MyROCK ASSIST™

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

Fax: 1-833-635-1481 | PO Box 592188, Orlando, FL 32859

MyROCK ASSIST Program Enrollment Form

ENROLLMENT INSTRUCTIONS

1. Complete all applicable sections of the **MyROCK ASSIST** Program Enrollment Form.
2. Ensure all applicable provider and patient signature fields are complete.
3. Fax the completed **MyROCK ASSIST** Program Enrollment Form and all required documentation to **MyROCK ASSIST** at 1-833-635-1481.

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

Scan to view the description of services or to enroll digitally at **MyROCKASSIST.com**

1 PATIENT INFORMATION

First Name* | Middle Initial | Last Name* | Email | Phone*
Cell Phone (preferred) ☐ Home Phone (optional) ☐

Preferred Method of Contact ☐ Phone ☐ Email

Address (No PO Boxes)*

Sex Assigned at Birth* ☐ Male ☐ Female

☐ I have read the **Text Messaging Consent** in Section 8 and expressly consent to receive text messages by or on behalf of the Program.

Date of Birth (MMDDYYYY)* | City* | State* | Zip*

Authorized Representative Name

Relationship to Patient ☐ Self ☐ Authorized Representative ☐ Caregiver

SIGN & DATE / /

I have read and agree to the **Authorization to Use and Disclose Health Information** in **Section 7**

SIGN & DATE / /

I have read and agree to the **Patient Certifications** in **Section 8**

*Indicates required field

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2 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 Employer: _____

Primary Rx Insurance _____ **Primary Medical Insurance** _____

Phone _____ Phone _____

Policy ID # _____ Group # _____ Policy ID # _____ Group # _____

Rx BIN # _____ Rx PCN # _____

Policyholder name (First Last) _____ Relationship to patient _____

3 PATIENT FINANCIAL INFORMATION (Required only if applying for PAP. Proof of income may be 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

Free supply of medication through the PAP is provided by Sanofi Cares North America (SCNA), a charitable organization of Sanofi under Section 501(c)(3) of the IRC.

4 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*

_____ _____ _____
Phone* Fax* Prescriber State License Number

_____ _____
Office Contact Name Email Address

*Indicates required field

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5 CLINICAL AND PRESCRIPTION INFORMATION*

Patient First Name* _____ Patient Last Name* _____

Current medications _____ Previous treatments tried, failed or intolerant to. _____

Any Known Drug Allergies _____ Diagnosis (ICD-10 Code)* _____

Anticipated Therapy Start Date (MM/DD/YYY) _____

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

Network Specialty Pharmacy Prescription REZUROCK® 200 mg tablet

☐ REZUROCK® (belumosudil) 200 mg tablet #30 Take 1 tablet daily

Refills _____

☐ For patients on strong CYP3A Inducers or co-administration with proton pump inhibitors REZUROCK® (belumosudil) 200 mg tablet #60 Take 1 tablet twice daily

Refills _____

Prescriber Printed Name (First and Last):

SIGN & DATE

Prescriber Signature* Date* / /

Quick Start or Other MyROCK ASSIST Free Goods Programs REZUROCK® 200 mg tablet

☐ REZUROCK® (belumosudil) 200 mg tablet #30 Take 1 tablet daily

Refills _____

☐ For patients on strong CYP3A Inducers or co-administration with proton pump inhibitors REZUROCK® (belumosudil) 200 mg tablet #60 Take 1 tablet twice daily

Refills _____

Prescriber Printed Name (First and Last):

SIGN & DATE

Prescriber Signature* Date* / /

*Indicates required field

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6 PRESCRIBER DECLARATION (SIGNATURE REQUIRED IN SECTION 5 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 **MyROCK 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 **MyROCK 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 **MyROCK 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.

7 AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I hereby authorize my healthcare providers, health insurance carriers, and pharmacy providers to disclose my individually identifying health information, including demographic information, full name, address, date of birth, telephone number, health insurance information, medical diagnosis and condition, prescription information, and information related to treatment, care management, and medication history ("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.

My information will be shared with Sanofi so that Sanofi may administer and provide me services through the **MyROCK ASSIST** patient support program. Sanofi may use My Information to:

- operate and administer the **MyROCK ASSIST** patient support program;
- verify insurance coverage, reviewing reimbursement requirements and coordinate coverage for REZUROCK® (belumosidil);
- determine 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;
- contact me to provide education, information, and support services to me related to REZUROCK;
- contact me to conduct market research and assess **MyROCK ASSIST** customer service and to provide therapy support services designed for people prescribed REZUROCK;
- contact me about opportunities to participate in research related to REZUROCK;
- provide me with ongoing therapy support, including by communicating with healthcare professionals or service providers.

All prescription-related support is limited to Sanofi product(s). Sanofi may use my de-identified information for quality assurance purposes, research, education, business analytics, marketing studies, or for other commercial purposes and to evaluate and improve operations and services.

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 and disclosing it only for the purposes allowed by me in the Authorization or as otherwise required by law.

Continued on next page ▸

MyROCK ASSIST Program Enrollment Form

7 AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION (Continued)

I understand that I do not have to sign this Authorization. A decision by me not to sign this Authorization will not affect my ability to obtain medical treatment, payment for treatment, insurance coverage, access to health benefits or Sanofi medications from covered entities such as Health Care Providers, Health Insurers, and Pharmacy Providers. However, if I do not sign this Authorization, I understand that I will not be able to participate in the **MyROCK ASSIST** Program.

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 **MyROCK ASSIST** at 833-635-1481or by mailing such request to **MyROCK ASSIST**, PO Box 592188, Orlando, FL 32859. **MyROCK ASSIST** will no longer seek disclosure of My 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 My Information that has already occurred in reliance on my Authorization.

If I revoke this Authorization, I will no longer be able to receive **MyROCK 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. 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 **MyROCK ASSIST** to collect My Information from my healthcare providers. I understand that my pharmacy, health insurers, and third-party vendors may receive remuneration (payment) from **MyROCK ASSIST** and Sanofi or its affiliates in exchange for providing me with support services and that sharing My Information helps facilitate the support services I will receive.

For more information about how Sanofi may use My Information for the purposes described on this form, view Sanofi's Privacy Policy and Consumer Health Data Privacy Policy. Depending on where I live, I may have certain rights with respect to my personal information, including the request to access or delete my personal information. Sanofi may not be required to fulfill my requests in certain circumstances. I understand that to exercise these rights, I may contact Sanofi's Privacy Office at PrivacyOfficeUSA@Sanofi.com.

8 PATIENT CERTIFICATIONS

MyROCK ASSIST Program Enrollment Consent. I am enrolling in the **MyROCK 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"). **MyROCK 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 **MyROCK 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 **MyROCK ASSIST** to verify my eligibility for **MyROCK ASSIST**, and I understand that such verification may include contacting me or my healthcare provider, insurance, and/or medical information.

Credit Check Consent. I authorize Sanofi to verify my eligibility for **MyROCK ASSIST**. I authorize Sanofi 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, Sanofi 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 Sanofi to use any consumer reports about me, and

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8 PATIENT CERTIFICATIONS (Continued)

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.

Conditions of Participation. 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 **MyROCK 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 **MyROCK ASSIST** Patient Assistance Program is conditioned upon timely verification of income. In addition, I agree to notify **MyROCK ASSIST** if my insurance situation changes.

Patients whose health insurance benefits include the use of an Alternative Funding Program are not eligible for the **MyROCK 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 **MyROCK ASSIST** Patient Assistance Program team if I am a member of such an insurance plan or if I am applying to the **MyROCK ASSIST** Patient Assistance Program on behalf of a patient who is a member of such an insurance plan. Further, the **MyROCK ASSIST** Patient Assistance Program team may take additional steps to verify the patient assistance program need. Therefore, if I am applying to the **MyROCK ASSIST** Patient Assistance Program for either myself or on behalf of a patient, I authorize **MyROCK 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.

Communications and Marketing. I authorize **MyROCK 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 **MyROCK ASSIST** Co-pay Card, or opt out of the Program entirely at any time by notifying **MyROCK ASSIST** by telephone at 1-844-523-6661 or by sending a letter to **MyROCK ASSIST**, PO Box 592188, Orlando, FL 32859 or by contacting Sanofi at PrivacyOfficeUSA@Sanofi.com. I also understand that the Services may be revised, changed, or terminated at any time.

Text Message Consent. I acknowledge that by checking the Text Messaging Consent box on page 1, I expressly consent to receive text messages from or on behalf of **MyROCK ASSIST** at the mobile telephone number(s) that I provide.

I confirm that I am the subscriber for the mobile telephone number(s) provided, and I agree to notify Sanofi promptly if any of my number(s) change in the future. I understand that my wireless service provider's message and data rates may apply. I understand that I can opt out of future text messages at any time by replying STOP to texts from my mobile phone or by calling 844-523-6661, and that I can get help for text messages calling 844-523-6661. I also understand that additional text messaging terms and conditions may be provided to me in the future as part of an opt-in confirmation text message. Message and data rates may apply. I understand that my consent is not required as a condition of participating in the Program or for purchasing any goods or services from Sanofi.