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

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 have them scan the QR code to 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

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?**

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 ImmunoGen and its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "ImmunoGen") 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 ImmunoGen 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/or 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**

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

Please see full Prescribing Information, including Boxed Warning.

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PATIENT CERTIFICATION

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 ImmunoGen and its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "ImmunoGen") 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 ImmunoGen 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 ImmunoGen may change or cancel the Program at any time.

I understand that my health information, contact information, and other information I, my Health Care Providers, Insurers, and others share with ImmunoGen and the Program is collected to provide me with the assistance I request and for other business purposes of the Program as described in this Enrollment Form and ImmunoGen's Privacy Policy, available online at https://www.immunogen.com/privacy-policy/. Depending on where I live, I may have certain rights with respect to my information, including the request to access or delete my personal information. I am aware that ImmunoGen may not be required to fulfill my requests in certain circumstances. I understand that to exercise these rights, I may contact the Privacy Office by emailing Privacy@ImmunoGen.com or by calling 1-833-ELAHERE.

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 ImmunoGen 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 ImmunoGen 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 ______

☐ By checking this box, I consent to receive program alerts from or on behalf of the Program via text message to the mobile telephone number(s) provided. I confirm that I am the subscriber for the mobile telephone number(s) provided, and I agree to notify the Program 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. At any time, I understand I may text STOP to cancel. 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. I understand that my consent is not required as a condition of purchasing any goods or services from ImmunoGen. I am entitled to receive a copy of this Consent for my records.

PLEASE OBTAIN PATIENT SIGNATURE ON PAGE 3 OF THIS FORM

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PATIENT AUTHORIZATION (PLEASE REVIEW AND SIGN BELOW)

By signing this Authorization, I authorize each of my physicians, pharmacists, including any non-commercial pharmacy that receives my prescription for ELAHERE (together "my Prescribed Product"), and other healthcare providers (together "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my Health Information, including but not limited to medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and or group numbers (together, "Health Information") to ImmunoGen and its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "ImmunoGen") for purposes of enrolling me and providing me services under the ELAHERE Support Services Program (collectively, the "Program"), as further described below.

Specifically, I authorize use and disclosure of my Health Information in order to:

I. To determine if I am eligible to participate in the Program, and enroll me in and contact me about the Program, including access support, co-pay assistance services, and patient financial assistance services.
II. Communicate with my Healthcare Providers and Insurers about benefits, coverage, and medical care, including compliance with Product treatments,
III. Facilitate dispensing of my prescription by a non-commercial pharmacy,
IV. Provide me with educational materials, information and services related to my treatment experience with my prescribed medication and my condition,
V. Verify, investigate, and coordinate with my Insurers regarding my Prescribed Product,
VI. Conduct surveys, data analytics, market research and other internal business activities related to the Program and ImmunoGen products and programs, and
VII. Contact me as otherwise required or permitted by law.

Once my Health Information has been disclosed to the Program, I understand that federal privacy laws no longer protect the information. I understand that I may refuse to sign this Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me, but I will not have access to the Program and the services provided under the Program. If I refuse to sign the Authorization, or revoke my Authorization later, I understand that this means I will not be able to participate or receive assistance from the Program.

I understand that my signed Authorization is valid for 2 years from date of signature, unless a shorter period is required by law, and that I may revoke this Authorization at any time in the future, except to the extent that actions have been taken in reliance on the Authorization. I understand that to revoke this Authorization I may mail a request to 2730 S. Edmonds Ln, STE 300, Lewisville, TX, 75067, fax to 1-833-IMGN-FAX (464-6329), or call 1-833-ELAHERE (352-4373). I understand that revoking this Authorization will end further uses and disclosure of my Health Information by the parties identified above except to the extent those uses and disclosures have been made in reliance upon this Authorization as permitted by applicable law. I am entitled to receive a copy of this Authorization.

My signature certifies that I have read and understand the above Patient Authorization.

Patient or Authorized Representative Name	Signature	Date

Representative Relationship (if applicable): ____________________

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