ENROLLMENT FORM:
Temporary Supply (Quick Start) Program & PAP

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

☐ **AadiAssist Temporary Supply (Quick Start) Program**

The AadiAssist Temporary Supply Program helps eligible patients who are experiencing coverage delays or issues obtain a limited supply (up to 60 days) of FYARRO™ (sirolimus protein-bound particles for injectable suspension) (albumin-bound) to help them start or stay on therapy.

Eligibility Criteria: Insured with Coverage Delays

- Patient must have an FDA-approved, on-label prescription for FYARRO
- Patient must be a resident of the contiguous United States, Alaska, or Hawaii
- Patient must be experiencing coverage delays due to prior authorization, change of employment, etc.

☐ **AadiAssist Patient Assistance Program (PAP)**

Through the AadiAssist PAP, patients who are uninsured or underinsured may be eligible to obtain access to FYARRO at no cost.

Eligibility Criteria: Uninsured/Underinsured

- Patient must have an FDA-approved, on-label prescription for FYARRO
- Patient must have an Annual Household Income <400% Federal Poverty Level (FPL)*
- Patient must be a resident of the contiguous United States, Alaska, or Hawaii
- Patient must have neither insurance coverage for nor access to other coverage for FYARRO

*Find current US Federal Poverty Guidelines online at www.aspe.hhs.gov/poverty-guidelines.
Aadi Bioscience reserves the right, anytime and without notice, to modify the terms and conditions of or discontinue this program.
Please contact AadiAssist with any additional questions.

1 Administering Prescriber Information

Administering Prescriber Name: _____

Facility Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Primary Contact Name: _____

Title: _____

Phone #: _____ Extention #: _____ Fax #: _____

Tax ID #: _____ NPI #: _____ State License #: _____

Medical Provider ID #: _____ Expiration: _____

2 Direct-To-Healthcare Provider Distribution

(Complete only if the shipping address is different from the Administering Prescriber address.)

Site: _____

Contact Name for Shipment: _____

Address: _____ City: _____ State: _____ ZIP: _____

Business Hours: _____

Phone #: _____

Fax #: _____

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3 Prescription and Prescriber Certification: FYARRO™ (sirolimus protein-bound particles for injectable suspension) (albumin-bound)

Patient Name: _____ Patient DOB: _____

Address: _____ City: _____ State: _____ ZIP: _____

Patient Weight (lbs/kg): _____

FYARRO is supplied as a single-dose vial containing 100 mg of sirolimus formulated as a sterile lyophilized powder for reconstitution.

Dosage and Directions: The recommended dosage of FYARRO is 100 mg/m^2 administered as an intravenous infusion over 30 minutes on days 1 and 8 of each 21-day cycle until disease progression or unacceptable toxicity.

Quantity (# of vials) to be Dispensed: _____

Number of Treatment Cycles/Number of Refills: _____

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed FYARRO based on my professional judgment of medical necessity and for an FDA-approved indication for FYARRO. I certify that, to the best of my knowledge, the patient does not have any other insurance coverage for FYARRO. I authorize Aadi Bioscience including its agents, administrators, and service providers to forward this prescription to a dispensing pharmacy on behalf of my patient and me.

SIGN HERE Prescriber Signature: _____ Date: _____

If you are requesting access to FYARRO and you are a New York State Prescriber, attach your order for FYARRO on your NYS official prescription form.

The patient must sign the authorization on the following page and submit it with the rest of the application. If approved, the patient's FYARRO will be sent to their treating facility.

4 Patient Information

First Name: _____ Last Name: _____ DOB: _____

Address: _____ City: _____ State: _____ ZIP: _____

Legal US Resident: ☐ Yes ☐ No Gender: ☐ Male ☐ Female ☐ Prefer not to answer

Phone #: _____ Email (optional): _____

OK to Contact: ☐ Yes ☐ No Insurance Status: ☐ Uninsured ☐ Insured

If uninsured, AadiAssist PAP will require documentation of denied coverage. If insured, please provide the reason for this application below.

_____

Diagnosis: _____ Primary Insurance: _____

Policy #: _____ Phone #: _____

5 Patient Financial Information (to be provided by the patient)

Annual household income: $ _____ Number of people in the household dependent on said income: _____

Income documentation may be required to assess AadiAssist PAP eligibility for uninsured patients. Acceptable forms of documentation include the most recent copy of US federal tax return, Social Security income statements, recent pay stubs, etc.

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6 Patient Authorization for PAP

By providing my signature below, I authorize Aadi Bioscience, including its agents, administrators, and service providers, to use and disclose the information on this form to permit Aadi Bioscience to assess my eligibility for this program and contact me. I verify that the information provided in this application form is current, complete, and accurate, and understand that it will be reviewed and relied upon to determine my eligibility for product assistance. I understand that I may not, and agree that I will not, seek reimbursement from any private insurance or public assistance program for any FYARRO™ (sirolimus protein-bound particles for injectable suspension) (albumin-bound) made available to me under the AadiAssist PAP. I understand that any product assistance is contingent upon my ability to meet the eligibility criteria, and Aadi Bioscience reserves the right to make an independent determination of financial and medical need. I also understand that Aadi Bioscience reserves the right, anytime and without notice, to modify or discontinue this program with respect with any patient or in its entirety. I authorize Aadi Bioscience to use and obtain information from my healthcare provider, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this application in order to provide assistance. If I experience an adverse event or a product technical complaint, I understand that it will be shared with Aadi Bioscience and that Aadi Bioscience may contact my healthcare provider or me to learn more about the event. I acknowledge that I am a legal resident of the United States. I certify that I do not have insurance through a government healthcare program, including Medicare, Medicaid, Tricare, or other public healthcare program.

I am providing "written instructions" under the Fair Credit Reporting Act to Aadi Bioscience, including its agents, administrators, and service providers, authorizing Aadi Bioscience to obtain information from my credit profile and or other information from Experian Health. I agree to provide Aadi Bioscience, including its agents, administrators, and service providers, any additional relevant documentation required to verify my household income as may be required by the AadiAssist PAP. I authorize Aadi Bioscience, including its agents, administrators, and service providers, to obtain such information solely to determine my eligibility for the AadiAssist PAP.

I may refuse to sign this authorization without any effect on my care or treatment from my healthcare provider. However, if I refuse to sign this form, I acknowledge that I will not be eligible to receive free product through the AadiAssist PAP. I can cancel this authorization at any time by calling 1-855-AADIHUB (1-855-223-4482). This cancellation will not affect any use or disclosure of my information made prior to receiving notice of cancellation.

Patient Name: _____

SIGN HERE Patient Signature: _____ Date: _____

Legal Representative Name: _____

Legal Representative Signature: _____ Date: _____

If signed by the patient's representative, include a description of the representative's relationship to the patient and such person's authority to act for the patient (eg, parent, guardian, etc).

_____

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

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