forgingbridges™ | TRUSELTIQ™ (infigratinib) capsules

TRUSELTIQ Enrollment Form

Print and fax completed enrollment forms to 833-551-2223.
All pages must be received to process enrollment.

Phone: 1-888-55BRIDGE (1-888-552-7434)
Fax: 833-551-2223
Web: TRUSELTIQ.com/forgingbridges

GETTING STARTED

ForgingBridges | TRUSELTIQ Access and Support program is here to help you feel supported on your path with TRUSELTIQ.
The program is designed to help you learn more about your disease and treatment, and to help you get started on your TRUSELTIQ treatment journey.
Please complete the form and let us know which support programs you would like to be enrolled in.

This form will enroll you in the ForgingBridges | TRUSELTIQ Patient Support Program.

☐ **By checking this box, you will be evaluated for all ForgingBridges | TRUSELTIQ Programs listed below. Otherwise, please check the program(s) you are interested in being evaluated for:**

☐ **Insurance Support and Financial Assistance**
Includes benefits verification, prior authorization, appeals support, and potential financial assistance options.

☐ **ForgingBridges | TRUSELTIQ Copay Assistance Program**
Helps patients manage out-of-pocket copay or coinsurance costs for those with commercial insurance or private prescription drug coverage.

☐ **Nurse and Educational Support**
ForgingBridges clinical staff will provide educational information on your disease and information on TRUSELTIQ. You will also opt into occasional reminder phone calls and emails.

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

Please read the consent details on page 4 that explain how your information will be used. If you have any questions, please feel free to reach out to our program staff at the number listed above. After you read the information on page 4, please sign below.

PATIENT SIGNATURE _____ (Patient or Legal Representative) _____ (Print Name) _____ (Date)

PATIENT CONSENT TO ENROLL IN FORGINGBRIDGES PATIENT ASSISTANCE PROGRAM

Please read the consent details on pages 4 and 5 that explain the consent and agreement to share financial information if needed. If you have any questions, please feel free to reach out to our program staff at the number listed above. After you read the information on pages 4 and 5, please sign below.

PATIENT SIGNATURE _____ (Patient or Legal Representative) _____ (Print Name) _____ (Date)

AGREE TO RECEIVE RELEVANT QED THERAPEUTICS, INC. MARKETING COMMUNICATIONS (OPTIONAL)

QED Therapeutics, Inc. (QED) would like to send you additional information about our product and financial assistance programs.

To learn more about how your information is used or if you decide that you no longer want to receive information about QED products and services, please contact ForgingBridges | TRUSELTIQ at: TRUSELTIQ@mckesson.com.

☐ **Check here if you are interested in sharing your story and/or experience with others. By checking this box, I understand that a representative from QED may contact me to discuss my experience with TRUSELTIQ.**

PATIENT SIGNATURE _____ (Patient or Legal Representative) _____ (Print Name) _____ (Date)

If you have any questions, please call 1-888-55BRIDGE (1-888-552-7434)

You are encouraged to report negative side effects of prescription drugs to the FDA by calling 1-800-FDA-1088 or visiting www.fda.gov/medwatch. You may also call BridgeBio at 1-844-550-BBIO (2246).

QED therapeutics
a bridgebio company

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PATIENT INFORMATION

Patient Name: _____ (First, MI, Last) DOB: _____ (mm/dd/yyyy)

Primary Phone: _____ Primary Email: _____

I consent to allow ForgingBridges to leave me a voicemail about treatment information: ☐ Yes ☐ No

Street: _____

City: _____ State: _____ ZIP: _____

Gender: ☐ Male ☐ Female Preferred Language (*If not English*): _____

PRIMARY INSURANCE INFORMATION

Please attach copies (front and back) of all available insurance and prescription cards.

☐ No Insurance

Primary Medical Insurance Name: _____

Insurance Phone: _____

Policy ID #: _____

Group #: _____

Primary Rx Medical Insurance Name (If different): _____

Rx Insurance Phone: _____

Policy ID #: _____

Group #: _____

Policy Holder Name: _____ (First, MI, Last) Social Security #: _____

Rx BIN #: _____ Rx PCN #: _____

Street: _____

City: _____ State: _____ ZIP: _____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Please attach copies (front and back) of all available insurance and prescription cards.

Secondary Medical Insurance Name: _____

Insurance Phone: _____

Policy ID #: _____

Group #: _____

Secondary Rx Medical Insurance Name (If different): _____

Rx Insurance Phone: _____

Policy ID #: _____

Group #: _____

Policy Holder Name: _____ (First, MI, Last) Social Security #: _____

Relationship to Patient: _____ Rx BIN #: _____ Rx PCN #: _____

Street: _____

City: _____ State: _____ ZIP: _____

QED therapeutics a bridgebio company

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FINANCIAL INFORMATION IF APPLYING FOR THE PATIENT ASSISTANCE PROGRAM (PAP)

Required only to apply for PAP.
Please visit TRUSELTIQ.com/forgingbridges for details.
Current Annual Household Income: $_____ Number of People In Household: _____

PRESCRIBER INFORMATION (PRESCRIBER TO FILL OUT)

Prescriber Name: _____
Prescriber/Facility Name: _____
Specialty: _____
Street: _____
City: _____ State: _____ ZIP: _____

NPI #: _____
Prescriber/Facility Contact Email: _____
Primary Contact Phone: _____
Prescriber/Facility Contact Fax: _____

TREATMENT AND PRESCRIPTION INFORMATION (PRESCRIBER TO FILL OUT)

Fill out both prescriptions in this section if you would like your patient to be considered for our free drug programs, including the QuickStart Program and/or PAP.

Date: _____

Prescribing Information: ☐ **In-Office Dispensing**

Specialty Pharmacy (Please contact ForgingBridges if you have questions about the In-network Pharmacy)

☐ **Biologics Specialty** ☐ **USBioservices** ☐ **No Preference**

Patient Name: _____

DOB (MM/DD/YYYY): _____

TRUSELTIQ (infigratinib) capsules:

Diagnosis: _____
ICD-9/ICD-10: _____
☐ TRUSELTIQ (infigratinib) capsules 125-mg dose pack
☐ TRUSELTIQ (infigratinib) capsules 100-mg dose pack
☐ TRUSELTIQ (infigratinib) capsules 75-mg dose carton
☐ TRUSELTIQ (infigratinib) capsules 50-mg dose pack
Directions: _____
Quantity: 28-day supply Refills: _____

TRUSELTIQ (infigratinib) capsules QuickStart Prescription:
(Provides up to 2 months free treatment to patients if their insurance coverage is delayed by more than 5 days.)

Diagnosis: _____
ICD-9/ICD-10: _____
☐ TRUSELTIQ (infigratinib) capsules 125-mg dose pack
☐ TRUSELTIQ (infigratinib) capsules 100-mg dose pack
☐ TRUSELTIQ (infigratinib) capsules 75-mg dose carton
☐ TRUSELTIQ (infigratinib) capsules 50-mg dose pack
Directions: _____
Quantity: 28-day supply Refills: _____

HEALTHCARE PROVIDER CONSENT

I certify that (1) the prescribed medicine is medically necessary for this patient and the treatment decision was based solely on my independent medical judgment, (2) services provided by QED Therapeutics, Inc. ("QED") on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use any QED product or service, (3) the patient provided me with an authorization to release their personal health information to QED (together with its affiliates, including but not limited to its third party business partners, vendors, and other agents) for purposes of enrollment in the Program and receipt of patient support services, and;

If my patient is eligible for free product, I understand that receiving free product is not contingent on any purchase obligations. I also understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; nor should it be sold, traded, or distributed for sale. I will notify Biologics immediately if TRUSELTIQ is no longer medically necessary for this patient's treatment or if my patient's insurance status changes. (1) I certify that I have obtained my patient's necessary legal authorization to forward the above service request form and furnish any information on this form to the insurer of the above named patient and (2) I authorize QED to forward the above prescription, by fax or other mode of delivery, to Biologics specialty pharmacy. I agree to comply with my state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. I understand that noncompliance with state-specific requirements could result in outreach to me as the prescriber.

PROVIDER SIGNATURE

_____ Provider Signature Required - No Stamps

_____ Print Name

_____ Date

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PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

By signing on page 1, I authorize my healthcare providers, insurers, and pharmacies ("Healthcare team") to disclose information often referred to as protected healthcare information ("Health Information") to QED Therapeutics, Inc. and its affiliates and agents (the "Parties"). Health Information includes information such as: (1) name, address, telephone, and other personal and contact information, (2) health insurance coverage related information, and (3) treatment-related information.

I authorize the Parties to use my Information for the following purposes:

- Enrolling me in the ForgingBridges Patient Assistance Program (the "Program")
- Providing me with educational information, nursing educational calls (if selected) and other treatment-related educational support
- Verifying, investigating, assisting, and helping with coordinating my health insurance coverage for TRUSELTIQ
- Assessing my initial and continued eligibility for various financial assistance programs
- Coordinating prescription fulfillment
- Contacting me regarding the Program
- Assisting with analyses related to the use of TRUSELTIQ

The Parties agree to use and disclose my Information only as allowed by me in this Authorization or as otherwise allowed by law. I understand that my pharmacy may get payments from QED Therapeutics, Inc. for my information and providing Program services. Once my Health Information and Financial Information (together "Information") has been disclosed to the Parties, I understand that federal privacy laws may no longer protect it from further disclosure.

I understand that I may refuse to sign this Authorization, that I may refuse to disclose all or some of my Information, and that a refusal to sign will not affect my ability to obtain medical care, insurance coverage, or access to health benefits. However, if I do not sign this Authorization, I understand I will not be able to participate in the Program. This Authorization expires ten years from the date signed below, or as otherwise required by state and local law, unless and until I cancel the Authorization before then. I may cancel this Authorization at any time by writing to ForgingBridges | TRUSELTIQ at 11800 Weston Parkway, Cary, NC 27513, or by sending an email to TRUSELTIQ@mckesson.com. I understand that canceling this Authorization will end my participation in the Program and will not affect any use or disclosure of the Information made before my request is received.

I understand that I have a right to receive a copy of this Authorization when it is signed.

PATIENT CONSENT TO ENROLL IN FORGINGBRIDGES PATIENT ASSISTANCE PROGRAM

By signing on page 1 of this enrollment form for ForgingBridges Patient Assistance Program (the "Program"), I authorize QED Therapeutics, Inc. and its affiliates and agents to provide me with services for which I am eligible under the Program.

I would like to be considered for free drug via the Program which requires a financial assistance assessment to determine eligibility. I also understand that I may be asked to provide certain financial information to the Parties depending on the services I am interested in receiving ("Financial Information").

I understand that this enrollment form also is a "written instruction" authorizing QED Therapeutics, Inc. and its vendor, under the Fair Credit Reporting Act ("FCRA"), to obtain information from my profile or other information from a credit reporting company, Experian Health, for the purpose of determining financial qualifications for programs administered by QED Therapeutics, Inc. I understand that I am affirmatively agreeing to these terms in order to be evaluated for free drug via the Patient Assistance Program. The accuracy of the Financial Information I provide is essential to the lawful operation of the Patient Assistance Program. I promise that any information, including financial and insurance information that I provide, are true and complete.

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PATIENT CONSENT TO ENROLL IN FORGINGBRIDGES PATIENT ASSISTANCE PROGRAM (CONT)

In addition to the consent provided above, if I enroll in QuickStart Free Drug Program I understand and agree that no free product received via the QuickStart Free Drug Program may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale. I understand that this program is not meant to encourage me or my physician to use or prescribe TRUSELTIQ. I also understand that the program only provides drug and that I will need to find alternative means to support other medical costs associated with the use of this medication. QED Therapeutics, Inc. reserves the right to review patient profiles, grant requests based on patient need, and to change program guidelines or terminate the program at any time without notification.

MARKETING COMMUNICATIONS

We will not sell or transfer your personal data to any unrelated third party for marketing purposes without your express permission. We may share such personal data with regulatory authorities, if required, or contact you to conduct market research.

I authorize QED and companies working with QED to contact me by mail, email, and/or telephone to provide me with the information I requested and other related information and services or programs that QED offers or sponsors, or other topics of interest. I understand that I am not required to provide this consent as a condition of purchasing any property, goods, or services from QED. I also understand that I may participate in the ForgingBridges | TRUSELTIQ Patient Support Program if I do not sign this optional marketing authorization.