ENROLLING YOUR PATIENTS IN THE ORGOVYX SUPPORT PROGRAM

We are dedicated to providing your patients ongoing support to help them start and continue taking ORGOVYX as prescribed. We know how important it is for patients to stay on track while on treatment. We're here to help.

The ORGOVYX Support Program offers eligible patients:
• Reimbursement support • Financial assistance • ORGOVYX Bridge Program
• Nurse support • ORGOVYX education

STEPS FOR PATIENTS

1. Provide information and sign
Ensure patients provide their information at the top of the Patient Start Form. Patients must also read the consent information on pages 1 and 2, provide their consent, and sign

2. Provide insurance information
The patient must provide their medical and pharmacy insurance information. They can either provide a copy of the front and back of their **pharmacy benefit** and **medical** insurance cards to be faxed with the form or provide the information directly on the form

3. Answer pharmacy call
Remind patients to look out for a call from RxCrossroads (1-866-469-6826) to set up to receive free medications

Patients may opt out of this program at any time by calling 1-833-ORGOVYX (1-833-674-6899) or submitting a written opt-out to the ORGOVYX Support Program, P.O. Box 2211, Columbus, OH 43216.

STEPS FOR PRESCRIBERS

1. Fill out patient insurance and practice information
Ensure that the patient's insurance information is either filled out on the form or that copies of their **pharmacy benefit** and **medical** insurance cards are faxed. Fill out the practice information on page 3, including NPI number

2. Fill out the appropriate prescription type for your patient:
- Bridge or Patient Assistance Program prescription
- ORGOVYX prescription to send to your preferred specialty pharmacy (Biologics or US Bioservices)

You can send an ORGOVYX prescription through your EMR/EHR system to your in-office dispensing pharmacy/specialty pharmacy of choice.

3. Sign to indicate prescriber certification
Review prescriber consent information and sign to authorize prescription

4. Fax completed forms (pages 1 and 3) to the ORGOVYX Support Program at 1-844-826-8875
Only pages 1 and 3 of this document need to be faxed

EHR=electronic health record; EMR=electronic medical record.

All * fields on the Start Form are required for enrollment.

Hours of operation: Monday-Friday, 8 AM-8 PM ET | Phone: 1-833-ORGOVYX (1-833-674-6899) | **FAX: 1-844-826-8875**
OrgovyxHCP.com | P.O. Box 2211, Columbus, OH 43216

Please see full Prescribing Information and Patient Product Information for ORGOVYX® (relugolix).

ORGOVYX® (relugolix) 120 mg tablets

ORGOVYX SUPPORT PROGRAM
PATIENT START FORM

FAX completed forms to 1-844-826-8875

If you have any questions or need more information, call 1-833-ORGOVYX (1-833-674-6899), Monday-Friday, 8 AM-8 PM ET, visit OrgovyxHCP.com, or write us at P.O. Box 2211, Columbus, OH 43216.

*Designates required fields.

Patient information

First Name* __________ Last Name* __________ Date of Birth* (MM/DD/YY) __________

Preferred Language ☐ English ☐ Spanish ☐ Other __________ Email __________

Address* __________ City* __________ State* ______ ZIP* ______

Home Phone* __________ Work Phone __________ Cell Phone* __________

Preferred Contact Phone Number ☐ Home ☐ Work ☐ Cell Best Time to Contact ☐ Morning ☐ Afternoon ☐ Evening
(You can select more than 1 option.)

OK to leave a message at your preferred contact phone number? ☐ Y ☐ N

Alternate Contact: Name __________ Relationship to Patient __________ Phone __________

Pharmacy benefit and medical insurance information

☐ Patient does not have insurance (if checked, skip this section).

FOR THIS SECTION: Fill out the pharmacy and medical insurance information below **OR** fax copies of the patient's PHARMACY BENEFIT and MEDICAL insurance cards along with this form to 1-844-826-8875.

Prescription Insurance Name* __________

Member Name __________ Group# __________ Prescription Insurance Phone __________

Member ID# __________ PCN# __________ BIN# __________

Medical Insurance Name* __________ Member Name __________

Medical Insurance Type ☐ Private/Commercial ☐ Medicare ☐ Medicaid Insurance Phone __________

Member ID# __________ Group# __________

Patient consent and signature

☐ I have read and agree to the PATIENT CERTIFICATION AND CONSENT TO PROGRAM TERMS on page 2 of this form.

☐ I understand that I am providing written instructions to Myovant Sciences under the Fair Credit Reporting Act authorizing Myovant Sciences to obtain information from my credit profile or other information from Experian Health. I give consent to Myovant Sciences to obtain such information solely to determine if my income meets eligibility standards of the Patient Assistance Program (PAP).

☐ I have read and agree to the Terms and Conditions for participation in the Copay Assistance Program on page 4 of this form.

☐ **I authorize the disclosure and use of my protected health information as described in the PATIENT AUTHORIZATION on page 2 of this form.**

OPTIONAL CONSENT TO RECEIVE CERTAIN CALLS AND TEXT MESSAGES

☐ I consent to receive marketing calls and texts from and on behalf of Myovant Sciences, made with an auto dialer or prerecorded voice, at the cell phone number for me (the patient) provided on this form. I understand that I do not need to provide this consent in order to purchase any Myovant Sciences products. I understand that text message and data rates may apply. I have reviewed and agree to the full terms and conditions located at https://www.myovant.com/. **Frequency May Vary. Reply STOP to cancel, HELP for help. View our privacy policy: https://www.myovant.com/privacy-policy/**

SIGN HERE **Patient Signature*** __________ **Date*** __________

Guardian Signature (If Applicable) __________ **Date** __________

Please see full Prescribing Information and Patient Product Information for ORGOVYX® (relugolix).

PATIENT CONSENT

PATIENT AUTHORIZATION TO SHARE AND USE PROTECTED HEALTH INFORMATION (PHI):

By signing below, I give consent to my healthcare team (my physicians, pharmacists, specialty pharmacies, and other healthcare providers, and my health insurers) to disclose information related to my medical condition and treatment, financial information, coverage information, and contact information (my "protected health information" or "PHI") to Myovant Sciences, Inc. (including its agents and contractors) to use for the following purposes:

- Enroll me in and contact me about the ORGOVYX Support Program
- Provide me with ORGOVYX Support Program services, which may include the following (also referred to as "Patient Support Services"):
  - Providing benefits investigation and reimbursement support, including help with prior authorization requirements or appealing a denied claim
  - Sending my prescription to the in-network specialty pharmacy
  - Providing me with financial assistance resources if I'm eligible, including copay assistance or free drug programs
  - Sending me an ORGOVYX Welcome Kit (where appropriate)
  - Enrolling me in the ORGOVYX Nurse Support Program
  - Communicating with my healthcare providers about ORGOVYX® (relugolix) and Patient Support Services
  - Providing me with disease management and other educational materials
  - Providing me with information about Myovant Sciences' products, services, and programs, which may include sending me surveys about my experience with these
  - Communicating with me through telephone or electronically to assist with adherence to my medication routine, and work with third parties to provide community resources and referrals
- Providing marketing communications to me regarding Myovant Sciences' products, services, and related activities

I understand that:

- This authorization expires one year from the date I sign it, unless a shorter period is required by state law or unless I cancel it before then
- I can cancel this consent at any time by writing to P.O. Box 2211, Columbus, OH 43216
- I may refuse to sign this consent
- My healthcare treatment and eligibility for and receipt of health care benefits are not conditioned on my signing this consent
- Once my PHI is disclosed to Myovant Sciences, federal privacy law may not protect it from disclosure to others, but Myovant Sciences intends to use or disclose my information only for the purposes stated above [or as otherwise permitted by law]
- I have a right to receive a copy of this authorization consent once I have signed it

PATIENT CERTIFICATION AND CONSENT TO PROGRAM TERMS:

I understand the following statements:

- The personal information that I provide to Myovant Sciences is true and complete, and I agree that, at any time during my participation in the ORGOVYX Support Program, Myovant Sciences may request additional documentation to verify my personal information
- I am not charged to enroll or participate in the ORGOVYX Support Program or required to purchase any Myovant Sciences product
- The ORGOVYX Support Program may change or end at any time, without notice
- If I qualify for, and receive, copay assistance or free medication from Myovant Sciences, I agree to comply with the program rules and agree that I will not seek or receive reimbursement for the assistance I receive from any third party, including from an insurance program, a health savings, flexible spending, or other health reimbursement account. If I have Medicare Part D, I will also not count any free medication I receive towards my true out-of-pocket costs (TrOOP)
- I understand that assistance may be temporary and I may be required to reapply as described in the program rules
- I will contact the ORGOVYX Support Program if my insurance changes or I am no longer prescribed ORGOVYX
- I understand that completing and signing the Patient Assistance Program (PAP) portion of this form does not guarantee my eligibility for the Myovant Sciences Patient Assistance Program

ORGOVYX SUPPORT PROGRAM
PATIENT START FORM

FAX completed forms to 1-844-826-8875

If you have any questions or need more information, call 1-833-ORGOVYX (1-833-674-6899), Monday-Friday, 8 AM-8 PM ET, visit OrgovyxHCP.com, or write us at P.O. Box 2211, Columbus, OH 43216.

*Designates required fields.

Select preferred dispensing method*: Please select one only.

☐ In-Office/Clinic Dispensing Pharmacy or Hospital/Health System Dispensing Pharmacy ____________________

Pharmacy Contact Name ______________________________ Office Phone ________________

☐ Specialty Pharmacy (Please select specialty pharmacy below.)

☐ Biologics ☐ US Bioservices

Prescriber information: Fill out your information and NPI number.

Practice Name* ______________________ Prescriber Name* ______________________

Specialty ______________________ NPI#* ________________

Supervising/Collaborating Physician Name ______________________________

Office Address* ______________________________ City*__________ State* ____ ZIP* ______

Primary Office Contact Name ______________________________ Office Phone* ____________

Office Contact Email ______________________________ Office Fax* ________________

Prescription: Fill out the prescription type that is relevant to your patient.

The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Patient's DOB* (MM/DD/YY) ________________ Patient's Full Name* ______________________________

Anticipated ORGOVYX Start Date ______________ Diagnosis/ICD-10 Code* ______________________________

Drug Name (NDC: 72974-120-01)	**Directions** (Please see dosage and administration section of the full Prescribing Information.)	**Quantity**	**Refills**
ORGOVYX® (relugolix) 120 mg tablets	**Loading dose:** Take 3 tablets (360 mg) by mouth on the first day of treatment. **Maintenance dose:** Take 1 tablet (120 mg) by mouth once daily around the same time each day. **OR:** ______________________________ (Specify any alternative or additional dosing instructions.)	**30 tablets**	Indicate the number of refills next to the selected prescription type below.

Ship to*: ☐ Doctor's Office ☐ Patient's Home

(Choose a shipping option only if selecting Bridge Program or Patient Assistance Program prescription below.)

Prescription type (select one only)*: Please see page 4 for full terms and conditions.

Free drug prescription

☐ Bridge Program (for commercial insurance only, max allowable 3 refills) **Refills** ___

☐ Patient Assistance Program (for patients with no insurance, insurance denial, or patients who can't afford out of pocket) **Refills** ___

Commercial or Medicare Part D prescription

☐ ORGOVYX Commercial or Medicare Part D prescription **Refills** ___

Prescriber Declaration

By signing this form, I certify that this medication is medically necessary for the patient. I further certify that the information provided in this form is accurate to the best of my knowledge and that the patient meets the eligibility requirements of any ORGOVYX Support Program selected above, including without limitation, the requirement that the patient be prescribed ORGOVYX for an FDA-approved indication. I acknowledge and agree that I may not bill for medication dispensed under the ORGOVYX Bridge Program or Patient Assistance Program to any private or government payer or other third party and that I will adhere to the terms and conditions of the ORGOVYX Support Program.

Prescriber's Signature* ______________________________ ☐ Dispense as Written

Date* ________________ (Wet signature is required.)

Please see full Prescribing Information and Patient Product Information for ORGOVYX® (relugolix).

HEALTHCARE PROVIDER CONSENT

By my signature, I certify that I have obtained any and all consents from the patient or the patient's legal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Myovant Sciences and its contractors and agents for purposes relating to Myovant Sciences, patient support programs, including, assisting the patient with benefits investigation, prior authorization/appeals assistance, financial assistance resources and information, such as copay support or free drug programs, for which the patient may be eligible, and other support for ORGOVYX® (relugolix).

I certify that I have obtained consent from the patient or the patient's legal representative to be contacted by Myovant Sciences, ORGOVYX, and/or parties acting on their behalf using an autodialer or prerecorded voice at the patient telephone number(s) provided on this form regarding the purposes described above and for other marketing and non-marketing purposes. I also give my permission to receive calls related to these services from Myovant Sciences, ORGOVYX, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at my telephone number(s) provided on this form.

For Specialty Pharmacy Triage: I give consent to Myovant Sciences to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. Transmission of this form shall be via fax or mail; verbal transmission does not constitute a valid prescription.

ORGOVYX COPAY ASSISTANCE PROGRAM: TERMS AND CONDITIONS

The ORGOVYX Copay Assistance Program ("Program") is for eligible patients with commercial prescription insurance for ORGOVYX. With this Program, eligible patients will pay as little as $10 per monthly ORGOVYX prescription. Patient must enroll in the Program by visiting www.ORGOVYX.com or by calling 1-833-ORGOVYX (833-674-6899). Card must be activated before use. This Program may not be redeemed more than once every 21 days. The Program is not valid for patients whose prescription claims are reimbursed, in whole or in part, by any state or federal government program, including, but not limited to, Medicaid, Medicare, Medigap, Department of Defense (DoD), Veterans Affairs (VA), TRICARE, Puerto Rico Government Insurance, or any state patient or pharmaceutical assistance program. Offer is not valid for cash-paying patients. Patient must be a resident of the US, Puerto Rico, or US Territories. This Program is void where prohibited by state law and on the date an AB rated generic equivalent for ORGOVYX becomes available. Certain rules and restrictions apply. This card is not insurance. This offer cannot be combined with any other coupon, discount, prescription savings card, or other offer. This offer is not conditioned on any past or future purchase, including refills. Patient and participating pharmacists agree not to seek reimbursement for all, or any part of the benefit received by the patient through this Program. Patient and participating pharmacists agree to report the receipt of Program benefits to any insurer or other third party who pays for or reimburses any part of the prescription filled using the Card, as may be required by such insurer or third party. Myovant Sciences reserves the right to revoke, rescind, or amend this offer without notice.

ORGOVYX BRIDGE PROGRAM: TERMS AND CONDITIONS

The ORGOVYX Bridge Program ("Program") provides ORGOVYX at no cost for a limited period to eligible patients with commercial insurance who have been prescribed ORGOVYX for an FDA-approved indication, and whose insurance coverage is delayed or who experience a temporary lapse in coverage. Commercially insured patients are eligible for up to 4 months of free product. This Program is not valid for patients whose prescription claims are reimbursed, in whole or in part, by any state or federal government program, including, but not limited to, Medicaid, Medicare, Medigap, Department of Defense (DoD), Veterans Affairs (VA), TRICARE, Puerto Rico Government insurance, or any state patient or pharmaceutical assistance program. Patients and prescribers must complete the ORGOVYX Support Program enrollment form, and prescribers must provide an ORGOVYX Bridge prescription. Patients will receive their drug supply each month for up to 4 months or until they receive insurance coverage approval, whichever occurs earlier. Patients must be residents of the United States or US Territories. Program is not available to patients who are uninsured or where prohibited by law such as Massachusetts and Minnesota. Patients may be asked to reverify insurance coverage status during the course of the Program. Patients and participating prescribers agree not to seek reimbursement for all, or any part of the benefit received by the patient through this Program. No purchase necessary. Program is not health insurance, nor is participation a guarantee of insurance coverage. Other limitations may apply. Myovant Sciences reserves the right to rescind, revoke, or amend the Program and discontinue support at any time without notice.

MYOVANT SCIENCES PATIENT ASSISTANCE PROGRAM: TERMS AND CONDITIONS

The Myovant Sciences Patient Assistance Program ("Program") provides ORGOVYX at no cost to eligible patients who are prescribed ORGOVYX for an FDA-approved indication. Patients and prescribers must complete the ORGOVYX Support Program enrollment form, and prescribers must provide a Patient Assistance Program prescription. Patients must meet Program eligibility requirements, which include, but are not limited to, lack of insurance coverage for ORGOVYX, financial criteria and income evaluation, and patients must be residents of the United States and US Territories. Program requires annual re-evaluation and re-enrollment for continued participation. Patients may be asked to reverify insurance coverage status during the course of the Program. Patient and participating prescribers agree not to seek reimbursement for all, or any part of, the free product received by the patient through this Program. Patients may not count the free product received from the ORGOVYX Support Program as an expense incurred for purposes of determining out-of-pocket costs for any plan, including true out-of-pocket costs ("TrOOP") for purposes of calculating the out-of-pocket threshold for Medicare Part D plans. Government health insured patients who meet the Program eligibility criteria are eligible to receive free product for the entire coverage year, and Myovant Sciences will notify patients' government health insurance plans that the patient is enrolled in the Program. No purchase necessary. Program is not health insurance, nor is participation a guarantee of insurance coverage. Other limitations may apply. Myovant Sciences reserves the right to rescind, revoke, or amend the Program and discontinue support at any time without notice.

Please see full Prescribing Information and Patient Product Information for ORGOVYX® (relugolix).

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