SpringWorks CareConnections™ Program for Treatment-Related Cost Reimbursement Form

Please print all information and email or fax all required supporting documentation to:

Fax: (844) 227-3747 or email to: info@springworkstxcares.com

This form is for patients who have been prescribed GOMEKLI™ (mirdametinib) and are enrolled in SpringWorks CareConnections™

If you have commercial insurance and you wish to seek reimbursement for treatment-related costs, for certain treatment-related tests, examinations and/or specialty visits during treatment with GOMEKLI, please complete and return this form, together with the supporting documentation listed below, to SpringWorks CareConnections in order to receive reimbursement for eligible treatment-related costs. Once your completed claim form, together with all required supporting documentation, is received, and all expenses and other eligibility information are verified, we will mail you a check for your commercial copay for eligible treatment-related cost reimbursement. You should receive it within approximately 6 to 8 weeks from program approval.*

Complete this form, and email, mail or fax it with the following supporting documentation:

Note: Failure to include any of the following will result in claim rejection:

1. The medical appointment receipt/invoice received from your doctor's office, which must include the following information:
   - ✓ Patient name and address
   - ✓ Doctor or health care provider name, address, and phone number
   - ✓ Date of treatment
   - ✓ The total charge for each service and associated copay amount/out of pocket expense paid
2. Copy of your explanation of benefits (EOB) from your health insurance

**Payment of the reimbursement is subject to expense verification and pursuant to the terms and conditions and eligibility criteria of the SpringWorks CareConnections treatment-related commercial copay program.*

PATIENT INFORMATION – ***Please print***

First Name Middle Last Name

Address 1 Address 2

City State Zip

Phone Email

PRESCRIBER INFORMATION – ***Please print***

First Name Middle Last Name

Address 1 Address 2

City State Zip

Phone

Your completed reimbursement form must be accompanied by the supporting documentation listed above in order to be eligible for reimbursement. Please highlight the amount of copayment or out-of-pocket expenses paid, if possible

CERTIFICATION STATEMENT

I, _____, certify that the information provided for this reimbursement request is accurate to the best of my knowledge, and the copayment or out-of-pocket expenses requested for reimbursement were actually incurred by me. I also certify that I am not enrolled in any state or federally funded healthcare program, including but not limited to, Medicare (Part A, Part B, Part D, Medicare Advantage Plan or Medicare Prescription Drug Benefit Plan), Medigap, Medicaid (including Medicaid patients enrolled in a managed care plan, VA, DOD, TRICARE or CHAMPUS, Puerto Rico Government Health Insurance Plan, nor am I a Medicare-eligible patient enrolled in an employer-sponsored health plan or prescription drug benefit program for retirees. I agree not to seek reimbursement for any part of the benefit received under SpringWorks CareConnections Program for GOMEKLI Treatment-Related Cost Reimbursement, and I acknowledge that I am responsible for reporting receipt of benefits to any insurer, health plan, or other third party who pays for or reimburses any part of any treatment-related costs paid for by the Program for GOMEKLI Treatment-Related Cost Reimbursement, as may be required.

Patient or Legal Guardian signature _____Date_____

For questions, please call the SpringWorks CareConnections™ GOMEKLI™ Program for Treatment-Related Cost Reimbursement at (844) 227-3755 between 8 AM – 10 PM ET, Monday to Friday