Phone: 1-844-KADMON1 (523-6661) | Monday through Friday, 8:00 AM-8:00 PM ET
Save this number to your phone so you know when **Kadmon ASSIST** is calling.

Fax: 1-833-635-1481 | PO Box 5266, Louisville, KY 40255

Kadmon ASSIST™ Program Enrollment Form

Kadmon ASSIST™

Instructions and Description of Services

Note: If additional information or assistance is needed, please contact **Kadmon ASSIST** *for an assessment of what services may be needed and the steps required.*

DESCRIPTION OF SERVICES

Benefits Investigation: Kadmon ASSIST will contact the patient's insurance company to collect information on coverage, patient benefits and prior authorization (PA) requirements. *Please complete sections 1 to 3 and 5 to 8 when requesting this service, and attach a copy of the patient's insurance/Medicare/ Medicaid card (front and back).*

Prior Authorization Support: Kadmon ASSIST will contact the patient's insurance company to collect information and the PA requirements and follow up on the status of any provider-/pharmacy-submitted PAs. *Please complete sections 1 to 3 and 5 to 8 when requesting this service.*

Quick Start Program: The Quick Start Program delivers a free 30-day supply of REZUROCK® (belumosudil) to eligible patients who are experiencing a delay in their coverage decision for their first REZUROCK prescription. If a submitted PA has been denied, the patient is eligible for Quick Start upon receipt of the PA denial. Proof of denial must be provided. *Please complete sections 1 to 3 and 5 to 8 when requesting this service.*

Patient Assistance Program (PAP): Kadmon ASSIST will provide free medication for up to 12 months to patients who qualify. Proof of income is required. *Please complete sections 1 to 9 when requesting this service.*

Bridge Program: The Bridge Program delivers a free 30-day supply of REZUROCK to eligible patients with commercial insurance who are facing an interruption in their insurance coverage. *Please complete sections 1 to 3 and 5 to 8 when requesting this service.*

Commercial Co-Pay Savings Program: Co-pay savings for eligible commercially or privately insured patients. *Please complete sections 1 to 3 and 5 to 8 when requesting this service.*

Product Delivery Coordination: Kadmon ASSIST will help identify a specialty pharmacy within the REZUROCK network and help coordinate product shipment to a preferred address.

ENROLLMENT INSTRUCTIONS

1. Complete all applicable sections of the **Kadmon ASSIST** Program Enrollment Form.
2. Ensure all applicable provider and patient signature fields are complete.

a. The following fields are required for the patient:

- ☐ Patient Full Name
- ☐ Patient Gender
- ☐ Patient Phone Number
- ☐ Patient Insurance Information (if applicable)
- ☐ Patient Date of Birth
- ☐ Patient Home Address, City, State and ZIP Code
- ☐ Patient Authorization Consent
- ☐ Patient Certification Consent
- ☐ Patient Household Income (only applicable to PAP, proof of income is required)
- ☐ Patient Household Size (only applicable to PAP)

b. The following fields are required for the prescriber:

- ☐ Prescriber Full Name
- ☐ Prescriber Fax Number
- ☐ Prescriber NPI Number
- ☐ Patient ICD-10 Code
- ☐ Prescriber Phone Number
- ☐ Prescriber Address, City, State and ZIP Code
- ☐ Prescriber Declaration Signature and Date
- ☐ Patient Prescription and Clinical Information

Note: Patient Authorization Consent is required in order to enroll the patient in support program services such as PAP, Quick Start Program, and Bridge Program. If Prescriber Signature and Date are received, Patient Authorization Consent is not required to proceed with Benefits Investigation or Prior Authorization Support, to communicate with the prescriber regarding the patient's benefits, or to transfer a prescription to a specialty pharmacy.

3. Fax the completed **Kadmon ASSIST** Program Enrollment Form and all required documentation to **Kadmon ASSIST** at **1-833-635-1481**.

PATIENT CONFIDENTIALITY: Patient confidentiality is of primary importance to us. All patient information will remain confidential.

IMPORTANT REMINDER: Please be certain that all applicable pages of the **Kadmon ASSIST** Program Enrollment Form are completed and to include all appropriate documentation when submitting this form. Incomplete forms slow the review process and, in some cases, may require the healthcare provider to reapply for the program(s).

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1. REQUESTED SERVICES (Check all that apply. See page 1 for a description of available services.)

- ☐ Benefits Investigation
- ☐ Prior Authorization/Appeals Support
- ☐ Quick Start Program
- ☐ Bridge Program
- ☐ Patient Assistance Program (PAP)
- ☐ Commercial Co-Pay Savings Program
- ☐ Product Delivery Coordination

2. PATIENT INFORMATION

Patient Name (First and Last):			
Date of Birth (MM/DD/YYYY):	Gender: ☐ Male ☐ Female ☐ Other ☐ Prefer not to answer		
Home Address:			
City:		State:	ZIP:
Patient Home Phone:	Patient Mobile Phone:		
Patient Work Phone:	Patient Email Address:		
Preferred Method of Contact: ☐ Home ☐ Mobile ☐ Work ☐ Email			
Authorized Representative:	Relationship to Patient: ☐ Self ☐ Authorized Representative ☐ Caregiver		
Authorized Representative Phone:	Is the Patient a resident of the US or a US territory?: ☐ Yes ☐ No		
Authorized Representative Email:			
Sign & Date — I have read and agree to the **Authorization to Use and Disclose Health Information** in **Section 8** **Signature:**		**Date:**	
Sign & Date — I have read and agree to the **Patient Certifications** in **Section 9** **Signature:**		**Date:**	

3. PATIENT INSURANCE INFORMATION (Attach a copy of the patient's insurance/Medicare/Medicaid card, front and back, if available. If requesting Quick Start Program supply because PA denial has already been received, attach a copy of the proof of denial to expedite the process.)

Does the Patient Have Health Insurance?: ☐ Yes ☐ No	Insurance Type: ☐ Commercial ☐ Government ☐ Other	
Primary Medical Insurance Provider:		
ID #:	Group #:	
Beneficiary/Cardholder Name:	Insurance Phone:	
Secondary Medical Insurance Provider:		
ID #:	Group #:	
Beneficiary/Cardholder Name:	Insurance Phone:	
Prescription Insurance Provider:	ID #:	Group #:

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4. PATIENT FINANCIAL INFORMATION (Required only if applying for the PAP. Proof of income is required.)

Employment Status: ☐ Employed ☐ Unemployed

Current Annual Household Income: $	Number of People in Household:

If there is no household income, indicate how the patient/household is being supported:

5. PRESCRIBER INFORMATION (Office contact will be the point of contact for all questions related to the Program Enrollment Form.)

Prescriber Name (First and Last):		Prescriber NPI Number:
Address:		
City:	State:	ZIP:

Primary Phone:	Secondary Phone:
Fax:	Prescriber State License Number:
Office Contact Name:	Office Contact Phone:
Email Address:	Preferred Method of Contact: ☐ Phone ☐ Fax ☐ Email
Supervising Physician Name (if required):	Supervising Physician Phone (if required):

6. PRESCRIPTION AND CLINICAL INFORMATION (Please completely fill out the prescription information below to prevent any potential delays.)

Patient Name (First and Last):	Patient Date of Birth (MM/DD/YYYY):
Primary Diagnosis (ICD-10 Code):	Secondary Diagnosis (ICD-10 Code):

Current Medications:

Previous Therapy:

Allergies:

Anticipated Therapy Start Date (MM/DD/YYYY):	Preferred Distribution Method: ☐ Patient ☐ Prescriber's Office ☐ Institutional Pharmacy

Ship to Address:

Preferred Specialty Pharmacy: ☐ Biologics by McKesson ☐ Onco360 ☐ Amber Specialty Pharmacy ☐ No Preference ☐ Prescription Faxed Back to Institutional Pharmacy

Institutional Pharmacy Name/Contact Information: _____

REZUROCK® (belumosudil) 200 mg tablet

Directions: _____ Quantity: _____ Refills: _____

Prescriber Printed Name (First and Last):

Sign & Date **Prescriber Signature:**	**Date:**

Click here for full Prescribing Information or visit REZUROCK.com.

Fax completed form to **1-833-635-1481**. For complete program details, visit **KadmonASSIST.com** or call **1-844-KADMON1 (523-6661)**.

Kadmon ASSIST™ Program Enrollment Form

7. PRESCRIBER DECLARATION (SIGNATURE REQUIRED IN SECTION 6 ON PAGE 3)

I certify that (1) the information contained in this application is current, complete and accurate to the best of my knowledge; (2) the above therapy is medically necessary and in the best interest of the patient identified above and that I will supervise the patient's treatment accordingly; (3) I have obtained any consent required under federal and state law for the release and use of the patient's personal health information, including diagnosis, treatment, medical and insurance information contained on this form to Sanofi and its agents, service providers and affiliates, including commercial and field-based teams, for purposes of benefits verification and coordination of dispensing therapy, or to otherwise assist the patient to initiate or continue the prescribed therapy and/or to evaluate the patient's eligibility for **Kadmon ASSIST** or other programs for REZUROCK® (belumosudil); and (4) I will not seek payment from any payer, patient, or other source for free product provided directly to the patient. I have obtained patient's permission to enroll them in **Kadmon ASSIST** and for them to be contacted by Sanofi in connection with this application. I understand that I am under no obligation to prescribe any Sanofi therapies or to participate in **Kadmon ASSIST** and that I have not received, nor will I receive, any benefit from Sanofi for prescribing a Sanofi therapy. I certify that I am a legal resident of the United States (and US territories). I authorize Sanofi and its agents to convey the above prescription by any means allowed under applicable law to the dispensing pharmacy.

8. AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

PATIENT: PLEASE READ THE FOLLOWING CAREFULLY, THEN DATE AND SIGN WHERE INDICATED IN SECTION 2 ON PAGE 2

I hereby authorize my healthcare providers, health insurance carriers, and pharmacy providers to use and disclose my individually identifying health information, including health insurance information, medical diagnosis and condition, prescription information, and name, address and telephone number ("My Information") to Sanofi, its affiliates and its agents and representatives ("Sanofi"), including Sanofi's commercial and field-based teams and third parties authorized by Sanofi for the following purposes in order to administer the **Kadmon ASSIST** patient support program, including: (1) Collecting, entering, and maintaining my health information in a database to gather information on my patient experience; (2) Verifying insurance coverage, reviewing reimbursement requirements and coordinating coverage for REZUROCK; (3) Determining eligibility for program offerings, including co-pay assistance, free drug or other financial assistance services, or to refer me to other programs or sources of funding; (4) Contacting me to provide education, information, and support services to me related to REZUROCK; (5) Contacting me to conduct market research and assess **Kadmon ASSIST** customer service and to provide therapy support services designed for people prescribed REZUROCK; (6) Performing data analytics with aggregated de-identified data to assess program efficiency; and contacting me about opportunities to participate in research related to REZUROCK; (7) Providing me with ongoing therapy support, including by communicating with healthcare professionals or service providers. All prescription-related support is limited to Sanofi product(s).

Once My Information has been disclosed to Sanofi, I understand that federal privacy laws may no longer protect it from further disclosure. However, I also understand that Sanofi has agreed to protect My Information by using reasonable efforts and disclosing it only for the purposes allowed by me in the Authorization or as otherwise required by law. I understand that I am entitled to a copy of this signed Authorization and may revoke (withdraw) this Authorization at any time by faxing a signed written request to **Kadmon ASSIST** at 833-635-1481 or by mailing such request to **Kadmon ASSIST**, PO Box 5266, Louisville, KY 40255. **Kadmon ASSIST** will no longer seek disclosure of my health information from my healthcare providers and health insurance carriers once it has received and processed my revocation. However, revoking this Authorization will not affect any use and disclosure of the health information that has already occurred in reliance on my Authorization.

If I revoke this Authorization, I will no longer be able to receive **Kadmon ASSIST** support services. This Authorization shall be valid for eighteen (18) months from the date indicated next to my signature in section 2 on page 2, unless earlier revoked by my written request or if state law deems it valid for a lesser period. MARYLAND HEALTHCARE PROVIDERS, under Md. Code HG § 4-303(b)(4), this authorization expires ONE YEAR from the date of signature on page 3. I understand that I do not have to sign this Authorization to obtain healthcare treatment or benefits; however, in order to receive the services and communications described above, I must sign the Authorization. Federal Law (including HIPAA) requires a signed Authorization in order for **Kadmon ASSIST** to collect this information from my healthcare providers. I understand that my pharmacy, health insurers, and third-party vendors may receive remuneration (payment) from **Kadmon ASSIST** and Sanofi or its affiliates in exchange for providing me with support services and that sharing my health information helps facilitate the support services I will receive.

9. PATIENT CERTIFICATIONS

PATIENT: PLEASE READ THE FOLLOWING CAREFULLY, THEN DATE AND SIGN WHERE INDICATED IN SECTION 2 ON PAGE 2

I am enrolling in the **Kadmon ASSIST** Patient Support Program (the "Program") and authorize Sanofi and their affiliates and agents to provide me services under the Program, as described in the Program Enrollment Form and as may be added in the future. Such services include medication and adherence communications and support, medicating dispensing support, coverage and financial assistance support, disease and medication education and other support services (the "Services").

Kadmon ASSIST is a patient support program that helps patients to gain access to REZUROCK and provides patients with education and resources related to REZUROCK.

If enrolling in the **Kadmon ASSIST** Co-pay Savings Program, I understand that the Co-pay Card information will be sent to my designated specialty pharmacy along with my prescription and any assistance with my applicable cost-sharing or co-payment for REZUROCK will be in accordance with the Program terms and conditions.

I authorize **Kadmon ASSIST** to verify my eligibility for the **Kadmon ASSIST** Patient Assistance Program, and I understand that such verification may include contacting me or my healthcare provider, insurance, and/or medical information. I authorize **Kadmon ASSIST** under the Fair Credit Reporting Act to use my demographic information to access reports on my individual credit history from consumer reporting agencies. I understand that, upon request, **Kadmon ASSIST** will tell me whether an individual consumer report was requested and the name and the address of the agency that furnished it. I further understand and authorize **Kadmon ASSIST** to use any consumer reports about me, and information collected from me, along with other information they obtain from public and other sources, to estimate my income in conjunction with the Patient Assistance Program eligibility determination process, if applicable. I further understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid and no free product may be sold, traded, or distributed for sale. If approved for the **Kadmon ASSIST** Patient Assistance Program, I will not seek to have the value of any medication provided to me under this program counted toward my true-out-of-pocket (TrOOP) cost for prescription drugs for my Medicare Part D Plan. Continuation in the **Kadmon ASSIST** Patient Assistance Program is conditioned upon timely verification of income. In addition, I agree to notify **Kadmon ASSIST** if my insurance situation changes.

Continued on next page ▸

Kadmon ASSIST™ Program Enrollment Form

9. PATIENT CERTIFICATIONS (Continued)

Patients whose health insurance benefits include the use of an Alternative Funding Program are not eligible for the **Kadmon ASSIST** Patient Assistance Program/need-based free drug. Patients with insurance plans or employers who sign up with these alternative funding vendors will have no coverage for specialty drugs that are identified on a list determined by the alternative funding vendor and will be required to apply to a manufacturer patient assistance program or pursue specialty drug prescription coverage through the alternative funding program to obtain such specialty drugs, including Sanofi products. I agree to inform **Kadmon ASSIST** Patient Assistance Program team if I am a member of such an insurance plan or if I am applying to the **Kadmon ASSIST** Patient Assistance Program on behalf of a patient who is a member of such an insurance plan. Further, the **Kadmon ASSIST** Patient Assistance Program team may take additional steps to verify the patient assistance program need. Therefore, if I am applying to the **Kadmon ASSIST** Patient Assistance Program for either myself or on behalf of a patient, I authorize **Kadmon ASSIST** Patient Assistance Program team to contact my/the patient's employer, insurer, and other third parties (such as pharmacy benefit managers and their affiliated partners) to verify prescription benefit design and coverage.

I authorize **Kadmon ASSIST** to contact me by mail, telephone or email with information about the Program, disease state and products, promotions, services, and research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys (together, the "Communications"). I understand that I may be contacted by Sanofi in the event that I report an adverse event. I understand that I do not have to enroll in the Program or receive the Communications, and that I can still receive REZUROCK® (belumosudil), as prescribed by my Healthcare Provider. I may opt out of receiving Communications and individual support services offered by the Program, including the **Kadmon ASSIST** Co-pay Card, or opt out of the Program entirely at any time by notifying **Kadmon ASSIST** by telephone at 1-844-523-6661 or by sending a letter to **Kadmon ASSIST**, PO Box 5266, Louisville, KY 40255. I also understand that the Services may be revised, changed, or terminated at any time.

Fax completed form to **1-833-635-1481**. For complete program details, visit **KadmonASSIST.com** or call **1-844-KADMON1 (523-6661)**.

Click here for full Prescribing Information or visit REZUROCK.com.