SpringWorks CareConnections™

ENROLLMENT FORM

PLEASE COMPLETE THE ENTIRE FORM, SIGN, AND FAX IT TO 844-227-3747.
CareConnections will acknowledge receipt.
Access a digital enrollment form at www.springworkstxcares.com, 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: _____
Preferred Contact Method: ◯ Call ◯ Text ◯ Email Preferred Time of Day to Contact: ◯ Morning ◯ Afternoon ◯ Evening
Care Partner First and Last Name: _____ Care Partner Phone: (___) _____

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

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

SECTION 3 | Patient Consents

Text Messaging ◯ I authorize SpringWorks Therapeutics or others on its behalf to contact me by 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.

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 11** and agree to the Authorization to Disclose/Use Health Information.

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

_____
Relationship to Patient/Legal Representative (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 11**.

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

_____
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 ◯ 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

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
If "Approved," Copay Amount: $_____ **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
Choose the ICD-10-CM code under category "D48.11 Desmoid Tumor" (**select all that apply**):

◯ D48.110 Desmoid Tumor of Head and Neck
◯ D48.111 Desmoid Tumor of Chest Wall
◯ D48.112 Desmoid Tumor, Intrathoracic
◯ D48.113 Desmoid Tumor of Abdominal Wall
◯ D48.114 Desmoid Tumor, Intraabdominal
◯ D48.115 Desmoid Tumor of Upper Extremity and Shoulder Girdle
◯ D48.116 Desmoid Tumor of Lower Extremity and Pelvic Girdle
◯ D48.117 Desmoid Tumor of Back
◯ D48.118 Desmoid Tumor of Other Site
◯ D48.119 Desmoid Tumor of Unspecified Site

Clinical Notes Attached? ◯ Yes ◯ No Tumor Focality (Select One): ◯ Unifocal ◯ Multifocal
Tumor Size(s): _____ Mutational Status: ◯ Presence of CTNNB1 Mutation ◯ Presence of APC Mutation
Current Medication(s): _____
Received Prior Treatment: ◯ Yes ◯ No, Treatment Naive
If Yes, **Select All That Apply:** ◯ Surgery ◯ Ablation Procedures ◯ Radiotherapy ◯ Chemotherapy ◯ Tyrosine Kinase Inhibitor (TKI) ◯ Other:_____

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PRESCRIBER TO COMPLETE

SECTION 7 | Prescriber Information

Prescriber First and Last Name: _____ Prescriber Title: _____

Prescriber Specialty: _____ NPI Number: _____ 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 OGSIVEO® (nirogacestat)

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

OGSIVEO PRESCRIPTION INFORMATION

The recommended dose of OGSIVEO is 150 mg administered orally twice daily. Please see US Prescribing Information for recommended and modified dosage.

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

Medication	Dosage Form and Strength	Quantity	Refills	Dosage Instructions
◯ **8.** OGSIVEO PRESCRIPTION	◯ 150 mg tablets ◯ 100 mg tablets	_____	_____	◯ Take 1 tablet orally twice daily
◯ **8A.** OGSIVEO QUICK START PROGRAM (NEW PATIENT)	◯ 150 mg tablets ◯ 100 mg tablets	56 tablets (28-day supply)	1	◯ Take 1 tablet orally twice daily
I approve the dispense of the free supply of OGSIVEO 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 OGSIVEO, has an immediate medical need for OGSIVEO, and meets all eligibility criteria found at www.springworkstxcares.com.				
◯ **8B.** OGSIVEO BRIDGE PROGRAM (EXISTING PATIENT)	◯ 150 mg tablets ◯ 100 mg tablets	56 tablets (28-day supply)	2	◯ Take 1 tablet orally twice daily
I approve the dispense of OGSIVEO 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 www.springworkstxcares.com.				

DISPENSE AS WRITTEN

PRESCRIBER SIGN HERE Prescriber Signature: _____ Date: ____/____/____ (MM/DD/YYYY)

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 OGSIVEO is medically necessary. 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 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 to release the individually identifiable health information included on this form to SpringWorks and CareConnections and for SpringWorks and CareConnections to use such information for purposes of verifying my patient's insurance coverage and eligibility; coordinating the dispensing of my patient's prescription medicine; and introducing SpringWorks support services to my patient, 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 OGSIVEO Already Been Sent to a Pharmacy?

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

SECTION 10 | Patient Support Services Requested

SpringWorks CareConnections offers services to patients prescribed OGSIVEO based on their individual needs. Which of these services are most relevant for your patient?

(Select all that apply): ◯ BI/PA/Appeal Support ◯ Copay Assistance ◯ Quick Start ◯ Bridge Program ◯ Patient Assistance Program

◯ Dispensing Through a Network Pharmacy ◯ OGSIVEO Education and Materials ◯ Nurse Advocate Support

Please see full Prescribing Information at **https://www.springworkstx.com/ogsiveo-prescribing-information**.

SECTION 11 | 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 and prescriptions (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

(9) as otherwise permitted 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 www.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 www.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 CareConnections Patient Assistance Program. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process.

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