

\* = to be completed by Prescribing Physician only

SERVICES REQUESTED

Benefits Verification/Prior Authorization/Appeals Support  
Co-Pay Assistance Program (for commercially insured patients)  
• Patients may also apply online at [CoverOne.com](http://CoverOne.com)

Bridge Program (for eligible patients)  
Patient Assistance Program (for eligible uninsured or underinsured patients)  
Nursing Support

1 Patient Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
DOB (mm/dd/yyyy) \_\_\_\_\_ Gender (optional) \_\_\_\_\_  
Phone \_\_\_\_\_ Home Work Cell  
Ok to leave voicemail? Yes No Preferred Language \_\_\_\_\_  
Email \_\_\_\_\_  
Preferred Method of Communication: Phone Email Text (opt-in below)

2 Patient Financial Information

(required if requesting Patient Assistance Program evaluation)

CoverOne Patient Assistance Program may provide TEPMETKO at no cost to eligible uninsured or underinsured patients. To apply for no-cost TEPMETKO, please complete the information below and include your most recent tax return (e.g., IRS Form 1040). Household income should include before-tax wages, Social Security benefits, and any other source of household income.

Household Size (no. of people) \_\_\_\_\_  
Household Income \_\_\_\_\_ Yearly Monthly

3 Patient Authorization and Consent

3A. I have read and understand the **Patient Authorization for Use and Disclosure of Health and Other Personal Information** and the **Patient Consent for CoverOne** and agree to the terms on page 3.

SIGN  
HERE

Patient or Personal Representative Signature \_\_\_\_\_ Date \_\_\_\_\_ Personal Representative Full Name (if applicable) \_\_\_\_\_

Authority/relationship of personal representative (if applicable): Legal Guardian Power of Attorney

3B. By checking this box, I confirm that I have read and understand the **Patient Opt-In for Automated Marketing Text Messages** and agree to the terms on page 4.

4 \*Patient Insurance Information (Please include a copy of both sides of the insurance card)

Type of Insurance(s)

Employer Medicare (check type):  
Healthcare Exchange Part A Part D with Low Income  
Medicaid Part B Subsidy (LIS)  
No Insurance Part D Advantage  
Other \_\_\_\_\_  
Has a prior authorization (PA) been initiated? Yes No  
• If "Yes", PA status? Approved Denied In Progress

Prescription Insurance Name \_\_\_\_\_

Cardholder (if different than patient) \_\_\_\_\_

RX ID # \_\_\_\_\_ RX Group # \_\_\_\_\_

RX BIN # \_\_\_\_\_ RX PCN # \_\_\_\_\_

Phone \_\_\_\_\_

Primary Medical Insurance Name \_\_\_\_\_

Cardholder (if different than patient) \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Phone \_\_\_\_\_

5 \*Prescribing Physician Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
NPI # \_\_\_\_\_ Tax ID # \_\_\_\_\_  
State License # \_\_\_\_\_

Office/Clinic/Institution Name \_\_\_\_\_

Main Phone \_\_\_\_\_ Fax \_\_\_\_\_

Office Contact Name \_\_\_\_\_

Office Contact Phone \_\_\_\_\_ (ext \_\_\_\_\_)

Office Contact Email \_\_\_\_\_

6 \*Patient Medical Information

Primary ICD-10-CM Code \_\_\_\_\_

Secondary ICD-10-CM Code \_\_\_\_\_

List Previous Therapies \_\_\_\_\_

Planned TEPMETKO Treatment Start Date \_\_\_\_\_

Does the patient have a METex14 skipping alteration? Yes No

Is the patient's primary cancer metastatic? Yes No

7 \*Pharmacy Information (Select one) Biologics Specialty Pharmacy In-office Dispensing Site: \_\_\_\_\_

8 \*Prescribing Physician Authorization

By signing below, I confirm that I have read and understand the **Prescribing Physician Certification for CoverOne** and agree to the terms on page 4.

SIGN  
HERE

Prescribing Physician Signature \_\_\_\_\_ Prescribing Physician Name (print) \_\_\_\_\_ Date \_\_\_\_\_

## TEPMETKO® (tepotinib) Prescription (Rx) Information

### FOR PRESCRIBING PHYSICIAN USE ONLY

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 eligibility criteria for the CoverOne Bridge Program.

Patient Full Name \_\_\_\_\_ DOB (mm/dd/yyyy) \_\_\_\_\_

Drug Name **TEPMETKO® (tepotinib) 225 mg tablets**

Quantity **15-day No refills (unless authorized by program)**

Directions **Take 1 OR 2 225 mg tablet(s) by mouth once a day (check only one box)**

#### Prescribing 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.

**SIGN  
HERE**

\_\_\_\_\_  
 Prescribing Physician Signature                      Prescribing Physician Name (print)                      Date

#### Rx for Insured Patients or CoverOne Patient Assistance Program Use

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

Patient Full Name \_\_\_\_\_ DOB (mm/dd/yyyy) \_\_\_\_\_

Drug Name **TEPMETKO® (tepotinib) 225 mg tablets**

Quantity \_\_\_\_\_ Refills (up to 12): \_\_\_\_\_

Directions **Take \_\_\_\_\_ 225 mg tablet(s) by mouth once a day**

#### Prescribing 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.

**SIGN  
HERE**

\_\_\_\_\_  
 Prescribing Physician Signature                      Prescribing Physician Name (print)                      Date

## Patient Authorization for Use and Disclosure of Health and Other Personal Information

### AUTHORIZATION

*By signing section 3 of the CoverOne Enrollment Form, I agree to the following:*

- I authorize my prescribing 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, if applicable, (6) conducting internal business activities that are necessary for enrollment or administration of 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, 200 Pier 4 Boulevard, Boston, MA 02210. 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.

### CONSENT

## Patient Consent for CoverOne

*By signing section 3 of the CoverOne Enrollment Form, I agree to 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, 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).
- If I apply and am eligible for no-cost product through the CoverOne Patient Assistance Program or Quick Start/Bridge Program, I will not seek reimbursement for such no-cost product from any insurance company or program, including federal healthcare programs, such as Medicare or Medicaid. I understand that if I currently have Medicare coverage, my eligibility for the CoverOne Patient Assistance Program will automatically expire on December 31st of the current calendar year and it will be necessary for me to submit a new CoverOne Enrollment Form (along with any required income documentation) if I would like to request additional assistance through the CoverOne Patient Assistance Program. I understand that the CoverOne Patient Assistance Program reserves the right to request additional documentation from me to support my request for assistance based on my financial hardship including, for example, additional documents relating to my income.
- I understand that CoverOne reserves the right to modify, change, or terminate the CoverOne program or any CoverOne services 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.

CERTIFICATION

Prescribing Physician Certification for CoverOne

By signing section 8 of the CoverOne Enrollment Form, I agree and certify to the following:

- TEPMETKO is medically appropriate for the patient identified above and that I, or a prescribing physician in my Practice, will be supervising the patient's treatment.
- I hereby certify that my office has obtained HIPAA-compliant authorization from the above-named patient to disclose medical and other protected health information necessary for EMD Serono to provide the services described in the Authorization on the previous page, including assisting the patient with obtaining insurance coverage for TEPMETKO.
- 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 no-cost product through the CoverOne Patient Assistance Program or Quick Start/Bridge Program, I will not seek reimbursement for such no-cost 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 no-cost 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>

TEXT OPT-IN

Patient Opt-In for Automated Marketing Text Messages

I authorize EMD Serono, Inc. (or its agents), to send marketing text messages to the cell phone number(s) listed (or to any future telephone number(s) provided by me to EMD Serono, Inc. or its agents) using an automatic telephone dialing system on a recurring basis. This consent also enables EMD Serono to contact me by text message to provide me with CoverOne Support Program services. Signing this consent is not a condition of participating in the CoverOne Support Program or purchasing products, goods, or services from EMD Serono. I understand that my mobile phone service provider may charge me fees for texts sent to me, and I agree that EMD Serono will have no liability for the cost of any such calls or texts. At any time, I may withdraw my consent to receive text messages by replying "STOP" via return text message or contacting EMD Serono in writing at EMD Serono, Inc. & CoverOne, 200 Pier 4 Boulevard, Boston, MA 02210.

To authorize your consent, please check the box in section 3B under Patient Authorization and Consent on page 1.