient Signature/Legal Representative

_____
Relationship to Patient (if applicable)

SIGN HERE 2 of 2

Patient Support Program: I have read and agree to enroll in the SpringWorks CareConnections Patient Support Program and to the Patient Certifications on **pages 3 and 4 in Section 10**.

_____ ____/____/____ (MM/DD/YYYY)
Patient Signature/Legal Representative

_____
Relationship to Patient/Legal Representative (if applicable)

PRESCRIBER TO COMPLETE

SECTION 4 | Patient Insurance Information

NOTE: You may attach a copy of both sides of the patient's insurance card(s) instead of, or in addition to, the below:

Coverage: ◯ Commercial/Private ◯ Medicare ◯ Medicaid ◯ VA/DoD/TRICARE ◯ Other ◯ Uninsured

Primary Prescription Insurance Name: _____ Group Number: _____

Phone Number: (____) _____ Policy ID: _____ PCN Number: _____ BIN Number: _____

Policy Holder First and Last Name: _____ Policy Holder Date of Birth: ____/____/____ (MM/DD/YYYY)

Policy Holder Relationship to Patient: _____

Secondary Prescription Insurance Name: _____ Group Number: _____

Phone Number: (____) _____ Policy ID: _____ PCN Number: _____ BIN Number: _____

Policy Holder First and Last Name: _____ Policy Holder Date of Birth: ____/____/____ (MM/DD/YYYY)

Policy Holder Relationship to Patient: _____

SECTION 5 | Patient Insurance Status

SpringWorks CareConnections will verify your patient's insurance coverage. Please share any coverage information you've already obtained.

Has a Prior Authorization (PA) Been Initiated? ◯ Yes ◯ No If "Yes," PA Status: ◯ Approved ◯ Denied ◯ Pending

Has an Appeal Been Initiated? ◯ Yes ◯ No If "Yes," Appeal Status: ◯ Approved ◯ Denied ◯ Pending

NOTE: Please attach any relevant insurer approval or denial letters

SECTION 6 | Patient Clinical Information

NOTE: Please attach any clinical notes or laboratory results relevant to therapy

1. Select ICD-10-CM code **Q85.01:** ◯ **Q85.01** Neurofibromatosis, type 1

2. Select the appropriate location-based code for NF1-associated PN(s) (**select all that apply**):

- ◯ D33.3 Benign neoplasm of cranial nerves
- ◯ D36.10 Benign neoplasm of peripheral nerves and autonomic nervous system, unspecified
- ◯ D36.11 Benign neoplasm of peripheral nerves and autonomic nervous system of face, head, and neck
- ◯ D36.12 Benign neoplasm of peripheral nerves and autonomic nervous system, upper limb, including shoulder
- ◯ D36.13 Benign neoplasm of peripheral nerves and autonomic nervous system of lower limb, including hip
- ◯ D36.14 Benign neoplasm of peripheral nerves and autonomic nervous system of thorax
- ◯ D36.15 Benign neoplasm of peripheral nerves and autonomic nervous system of abdomen
- ◯ D36.16 Benign neoplasm of peripheral nerves and autonomic nervous system of pelvis
- ◯ D36.17 Benign neoplasm of peripheral nerves and autonomic nervous system of trunk, unspecified
- ◯ Other: _____

Clinical Notes Attached? ◯ Yes ◯ No

Allergies: _____ Current Medication(s): _____

Received Prior Treatment: ◯ Yes ◯ No, Treatment Naive

If Yes, **Select All That Apply:** ◯ Prior Surgery If Yes: Date __/__/_____ ◯ Prior Systemic Therapy (**Please Specify Below**)

Medication Name: _____ Start Date: ____/____/____ Stop Date: ____/____/____ ◯ Current

Medication Name: _____ Start Date: ____/____/____ Stop Date: ____/____/____ ◯ Current

Other: _____

SpringWorks CareConnections™

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PRESCRIBER TO COMPLETE

SECTION 7 | Prescriber Information

Prescriber First and Last Name: _____ Prescriber Title: _____

Prescriber Specialty: _____ NPI Number: _____ Tax ID: _____ DEA Number: _____

Site/Facility Name: _____ Street Address: _____

City: _____ State: _____ ZIP: _____ Telephone: (____) _____ Fax: (____) _____

Office Contact First and Last Name: _____ Office Contact Email: _____

Office Contact Phone: _____ Preferred Contact Method: ◯ Phone ◯ Email ◯ Fax

SECTION 8 | Prescription for GOMEKLI™ (mirdametinib)

NOTE: Complete GOMEKLI Prescription Information section AND either section 8A or 8B (if applicable).

GOMEKLI PRESCRIPTION INFORMATION

The recommended dosage of GOMEKLI is 2 mg/m^2 orally twice daily (approximately every 12 hours) with or without food for the first 21 days of each 28-day cycle. The maximum dose is 4 mg twice daily. Continue treatment with GOMEKLI until disease progression or unacceptable toxicity. The recommended dosage is based on body surface area (BSA). Please see US Prescribing Information for recommended and modified dosage.

Patient Name: _____ **Date of Birth:** _____ /_____ /_____ (MM / DD / YYYY)

National Drug Code (NDC): **Capsules:** 1 mg (NDC: 82448-130-42) 42 per bottle | 2 mg (NDC: 82448-260-42) 42 per bottle | 2 mg (NDC: 82448-260-84) 84 per bottle
Tablets: 1 mg (NDC: 82448-134-42) 42 per bottle | 1 mg (NDC: 82448-134-84) 84 per bottle

Medication	Dosage Form, Strength, and Quantity	Refills	Dosage Instructions
◯ **8.** GOMEKLI PRESCRIPTION	◯ _____ 1 mg capsules (21-day supply) ◯ _____ 2 mg capsules (21-day supply) ◯ _____ 1 mg tablets (21-day supply)	_____	◯ Capsules: ___mg orally twice daily ◯ Tablets: ___mg swallowed whole or dispersed and administered as oral suspension twice daily
◯ **8A.** GOMEKLI QUICK START PROGRAM (NEW PATIENT)	◯ _____ 1 mg capsules (21-day supply) ◯ _____ 2 mg capsules (21-day supply) ◯ _____ 1 mg tablets (21-day supply)	Up to 5	◯ Capsules: ___mg orally twice daily ◯ Tablets: ___mg swallowed whole or dispersed and administered as oral suspension twice daily
I approve the dispense of GOMEKLI as shown above to my patient if they experience a qualified delay in obtaining insurance coverage. I certify that my patient has not previously been treated with GOMEKLI, has an immediate medical need for GOMEKLI, and meets all eligibility criteria found at springworkstxcares.com/gomekli/hcp.			
◯ **8B.** GOMEKLI BRIDGE PROGRAM (EXISTING PATIENT)	◯ _____ 1 mg capsules (21-day supply) ◯ _____ 2 mg capsules (21-day supply) ◯ _____ 1 mg tablets (21-day supply)	Up to 2	◯ Capsules: ___mg orally twice daily ◯ Tablets: ___mg swallowed whole or dispersed and administered as oral suspension twice daily
I approve the dispense of GOMEKLI as shown above to my patient if they experience a qualified lapse in insurance coverage. I certify that my patient meets all eligibility criteria found at springworkstxcares.com/gomekli/hcp.			

DISPENSE AS WRITTEN

PRESCRIBER SIGN HERE

Prescriber's Signature: _____ Date: _____ /_____ /_____ (MM / DD / YYYY)

Any Special Instructions: _____

My signature above certifies that the person named on this form is my patient, the information provided, to the best of my knowledge, is complete and accurate, and that therapy with GOMEKLI is medically necessary. I verify that the patient and healthcare provider information on this enrollment form was completed by me or at my direction and I have discussed with my patient the SpringWorks CareConnections™ program or any other SpringWorks-affiliated patient support services and activities (the "Patient Support Program"). I authorize SpringWorks CareConnections to transmit the above prescription to the appropriate specialty pharmacy for my patient. I understand that I am under no obligation to prescribe any SpringWorks products and that I have not received, nor will I receive any benefit from SpringWorks for doing so. I will notify SpringWorks immediately if the therapy with GOMEKLI is no longer medically necessary for this patient's treatment or if my patient's insurance or financial status changes. I understand that I must comply with my practicing state's specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements may result in the dispensing pharmacy reaching out to me. I will not seek reimbursement from any third-party payer or government entity for any product provided free of charge by SpringWorks. Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form.

PRESCRIBER CONSENT

◯ I certify that I have obtained all necessary consents, authorizations and permissions, including from my patient, required by applicable state and federal laws, including the applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and applicable states laws needed to release the individually identifiable health information included on this form to SpringWorks and SpringWorks CareConnections and each of their respective designated agents and services providers, and for SpringWorks and SpringWorks CareConnections to use such information for purposes of verifying my patient's insurance coverage and eligibility; assisting with financial assistance resources and information, such as co-pay support or free drug patient assistance programs for which the patient may be eligible; coordinating the dispensing of my patient's prescription medicine; contacting the patient with educational materials about the patient's prescription medication; and introducing SpringWorks support services to my patient (eg, the Patient Support Program), including contacting my patient by telephone or mail for these purposes.

SECTION 9 | Preferred Specialty Pharmacy

◯ No Preference ◯ Biologics by McKesson ◯ Onco360 ◯ In-Office Medically Integrated Dispensing Pharmacy

If Preferred Pharmacy Is an Eligible Medically Integrated Dispensing Site:

Pharmacy NPI: _____ Contact Name: _____ Phone: (____) _____ Fax: (____) _____

Has a Prescription for GOMEKLI Already Been Sent to a Pharmacy?

◯ Yes ◯ No If "Yes," Date Prescribed: _____ /_____ /_____ (MM / DD / YYYY)

Pharmacy Name: _____

Please see full Prescribing Information at springworkstx.com/gomekli-prescribing-info.

SECTION 10 | Authorization and Certifications

I hereby authorize and direct my healthcare providers, pharmacies, health insurers, and health plans or programs that provide me healthcare benefits, and their respective staff and service providers ("Healthcare Entities") to use and disclose the following information ("Personal Information") about me in their possession to SpringWorks Therapeutics, Inc. ("SpringWorks") and its representatives, affiliates, contractors, agents, vendors, and partners (collectively "SpringWorks Entities"):

- Information regarding my medical condition and treatment, including relevant diagnoses, prescriptions, and related health information (including fill and refill information);
- Information about my health insurance benefits, including deductibles and out-of-pocket costs; and
- All information about me included in this form.

I understand that the purpose of this disclosure is so that SpringWorks Entities may use and further disclose my Personal Information for the following purposes:

(1) verifying, investigating, coordinating, and resolving insurance coverage or reimbursement inquiries and payment for SpringWorks products;

(2) operating, administering, enrolling me in, and/or continuing my participation in the SpringWorks CareConnections™ program or any other SpringWorks-affiliated patient support services and activities (the "Patient Support Program") related to my condition or treatment including, but not limited to, financial assistance programs such as commercial copay and/or patient assistance programs, drug coverage verification, patient education services, adherence programs, and disease management support;

(3) coordinating my receipt of and payment for SpringWorks products;

(4) utilizing a third-party financial screening tool (eg, Experian or TransUnion), to determine eligibility for financial assistance or free drug programs;

(5) contacting me about the Patient Support Program (including sending me supplemental educational materials, information, offers and services related to my treatment or my medical condition, or communicating with me to facilitate fulfillment of my prescribed medication[s]);

(6) contacting and providing my Personal Information to Healthcare Entities, patient advocacy organizations, patient assistance programs, copay assistance, or similar programs to determine eligibility for coverage and enrollment;

(7) managing the Patient Support Program, including evaluating the effectiveness of the Patient Support Program and for administrative purposes;

(8) de-identifying my Personal Information by aggregating it for research purposes, and data analytics to develop and evaluate products, services, materials, and treatments, and improve the Patient Support Program; and

(9) as otherwise permitted by law.

I understand that once my Personal Information has been disclosed to the SpringWorks Entities, it may no longer be protected by federal privacy law and could be re-disclosed to others, but that the SpringWorks Entities intend to use and disclose my Personal Information received pursuant to this authorization only for the purposes described above or as required by law.

I understand and agree that the pharmacy that is dispensing my Product may receive remuneration from the SpringWorks Entities in exchange for disclosing my Personal Information to the SpringWorks Entities for providing me with support services in connection with the Patient Support Program.

No Impact to Treatment

I understand that I am not required to sign this Authorization and that treatment from my Healthcare Entities, payment for treatment, my access to SpringWorks medications (except for participation in a free drug program), and my eligibility for health insurance benefits are not conditioned upon me signing this Authorization. I understand, however, that if I do not sign this Authorization, I will not be able to receive support services through the Patient Support Program. Participation in the Patient Support Program is voluntary, and services are subject to change. I understand that participation in the Patient Support Program is subject to the terms, conditions, and eligibility criteria available at **springworkstxcares.com**, and that SpringWorks has the sole discretion to determine Patient Support Program eligibility. I understand that SpringWorks reserves the right to rescind, revoke, or amend any service under any Patient Support Program at any time without notice.

Cancellation

I may cancel this Authorization at any time by calling 844-CARES-55 (844-227-3755) or by requesting such cancellation in writing at SpringWorks Therapeutics c/o Patient Support Services, 150 Hilton Drive, Jeffersonville, IN 47130. Canceling this Authorization will prohibit further use and disclosure of my Personal Information; however, canceling this Authorization will not impact uses and disclosures of my Personal Information that has already happened. I understand that once my Personal Information has been disclosed, federal health information privacy laws may no longer protect my Personal Information from further disclosure. Cancellation of this Authorization ends my participation in the Patient Support Program.

This Authorization will expire five (5) years from the date it is signed or earlier if required by applicable law, unless earlier withdrawn by me. I understand that I am entitled to receive a copy of this signed Authorization.

I understand that my Personal Information is also subject to the SpringWorks privacy policy available at **springworkstx.com/privacy-policy**.

Fair Credit Reporting Act (FCRA) Certification

I understand that I am providing "written instructions" authorizing SpringWorks and its vendors, under the FCRA, to obtain information from my credit profile or other information from the vendor, solely for the purpose of determining financial qualifications for programs administered by SpringWorks, including the SpringWorks CareConnections Patient Assistance Program. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process.

PLEASE COMPLETE THE ENTIRE FORM, SIGN, AND FAX IT TO 844-227-3747.

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