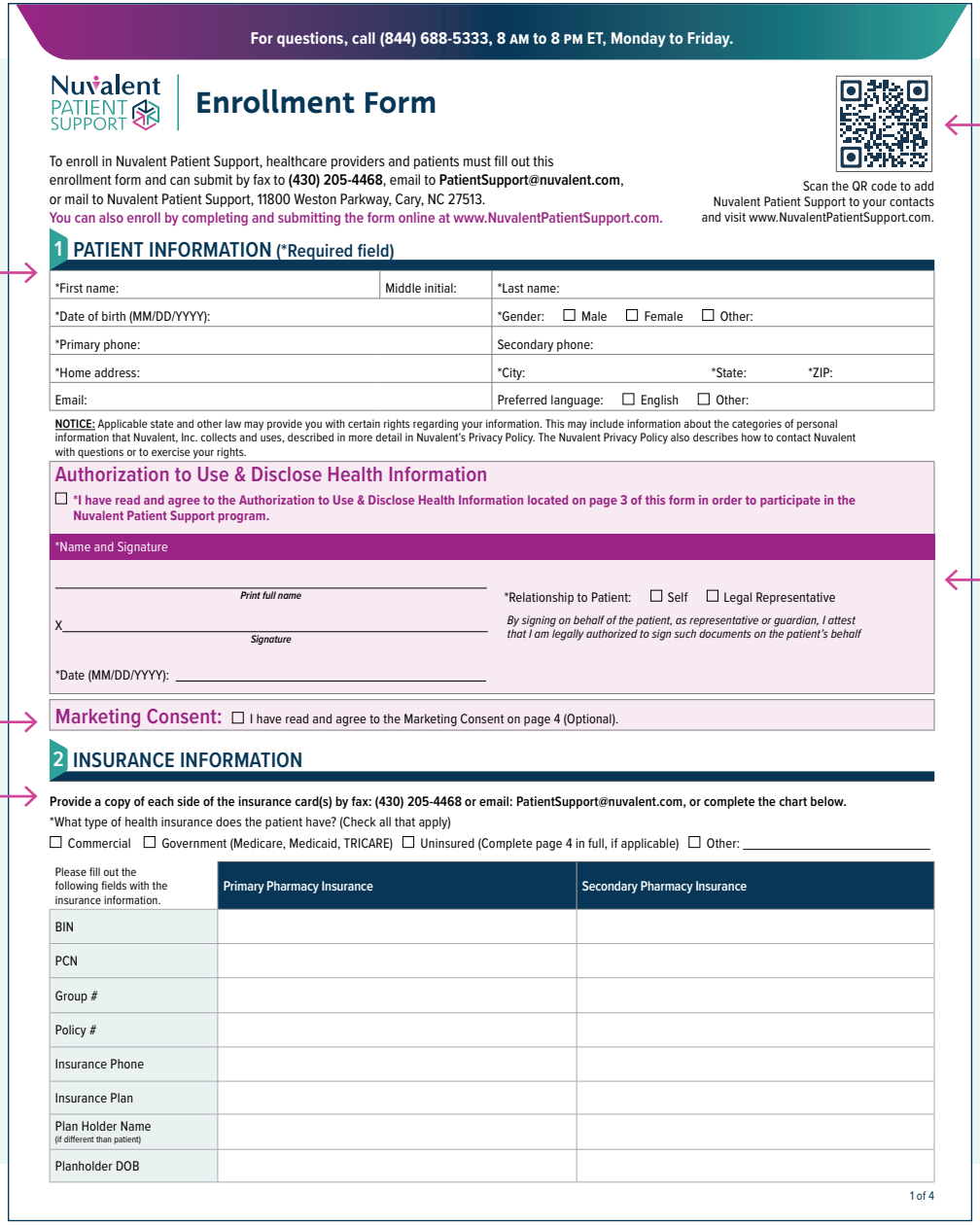
How to Complete the Enrollment Form

This Enrollment Form Guide is intended to serve as an overview of the Nuvalent Patient Support Enrollment Form. The full instructions are included on the Enrollment Form. Please be sure to read the full instructions and complete the Enrollment Form itself. This Guide is not a replacement for the Enrollment Form or its instructions. If there are any discrepancies between this Guide and the Enrollment Form, please follow the Enrollment Form and the full instructions provided with it. Please note: The Enrollment Form is four pages long.



For questions, call (844) 688-5333, 8 AM to 8 PM ET, Monday to Friday.

Nuvalent PATIENT SUPPORT

Enrollment Form

To enroll in Nuvalent Patient Support, healthcare providers and patients must fill out this enrollment form and can submit by fax to **(430) 205-4468**, email to **PatientSupport@nuvalent.com**, or mail to Nuvalent Patient Support, 11800 Weston Parkway, Cary, NC 27513.
You can also enroll by completing and submitting the form online at www.NuvalentPatientSupport.com.

Scan the QR code to add Nuvalent Patient Support to your contacts and visit www.NuvalentPatientSupport.com.

1 PATIENT INFORMATION (*Required field)

*First name:	Middle initial:	*Last name:
*Date of birth (MM/DD/YYYY):		*Gender: ☐ Male ☐ Female ☐ Other:
*Primary phone:		Secondary phone:
*Home address:		*City: *State: *ZIP:
Email:		Preferred language: ☐ English ☐ Other:

NOTICE: Applicable state and other law may provide you with certain rights regarding your information. This may include information about the categories of personal information that Nuvalent, Inc. collects and uses, described in more detail in Nuvalent's Privacy Policy. The Nuvalent Privacy Policy also describes how to contact Nuvalent with questions or to exercise your rights.

Authorization to Use & Disclose Health Information

☐ ***I have read and agree to the Authorization to Use & Disclose Health Information located on page 3 of this form in order to participate in the Nuvalent Patient Support program.**

*Name and Signature

_____
Print full name

X_____
Signature

*Date (MM/DD/YYYY): _____

*Relationship to Patient: ☐ Self ☐ Legal Representative

By signing on behalf of the patient, as representative or guardian, I attest that I am legally authorized to sign such documents on the patient's behalf

Marketing Consent: ☐ I have read and agree to the Marketing Consent on page 4 (Optional).

2 INSURANCE INFORMATION

Provide a copy of each side of the insurance card(s) by fax: (430) 205-4468 or email: PatientSupport@nuvalent.com, or complete the chart below.

*What type of health insurance does the patient have? (Check all that apply)

☐ Commercial ☐ Government (Medicare, Medicaid, TRICARE) ☐ Uninsured (Complete page 4 in full, if applicable) ☐ Other: _____

Please fill out the following fields with the insurance information.	Primary Pharmacy Insurance	Secondary Pharmacy Insurance
BIN		
PCN		
Group #		
Policy #		
Insurance Phone		
Insurance Plan		
Plan Holder Name (if different than patient)		
Planholder DOB		

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Fill out this section with the patient's demographic information. All fields with an asterisk must be filled out completely.

Optional: Patient can choose to opt into receiving marketing communications from Nuvalent by completing this section.

Provide the patient's insurance information by faxing, emailing, or uploading a copy of the insurance card(s), or by completing the chart. If the chart is completed, copies of the insurance card(s) do not need to be submitted. In either case, be sure to select the insurance type.

Scan the QR code to save the Nuvalent Patient Support contact information. Saving the phone number can help patients recognize incoming calls from Nuvalent Patient Support.

The patient or their Legal Representative is required to read the Authorization to Use & Disclose Health Information (on page 3 of the Enrollment Form) and fill out this section if they wish to enroll in Nuvalent Patient Support.

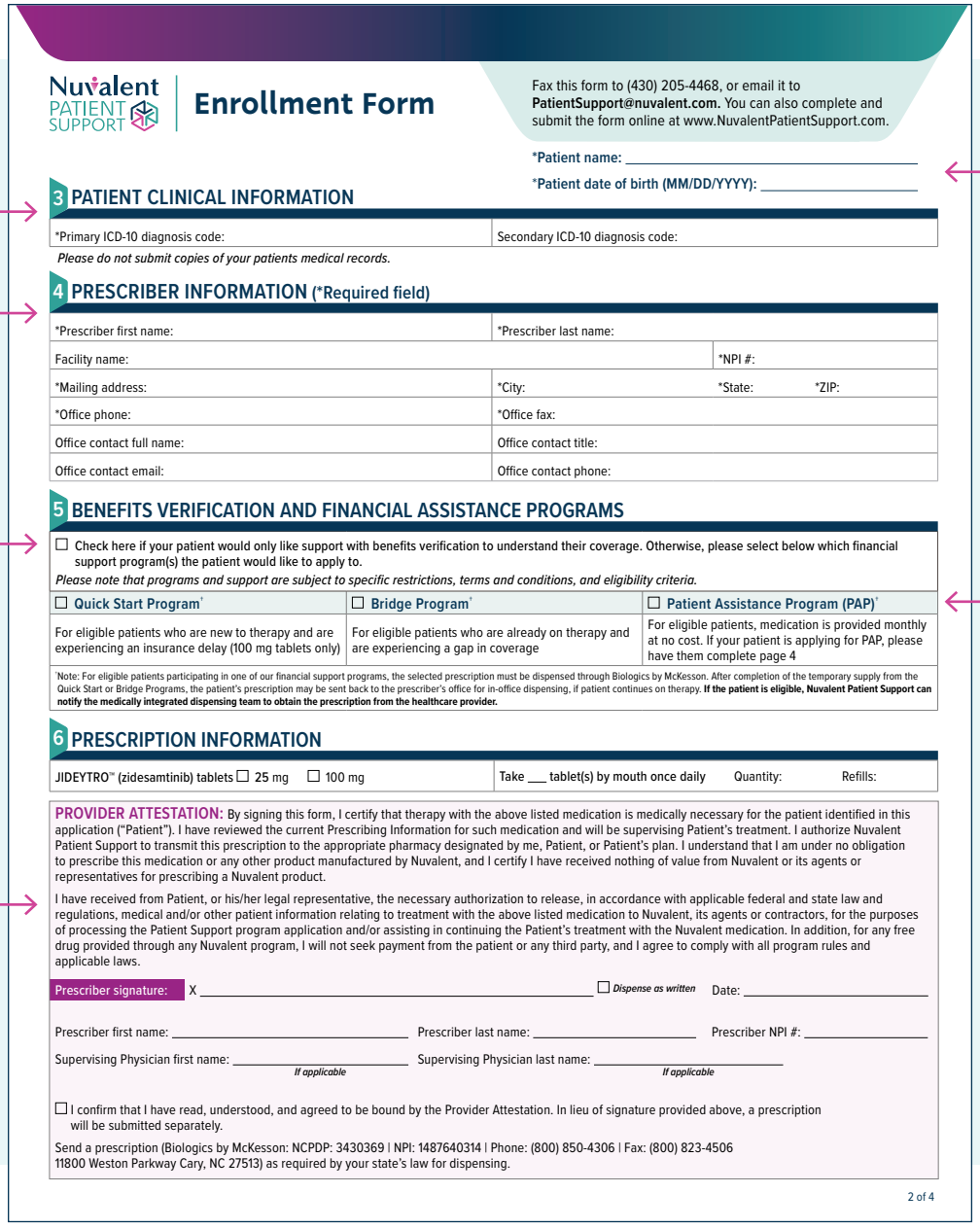
How to Complete the Enrollment Form (cont'd)

Healthcare providers must complete this section of the form with the required primary diagnosis code and a secondary code, if needed.

Healthcare providers must fill out the required fields, including first and last name, mailing address, NPI number, and office phone and fax numbers. Additional office details are optional.

Check this box for Nuvalent Patient Support to assess patient eligibility for all programs listed below. Otherwise, check the box for the specific program(s) of interest, and Nuvalent Patient Support will assess patient eligibility for the selected programs.

Healthcare providers must sign the required attestation and fill out the following information. Alternatively, they may check the box below and send in a prescription to Biologics by McKesson, which will count as the attestation.



Nuvalent PATIENT SUPPORT | **Enrollment Form**

Fax this form to (430) 205-4468, or email it to **PatientSupport@nuvalent.com.** You can also complete and submit the form online at www.NuvalentPatientSupport.com.

*Patient name: _____

*Patient date of birth (MM/DD/YYYY): _____

3 PATIENT CLINICAL INFORMATION

*Primary ICD-10 diagnosis code:	Secondary ICD-10 diagnosis code:

Please do not submit copies of your patients medical records.

4 PRESCRIBER INFORMATION (*Required field)

*Prescriber first name:	*Prescriber last name:	
Facility name:		*NPI #:
*Mailing address:	*City: *State: *ZIP:	
*Office phone:	*Office fax:	
Office contact full name:	Office contact title:	
Office contact email:	Office contact phone:	

5 BENEFITS VERIFICATION AND FINANCIAL ASSISTANCE PROGRAMS

☐ Check here if your patient would only like support with benefits verification to understand their coverage. Otherwise, please select below which financial support program(s) the patient would like to apply to.

Please note that programs and support are subject to specific restrictions, terms and conditions, and eligibility criteria.

☐ Quick Start Program†	☐ Bridge Program†	☐ Patient Assistance Program (PAP)†
For eligible patients who are new to therapy and are experiencing an insurance delay (100 mg tablets only)	For eligible patients who are already on therapy and are experiencing a gap in coverage	For eligible patients, medication is provided monthly at no cost. If your patient is applying for PAP, please have them complete page 4

†Note: For eligible patients participating in one of our financial support programs, the selected prescription must be dispensed through Biologics by McKesson. After completion of the temporary supply from the Quick Start or Bridge Programs, the patient's prescription may be sent back to the prescriber's office for in-office dispensing, if patient continues on therapy. **If the patient is eligible, Nuvalent Patient Support can notify the medically integrated dispensing team to obtain the prescription from the healthcare provider.**

6 PRESCRIPTION INFORMATION

JIDEYTRO™ (zidesamtinib) tablets ☐ 25 mg ☐ 100 mg	Take ___ tablet(s) by mouth once daily	Quantity:	Refills:

PROVIDER ATTESTATION: By signing this form, I certify that therapy with the above listed medication is medically necessary for the patient identified in this application ("Patient"). I have reviewed the current Prescribing Information for such medication and will be supervising Patient's treatment. I authorize Nuvalent Patient Support to transmit this prescription to the appropriate pharmacy designated by me, Patient, or Patient's plan. I understand that I am under no obligation to prescribe this medication or any other product manufactured by Nuvalent, and I certify I have received nothing of value from Nuvalent or its agents or representatives for prescribing a Nuvalent product.

I have received from Patient, or his/her legal representative, the necessary authorization to release, in accordance with applicable federal and state law and regulations, medical and/or other patient information relating to treatment with the above listed medication to Nuvalent, its agents or contractors, for the purposes of processing the Patient Support program application and/or assisting in continuing the Patient's treatment with the Nuvalent medication. In addition, for any free drug provided through any Nuvalent program, I will not seek payment from the patient or any third party, and I agree to comply with all program rules and applicable laws.

Prescriber signature: X _____ ☐ *Dispense as written* Date: _____

Prescriber first name: _____ Prescriber last name: _____ Prescriber NPI #: _____

Supervising Physician first name: _____ *If applicable* Supervising Physician last name: _____ *If applicable*

☐ I confirm that I have read, understood, and agreed to be bound by the Provider Attestation. In lieu of signature provided above, a prescription will be submitted separately.

Send a prescription (Biologics by McKesson: NCPDP: 3430369 | NPI: 1487640314 | Phone: (800) 850-4306 | Fax: (800) 823-4506
11800 Weston Parkway Cary, NC 27513) as required by your state's law for dispensing.

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Enter the patient's full name and date of birth so the form can be matched to the correct patient.

If the patient is applying for the Patient Assistance Program, ensure that the patient completes the required information for the program on page 4 of the Enrollment Form.