Please complete and fax signed enrollment form and prescription(s) to 1-844-501-0062.

CoverOne
Phone: 844-662-3631
Fax: 1-844-501-0062
CoverOne.com

The patient is requesting assistance with the following services for TEPMETKO® (tepotinib) (select all that apply):

- ☐ Verification of Insurance Benefits/Drug Coverage
- ☐ Quick Start/Bridge Program for Eligible Patients
- ☐ Prior Authorization Assistance/Guidance
- ☐ Apply for Co-Pay Assistance (for privately insured patients only) **here or online through the CoverOne Copay Enrollment Portal**
- ☐ Patient Assistance Program: Please apply if uninsured or you are unsure if you have insurance coverage for TEPMETKO.* **Complete a prescription on page 2 for the patient if applying for Patient Assistance Program**
- ☐ Appeals Assistance
- ☐ Other ______________________

PATIENT INFORMATION

First Name:	Last Name:	Date of Birth:	Home Phone #:
Street Address (No PO Box):			Work Phone #:
City:	State:	ZIP:	Email:	Cell Phone #:

Gross Annual Household Income*: $ | Number of People in Household: | Is patient a U.S. citizen or U.S. resident? ☐ **YES** / ☐ **NO**

INSURANCE INFORMATION – Please provide copies of all pharmacy and medical insurance cards (front and back)

Does the patient have pharmacy and/or medical benefits through any private or government health insurer/payer/program? ☐ **YES** / ☐ **NO**
If "YES", please check applicable boxes and complete all that apply below.

Government Health Insurers/Payers/Programs

☐ Medicare Part C (Medicare Advantage) ☐ Medicare Part A ☐ Medicaid ☐ Veterans Affairs
☐ Medicare Part D - Drug Plan ☐ Medicare Part B ☐ TRICARE ☐ Other: ______________

If Part D, does patient receive Low Income Subsidies (LIS)? ☐ **YES** / ☐ **NO**

List Medicare Beneficiary Identifier: ______________________

	Name of Insurer/Plan:	*Policy ID #:*	*Group #:*	*Insurer /PBM Phone #:*	*Policy Holder Name*
☐ **Private** - Pharmacy Benefits Manager **RxBIN:** ________ **RxPCN:** ________ **RxGrp:** ________					
☐ **Private Insurance** - Medical (Primary) Is this an ACA Qualified Health Plan? ☐ **YES** / ☐ **NO**					
☐ **Private Insurance** - Medical (Secondary) Is this an ACA Qualified Health Plan? ☐ **YES** / ☐ **NO**					

PATIENT SIGNATURE – By signing below, I confirm that I have read and understand the *Authorization for Use* and *Disclosure of Health and Other Personal Information* and the *Patient Consent for CoverOne* and agree to the terms on pages 3 and 4.

Patient Name (print) ______________ Patient Signature (required) ______________ Date ________

Legal Representative/Guardian Signature (If applicable) ______________ Relationship to Patient ______________ Date ________

PHYSICIAN INFORMATION

Prescribing Physician Name:	State License #:	NPI:
Facility Name:	Physician Tax ID #:	PTAN:
Street Address (No PO Box):	Phone:	Fax:

City:	State:	ZIP:	Office Contact Name:
Physician Email:			Office Contact Email:

PATIENT MEDICAL INFORMATION:
Primary ICD-10-CM code: Secondary ICD-10-CM code: | Treatment Start Date:

Does the patient have a *MET*ex14 skipping alteration?
☐ **YES** / ☐ **NO**

List Previous Therapies:

Is the patient's primary cancer metastatic? ☐ **YES** / ☐ **NO**

PHYSICIAN SIGNATURE – **By signing below, I confirm that I have read and understand the *Treating Physician Certification for CoverOne* and agree to the terms on Page 4.**

Physician Name (print) ______________ Physician Signature (required) ______________ Date ________

*For patients applying to the Patient Assistance Program, include before-tax wages, Social Security benefits, and any other source of household income.
NOTE: Please include income documentation if applying for the Patient Assistance Program.

Rx SECTION FOR PHYSICIAN –

Please complete and sign one or both of the prescriptions for your patient based on specific patient needs.

Rx FOR COVERONE BRIDGE PROGRAM ONLY

This Rx should only be used for patients who have experienced an insurance delay and meet the eligibility criteria for the CoverOne Bridge Program.

Patient Name:	Date of Birth:	Drug Name: TEPMETKO® (tepotinib)	225 mg tablets
Directions: Take ______ 225 mg tablet(s) by mouth ______ times a day		Quantity: 15-day No Refills (unless authorized by program)	

Physician Prescription Signature – I certify that TEPMETKO® (tepotinib) is medically necessary for the patient above, and that it is prescribed in accordance with the FDA-approved prescribing information and this information is accurate to the best of my knowledge. I authorize EMD Serono, and its affiliates, business partners, and agents, to transmit this prescription to the designated pharmacy to dispense TEPMETKO® (tepotinib) to the patient.

Prescriber Name: ______________________ Prescriber Signature: ______________________ Date: __________

Rx FOR INSURED PATIENTS OR COVERONE PAP USE

This should only be used for insured patients for fill through Biologics Specialty Pharmacy, or for use with eligible CoverOne Patient Assistance Program patients.

Patient Name:	Date of Birth:	Drug Name: TEPMETKO® (tepotinib)	225 mg tablets
Directions: Take ______ 225 mg tablet(s) by mouth ______ times a day		Quantity: ______ Refills (up to 12): ______	

Physician Prescription Signature – I certify that TEPMETKO® (tepotinib) is medically necessary for the patient above, and this information is accurate to the best of my knowledge. I authorize EMD Serono, and its affiliates, business partners, and agents, to transmit this prescription to the designated pharmacy to dispense TEPMETKO® (tepotinib) to the patient.

Prescriber Name: ______________________ Prescriber Signature: ______________________ Date: __________

Authorization for Use and Disclosure of Health and Other Personal Information

By signing the CoverOne Enrollment Form, I agree to the following:

- I authorize my physician(s), pharmacist(s), other health care providers, patient advocacy organizations and insurance companies ("My Health Care Providers and Plans") to disclose my health and other personal information, including, but not limited to, the information on this form ("My Health Information") to EMD Serono, Inc., and its agents and representatives, including any company that assists the CoverOne program (collectively, "EMD Serono") in order that I may participate in CoverOne. My Health Information may also include, but is not limited to, information regarding my diagnosis of and treatment for the one or more conditions for which I may be or have been prescribed TEPMETKO® (tepotinib) (the "Product"), financial information, insurance status, information included in any Statement of Medical Necessity for me for a Product Prescription and Service Request Form, and any other information deemed relevant by My Health Care Providers and Plans regarding my health care condition or medications.
- EMD Serono may use and further disclose my Health Information obtained pursuant to this Authorization in order to: (1) contact me by mail, email, and/or telephone to enroll me in and administer CoverOne; (2) provide me with materials relating to CoverOne; (3) verify the accuracy of the information I provide and in my application for CoverOne; (4) provide me with reimbursement support services, (5) provide Quick Start/Bridge Program services; and (6) conducting quality assurance, surveys, and other internal business activities in connection with CoverOne.
- I understand that this Authorization will remain in effect for ten (10) years, or such shorter period as may be required by state law, from the date of my signature, unless I revoke this authorization earlier by contacting EMD Serono in writing at EMD Serono, CoverOne Program, One Technology Place, Rockland, MA 02370. If I revoke this Authorization, My Health Care Providers and Plans will stop disclosing this information to EMD Serono.
- I understand that my refusal to sign this Authorization will not affect my ability to receive TEPMETKO, my treatment, payment for treatment, eligibility for or enrollment in health benefits; however, such refusal will limit my ability to receive support services for TEPMETKO through CoverOne.
- I understand that, once my Health Information is disclosed pursuant to this Authorization, it may be subject to redisclosure and no longer protected by federal privacy laws.
- I understand that I have the right to receive a copy of this Authorization.

Patient Consent for CoverOne

By signing the CoverOne Enrollment Form, I agree and certify the following:

- I confirm that all financial and insurance information is complete and accurate. Additionally, during participation in CoverOne, and while I am receiving treatment with TEPMETKO® (tepotinib), I agree to immediately notify CoverOne if my health insurance status changes in the future, if I obtain any new health insurance plan, or if I become entitled to, or enroll in a government health insurance program/payer (i.e., Medicare or Medicaid).
- I understand that CoverOne reserves the right to modify, change, or terminate the CoverOne program at any time with or without notice.
- I understand that if I am a California resident I have certain rights with respect to my personal information that are described in the EMD Serono California Consumer Privacy Act Privacy Policy available at https://www.emdserono.com/us-en/privacy-policy.html.
- I understand that information from CoverOne program participants may be summarized for statistical or other purposes but such summaries will not contain information that identifies me personally.
- **I understand that EMD Serono, through CoverOne, is collecting patients' relevant financial income and personal health information, including information relating to medical conditions, treatment, care management, prescriptions, and health insurance, for the purpose of determining the patients' eligibility for CoverOne and subsequently administering the program benefits or related services.**

Treating Physician Certification for CoverOne

By signing the CoverOne Enrollment Form, I agree to and certify the following:

- TEPMETKO is medically appropriate for the patient identified above and that I, or a physician in my Practice, will be supervising the patient's treatment.
- CoverOne is a patient assistance program available to assist patients, and that program participation is voluntary, and that patient eligibility for services is not connected to or contingent on any past or future purchase of TEPMETKO.
- If the patient applies for and is eligible for donated product through the CoverOne Patient Assistance Program or Quick Start/Bridge Program, I will not seek reimbursement for such donated product from any insurance company or program, including federal healthcare programs, such as Medicare or Medicaid. Additionally, I agree to notify CoverOne immediately if the patient is no longer receiving TEPMETKO through the Patient Assistance Program and agree to return unused donated Patient Assistance Program product to CoverOne.
- I understand that information concerning program participants may be summarized for statistical or other purposes and provided to EMD Serono.
- The information provided on the enrollment form is complete and accurate to the best of my knowledge.
- CoverOne reserves the right to modify, change, or terminate the CoverOne program at any time with or without notice.
- **I understand that EMD Serono is collecting physicians' relevant personal information to document that it has obtained the required certifications and authorizations to administer CoverOne.**

EMD Serono, Inc. does not guarantee coverage or reimbursement for TEPMETKO. Coverage and reimbursement decisions are made by insurance companies following the receipt of claims. EMD Serono's Privacy Policy can be found here: https://www.emdserono.com/us-en/privacy-policy.html

EMD SERONO

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