ENROLLMENT FORM: Co-Pay Support Program

To be completed by the Prescriber or an appropriate representative

Please complete the entire form, sign, and fax this form to 1-866-FAX-AADI (1-866-329-2234)

For assistance, call 1-855-AADIHUB (1-855-223-4482) Monday-Friday 8 AM - 8 PM ET

☐ **Benefits investigation and coverage determination for FYARRO® (sirolimus protein-bound particles for injectable suspension) (albumin-bound)** *(Please complete page 1 only).*

☐ **Refer patient to AadiAssist Co-Pay Support Program** *(Please complete pages 1 and 2).*

1 Patient Information

First Name:_____ Last Name:_____ DOB:_____

Address:_____ City:_____ State:_____

ZIP:_____ SSN:_____ US Resident: ☐ Yes ☐ No Gender: ☐ Male ☐ Female ☐ Prefer Not to Answer

Primary Phone #: _____ Secondary Phone #: _____

Email (optional): _____

Additional Contact Name: _____ Additional Contact Phone #: _____

Preferred Contact Method: ☐ Call ☐ Email ☐ Text Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

2 Insurance Information

Please attach a front and back image of the patient's insurance card. This section does not need to be filled out if images of the patient's insurance card are attached.

☐ No Insurance

Primary Insurance: _____ Secondary Insurance: _____

Primary Insurance Phone #:_____ Secondary Insurance Phone #:_____

Subscriber Name:_____ Subscriber Name:_____

Medicaid Provider ID #:_____ Medicaid Provider ID #:_____

Subscriber ID #:_____ Subscriber ID #:_____

Policy/Group #:_____ Policy/Group #:_____

Site of Service:_____

Diagnosis:_____

3 Patient Certification and Signature

My signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge, and that I have read, understand, and agree to the Patient Authorization to release my Protected Health Information as indicated on the reverse side of this form (page 2), including, but not limited to, spoken or written facts about my health and payment benefits that I may have. I understand Protected Health Information may include copies of records from my healthcare providers or health plans about my health or healthcare. I understand, accept, and will comply with all requirements and restrictions described in the eligibility requirements provided on the back of this form.

SIGN HERE Patient Signature: _____ Date:_____

Legal Representative Signature: _____ Relationship to Patient:_____ Date:_____

Ensure the applicant signs and dates this section in each place indicated. This enrollment cannot be processed without the patient's signatures.

4 Prescriber Information

First Name: _____ Last Name: _____ Practice Name: _____

Address: _____ City:_____ State: _____

ZIP:_____ Tax ID #:_____ NPI #:_____ Group NPI #:_____

Office Contact:_____ Office Phone:_____ Office Fax:_____

5 Physician Certification and Signature

By signing this enrollment form, I certify that I have prescribed FYARRO based on my professional judgment of medical necessity for an FDA-approved indication, and that I will supervise the patient's medical treatment. I authorize the release of medical and/or other patient information relating to FYARRO therapy to agents and service providers of Aadi Bioscience (including, but not limited to, PANTHERx Rare, LLC) to use and disclose as necessary for fulfillment of the prescription and to furnish any information on this form to the insurer of the above-named patient for the purpose of verifying benefit eligibility and obtaining coverage authorization.

SIGN HERE Prescriber Signature: _____ Date:_____

(No stamps accepted. Original signature required. If required by applicable law, please attach copies of all prescriptions on official state prescription forms).

Ensure the prescriber signs and dates this section in each place indicated. This enrollment cannot be processed without the prescriber's signature.

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6 Patient Authorization for Use and Disclosure of Personal and Health Information

By signing this Authorization, I authorize each of my physicians, pharmacists, including any specialty pharmacy that receives my prescription for FYARRO® (sirolimus protein-bound particles for injectable suspension) (albumin-bound), and other healthcare providers (together "Healthcare Providers"), and each of my health insurers (together, "Insurers"), to disclose my Protected 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, "Protected Health Information") to Aadi Bioscience, its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Aadi Bioscience") including providers of alternate sources of funding for prescription drug costs, and other service providers supporting access programs for Healthcare Providers and patients for the purposes described below.

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

I. Enroll me in, and contact me about, AadiAssist Co-Pay Support Program, including benefits investigation support, and verify eligibility for AadiAssist Co-Pay Support Program
II. Provide me with educational materials, information, and services related to my treatment experience with FYARRO
III. Verify, investigate, assist with, and coordinate my coverage for FYARRO with my Insurers
IV. Contact me to conduct surveys in relation to my experience with AadiAssist Co-Pay Support Program
V. Allow for data analytics, market research, other internal-related business activities, and use for communications with healthcare providers

I understand once my Protected Health Information has been disclosed to Aadi Bioscience, federal privacy laws no longer protect the information. However, Aadi Bioscience agrees to protect my Health Information by using and disclosing it only for the purposes described in this Authorization or as permitted by law.

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. 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 AadiAssist Co-Pay Support Program.

☐ I do not want to receive any marketing educational materials, or be contacted to conduct surveys or marketing research.

This Authorization will last until I am no longer participating in AadiAssist Co-Pay Support Program. I understand that I may cancel this Authorization at any time by calling 1-855-AADIHUB (1-855-223-4482). I understand that revoking this Authorization will end further uses and disclosure of my Protected 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.

7 Patient Consent for AadiAssist Co-Pay Support Program

I understand that completing this form does not ensure that I will qualify for the AadiAssist Co-Pay Support Program. I represent that the information provided in this enrollment form is complete and accurate. I agree to notify and shall be responsible for notifying the program administrator for the AadiAssist Co-Pay Support Program if I no longer meet the criteria for the AadiAssist Co-Pay Support Program or if my insurance status changes. I understand that Aadi Bioscience reserves the right at any time and without notice to me to modify and/or discontinue any or all of the AadiAssist Co-Pay Support Program, including modification of eligibility criteria and immediate termination of assistance provided by the AadiAssist Co-Pay Support Program. I understand that I may decline to sign this form and decline being considered for the AadiAssist Co-Pay Support Program. I certify that I do not have insurance through a government healthcare program including Medicare, Medicaid, Tricare or other public healthcare program. I have read and agree to comply with all program terms and conditions (available at www.aadiassist.com).

The AadiAssist Co-Pay Support Program provides savings on out-of-pocket expenses of FYARRO, up to a maximum dollar amount of $25,000 annually for commercially or privately insured patients. Patients pay $0 out-of-pocket for FYARRO, which includes co-pay and co-insurance, up to a maximum dollar amount of $25,000 annually. The AadiAssist Co-Pay Support Program only assists with the cost of FYARRO; the patient is responsible for cost-share of treatments and office visits. The AadiAssist Co-Pay Support Program does not support any claims covered, paid, or reimbursed, in whole or in part, Medicare, Medicaid, or other federal or state healthcare programs. Terms and conditions apply.

I request assistance with out-of-pocket costs of FYARRO and hereby authorize and direct the AadiAssist Co-Pay Support Program, sponsored by Aadi Bioscience, to issue payment directly to the practice infusing the drug, and I confirm that I have not made any payments to the practice related to the administration of FYARRO.

Patient Name: _____

SIGN HERE Patient Signature: _____ Date: _____

Legal Representative Name: _____

Legal Representative Signature: _____ Date: _____

Please be sure the applicant signs and dates this section in each place indicated. This enrollment cannot be processed without the patient's signatures.

FYARRO® is a registered trademark of Aadi Bioscience, Inc.

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