ELAHERE® (mirvetuximab soravtansine-gynx) Enrollment Form

Phone: 1-833-352-4373 | Fax: 1-833-464-6329 | Monday to Friday, 8 AM to 8 PM ET

ELAHERE® mirvetuximab soravtansine-gynx injection 100 mg SUPPORT SERVICES

Please complete this form in its entirety, obtain patient signature on pages 2 and 3, and fax to 1-833-464-6329. If the patient is unable to provide a signature directly on the form, please access the Consent Form or call the ELAHERE Support Services Program® at 1-833-352-4373 to have the e-Consent link emailed to them.

SERVICES AVAILABLE

- **Access Support:** Reimbursement support and prior authorization research
- **Co-pay Only:** Eligibility determination and enrollment into co-pay services
- **PAP Enrollment:** Free drug services for eligible patients

PATIENT INFORMATION

Privacy Notice: For information on how we collect and process your personal data, including the categories we collect, purposes for their collection, and disclosures to third parties visit https://abbv.ie/PrivacyPatient.

Consent to process my sensitive personal information: Through my submission of the ELAHERE© Support Services Program form, I consent to the collection, use, and disclosure of my personal health data, as described in the Privacy Notice above and in AbbVie's Privacy Notice in the "How We May Disclose Personal Data." My consent is required to process sensitive personal data under certain privacy laws, and I have the right to withdraw my consent by visiting "Your Privacy Choices" on AbbVie's website.

First Name		Last Name	
Date of Birth / /	Gender ☐ M ☐ F ☐ Other	United States or Puerto Rico Resident ☐ Yes ☐ No	
Address	City	State	ZIP
Home Phone	Cell Phone	Patient Email Address	
Preferred Contact ☐ Cell Phone ☐ Home Phone ☐ Email ☐ Text		Best Time to Call ☐ Morning ☐ Afternoon ☐ Evening	
Alternate Contact Name		Alternate Contact Phone	
Insurance ☐ Commercial ☐ Government ☐ Uninsured		Secondary Insurance ☐ Commercial ☐ Government	
Insurance Name		Secondary Insurance Name	
Insurance Phone Number		Secondary Insurance Phone Number	
Insurance ID Number		Secondary Insurance ID Number	
Insurance Group Number		Secondary Insurance Group Number	
FOR PATIENT ASSISTANCE PROGRAM (PAP)			
Household Size		Household Income	

PRESCRIBER INFORMATION

First Name		Last Name	
Prescriber NPI		Prescriber Tax ID Number	
Facility Name		Facility NPI	
Address	City	State	ZIP
Primary Office Contact	Phone Number	Fax Number	
Prescriber Preferred Contact ☐ Office Phone ☐ Email ☐ Fax			
Billing Contact Phone	Office Contact Email	Billing Contact Email	

TREATMENT INFORMATION

Primary Diagnosis Code (ICD-10)	Planned Infusion Start Date	Previous Treatment(s) ☐ Yes (1–3 treatments) ☐ No

PRESCRIPTION INFORMATION (PAP ONLY)

Current Medications | Allergies to Medications

Medication	Strength/Form	Adjusted Ideal Body Weight	Directions for Administration	Qty	Refills
ELAHERE® (mirvetuximab soravtansine-gynx) ☐ Dispense As Written	☐ 100 mg/20 mL (5 mg/mL) in single-dose vial		_____ mg IV every 3 weeks		

☐ **Does the patient have a diagnosis consistent with the FDA-approved indication or an indication identified as medically accepted by a major drug compendium such as the National Comprehensive Cancer Network® (NCCN®) Compendium?**

PLEASE OBTAIN PATIENT SIGNATURES ON PAGES 2 AND 3 OF THIS FORM

Please see full Prescribing Information, including Boxed Warning.

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ELAHERE SUPPORT SERVICES

PRESCRIPTION CERTIFICATION

I certify that: (1) the information provided is current, complete and accurate to the best of my knowledge; (2) this patient has ovarian cancer; (3) the product prescribed is medically necessary for this patient; (4) if this patient is seeking product at no charge under the patient assistance program, the product has been prescribed for a Food and Drug Administration ("FDA") approved indication or an indication identified as medically accepted by a major drug compendium such as the National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium; and (5) I am authorized under state law to prescribe the product and will supervise the administration of the product.

I understand that submission of this Enrollment Form does not guarantee that assistance will be provided under the ELAHERE Support Services Program® ("Program") and that AbbVie and its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "AbbVie") may change or cancel the Program at any time. I agree to immediately notify a Program representative if I become aware of any changes in the patient's medical, financial and/or insurance information which may affect their eligibility for participation in the Program. I agree that the Program may contact me for additional information relating to this patient's eligibility or participation in the Program by fax, e-mail and/or telephone.

I understand that I am under no obligation to prescribe ELAHERE. I agree that, if this patient receives product at no charge under the Program, the product received will be used solely for this patient and I will not submit claims nor make any attempt to receive reimbursement for that product. I certify that my practice or facility routinely collects self-pay obligations from patients, including without limitation copays, deductibles and/or coinsurance.

I understand that any information provided is for the sole use of AbbVie and the Program to verify this patient's insurance coverage status, to assess the patient's eligibility for participation in applicable components of the Program, and to otherwise administer the Program. I further certify that I have obtained from my patient all required written authorizations and/consents for the release of my patient's personal, medical and insurance information to the Program. By signing this Enrollment Form, I authorize the release of patient health or other information to representatives and service providers of the Program (including but not limited to dispensing pharmacies) to use and disclose as necessary in connection with this patient's enrollment and participation in the Program.

Prescriber Certification Signature (original signature required) _____ Date _____

PATIENT AUTHORIZATION

I certify that I am 18 years old or older and a resident of the United States or Puerto Rico and I am receiving care from a licensed healthcare provider authorized to prescribe, dispense and administer prescription drugs in the United States.

By checking one or more boxes below, I am applying to enroll in one or more of the components of ELAHERE Support Services Program ("Program"). I am authorizing AbbVie and its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "AbbVie") to provide assistance to me under the Program. I certify that the information provided is current, complete and accurate to the best of my knowledge and I agree to notify the Program at 1-833-ELAHERE (352-4373) immediately if any information provided changes. I understand that AbbVie may request additional information relevant to my eligibility or participation in the Program and may review and audit any information provided to confirm its accuracy. I understand that AbbVie may change or cancel the Program at any time.

X **Access Support (Assistance determining product coverage and coverage requirements and other reimbursement support)**
Note that Access Support is provided to all patients in the Program because such support is necessary to confirm eligibility for Copay Assistance and the Patient Assistance Program.

☐ **Copay Assistance (Financial assistance with copay, deductible or coinsurance obligations of commercially insured patients)**
By checking this box, I certify that I am seeking copay assistance and that: (1) I have commercial health insurance and I am not enrolled in any government funded health program including without limitation Medicare, Medicaid, Medigap, TRICARE, Veterans Affairs healthcare, any state prescription assistance program or Puerto Rico Government Health Insurance; (2) my commercial health insurer does not prohibit the use of copay assistance and (3) I will report any copay assistance to my health insurer as may be required.

☐ **Patient Assistance Program (ELAHERE at no charge for financially needy eligible patients)**
By checking this box, I certify that I am seeking patient financial assistance and that I understand that I must meet specific eligibility requirements in order to receive ELAHERE at no charge under the Program. Those requirements include being uninsured or underinsured as defined by Program standards and meeting the Program income guidelines, which currently require an annual gross income equal to or less than 600% of the Federal Poverty Level. **Uninsured** means I have no medical benefits insurance coverage and **underinsured** means I have insurance that does not cover ELAHERE *or* my insurance has denied coverage for ELAHERE for me even after an appeal *or* my insurance covers ELAHERE but has a copay, coinsurance or deductible that I cannot afford.

I understand that my income will be validated through Experian Health's household income assessment tool. I am therefore providing "written instructions" to AbbVie and Sonexus Health under the Fair Credit Reporting Act authorizing the Program to obtain information from my credit profile or other information from Experian Health. I authorize AbbVie and Sonexus Health to obtain such information solely for the purpose of determining financial qualifications for the Program. I understand that I must affirmatively agree to the terms in this notice by signing below in order to proceed in the Program financial screening process. If my income cannot be verified through Experian, I understand that the Program may request other proof of income from me, such as my IRS 1040 form.

I understand that, if I qualify and I am enrolled in the Program, I am not required to receive treatment from any given provider and may cease treatment at any time. I understand that neither I nor my health insurance will be charged for any product provided at no charge. I certify that I will not claim reimbursement from my health insurance or any third party for product provided at no charge. I understand that eligibility for such product will be re-verified monthly.

Additional information on Program terms and conditions, including eligibility requirements is available at www.ELAHERE.com.

My signature certifies that I have read and understand the above statements and agree to the outlined terms.

Patient or Authorized Representative Name _____ Signature _____ Date _____

Representative Relationship (if applicable) _____

PATIENT CONSENT FOR TEXT ALERTS ON PROGRAM AND PATIENT RESOURCES

Patient Cell Phone Number _____

☐ **Text Consent:** I consent to receive Program automated and recurring text messages from "AbbVie," including services updates, refill reminders, and Rx notifications to the above mobile number. Message and data rates may apply. I am not required to consent as a condition of receiving goods or services. I can reply HELP for help. I can reply STOP to opt out at any time. View Privacy Notice and mobile T&C here.

PLEASE OBTAIN PATIENT SIGNATURES ON PAGES 2 AND 3 OF THIS FORM

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HIPAA AUTHORIZATION (PLEASE REVIEW AND SIGN BELOW)

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION: I authorize my health care providers and staff, health plan, and pharmacies (collectively, my "Healthcare Providers") to disclose individually identifiable information about me, my health or condition(s), treatment and care that I have received, my insurance coverage, my payment information, and my medication history and prescriptions (collectively, "Protected Health Information") to AbbVie Inc. and/or its designated affiliates, agents, representatives, and service providers (collectively, "AbbVie") in order for AbbVie to

(i) enroll me in, provide, operate and administer the ELAHERE Support Services Program ("Program");
(ii) provide me with information concerning the Program; and
(iii) develop, evaluate, and improve products, services, materials, and programs related to my condition or treatment. I understand that Protected Health Information disclosed to AbbVie under this Authorization will no longer be protected by HIPAA and may be subject to redisclosure by AbbVie

I understand that I am not required to sign this Authorization and that my Healthcare Providers will not otherwise condition my treatment, payment, health insurance enrollment, or eligibility for health care benefits to which I am otherwise entitled on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I cannot take part in the Program. I understand that this Authorization will expire once I am no longer participating in the Program, unless I cancel it sooner. I understand that I may cancel this Authorization at any time by making a data subject rights request at https://abbviemetadata.my.site.com/AbbvieDSRM or by writing to privacydsr@abbvie.com. However, I understand that if I cancel this Authorization, it will end my enrollment in the Program. I understand that cancelling this Authorization will not affect any use or disclosure of my Protected Health Information that has already taken place in reliance on this Authorization.

My signature below certifies that I have read, understood, and agree to the release of my Protected Health Information pursuant to this Authorization. I verify the information provided is true and correct. If I am the caregiver/representative of the patient, I confirm I am authorized to sign on behalf of the patient.

Note: You have a right to receive a copy of this Authorization. You may print a copy of or save this Authorization and retain a copy for your records.

Patient or Authorized Representative Name	Signature	Date

Representative Relationship (if applicable)

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