REACH4RYTELO™

RYTELO™ (imetelstat) for Injection 47 mg 188 mg

Enrollment Form

Phone: 1-844-4RYTELO
Fax: 1-888-224-2518
Monday - Friday, 8 AM to 8 PM ET

After submitting this form, a dedicated REACH4RYTELO Case Manager may reach out to you to walk you through the next steps of the process and answer any questions.

CLEAR FORM

1. REQUESTED PATIENT SUPPORT

Check all boxes that apply ☑

All patients enrolled in REACH4RYTELO will receive access and reimbursement support. If you would like to be considered for patient support offerings, please check the appropriate box below:

☐ Copay Program Eligibility Screening ☐ Patient Assistance Program (PAP) Eligibility Screening ☐ Temporary Patient Assistance Program (TPAP) Eligibility Screening

2. PATIENT INFORMATION

First name:	Last name:	MI:	Preferred name:
Address:	Apt/Unit #:	City:	
State:	ZIP code:	Phone #: ( ) -	Preferred language:
Email:	Date of birth: / /	Gender: ☐ M ☐ F	SSN (Last 4 digits):
Alternate contact name:	Alternate contact phone #: ( ) -	Relationship to patient:	

CONTACT AUTHORIZATION

I authorize REACH4RYTELO to provide me and my healthcare provider information on my benefits and other communications that contain reference to the REACH4RYTELO program dispensing pharmacy, including the PAP pharmacy, through the following (select all that apply):	☐ Phone call ☐ Text ☐ Email ☐ US mail	**Note:** If I don't select a contact preference, I understand that REACH4RYTELO will provide program communications to me by phone and/or through my healthcare provider.
I authorize REACH4RYTELO to leave a detailed message if I am unavailable when they call, and in the event of contact through email or text, I grant REACH4RYTELO permission to include details such as the name of my prescription.	☐ Yes ☐ No	

3. INSURANCE INFORMATION

Please include a copy of the front and back of insurance card(s).

☐ Patient is uninsured (ie, no health insurance through any public or private payer)—SEE OPTIONAL "PATIENT FINANCIAL INFORMATION" IN SECTION 5

☐ Patient is insured (Please fill out all of the applicable insurance information below—Include copy [front & back] of all insurance cards, including medical and prescription.)

PRIMARY INSURANCE

Primary insurance:		Plan name:	Insurance phone #: ( ) -
Subscriber name:		Is this a government healthcare program (ie, Medicaid, Medicare, VA, TRICARE)? ☐ Yes ☐ No	
Policyholder name:		Policyholder relationship to patient:	
Member ID #:	Policy/Group #:	Rx Bin #:	Rx PCN #:

☐ **SECONDARY INSURANCE** (Check this box if patient has secondary insurance coverage and include a copy [front and back] of insurance cards, if available.)

Secondary insurance:		Plan name:	Insurance phone #: ( ) -
Subscriber name:		Is this a government healthcare program (ie, Medicaid, Medicare, VA, TRICARE)? ☐ Yes ☐ No	
Policyholder name:		Policyholder relationship to patient:	
Member ID #:	Policy/Group #:	Rx Bin #:	Rx PCN #:

☐ Check this box if patient has tertiary insurance coverage (eg, Supplemental) and include a copy (front and back) of insurance cards, if available.

VA=Veterans Affairs.

REACH4RYTELO™ Enrollment Form PHONE: **1-844-4RYTELO** | FAX: **1-888-224-2518**

Patient Name: **Date of Birth:** / /

4. PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL DATA

By signing below, I authorize my healthcare providers (including pharmacists) and health insurance plan(s) to disclose to Geron Corporation and its agents and contractors (collectively, "Geron") information about me, my health, and my finances, including the information provided on this enrollment form (collectively, "My Information"), for purposes related to my enrollment and participation in the REACH4RYTELO patient support program (the "Program"). I further authorize Geron to use My Information, and to share it with my caretakers, as well as healthcare providers and health insurers, for those purposes, including to:

- Process my application for the Program.
- Provide the Program services to me, including verifying my insurance benefits, researching insurance coverage options, and referring me and my caretakers to other plans, support, or assistance programs that may be able to help me.
- Provide me with copay assistance or free medication, if I am eligible.
- Contact me by email, phone (including with prerecorded messages), or text messages (for which message or data rates may apply and which I may stop at any time by texting "STOP") to provide me with Program-related alerts, refill reminders, survey forms, or other information or marketing offers that Geron believes may be of interest to me.
- Conduct internal business, audit, and compliance activities, including analyses that may involve combining My Information with other information.

1. I understand that, once My Information has been disclosed pursuant to this authorization, certain federal privacy regulations may no longer apply and the information could be disclosed to others, but that Geron intends to use and disclose My Information only as described in this authorization or as otherwise permitted by law. I further understand that I may refuse to sign this authorization without altering my eligibility for health insurance benefits and healthcare treatment, but that I must sign this authorization to be eligible to participate in the Program.
2. I understand that this authorization will be effective for 5 years from the date of my signature below, unless it expires earlier by law or if I cancel it prior to its expiration date, which I may do by sending a notice of cancellation to: REACH4RYTELO Patient Support Program, PO Box 1587, Jeffersonville, IN 47131.
3. I understand that if I do cancel the authorization, that will not invalidate uses and disclosures of My Information made before my notice of cancellation is received by the Program.
4. I understand that I may have rights under state law to access My Information or request that My Information be corrected or deleted, as described in Geron's Privacy Policy posted at **https://www.geron.com/privacy-policy/**.
5. I have a right to receive a copy of this authorization after I have signed it.

X **SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE UNDER FEDERAL OR STATE LAW** (REQUIRED):	**DATE:** / /
PATIENT REPRESENTATIVE'S NAME (IF SIGNING FOR THE PATIENT):	**PATIENT REPRESENTATIVE'S RELATIONSHIP TO PATIENT:**	**PHONE #:** ( ) -

REACH4RYTELO™ Enrollment Form

PHONE: **1-844-4RYTELO** | FAX: **1-888-224-2518**

Patient Name: **Date of Birth:** / /

5. PATIENT FINANCIAL INFORMATION

Required if applying for PAP or TPAP

Current annual household income (pre-tax): $ (Documentation for all sources of income may be required)

Number of people in household supported by current annual income: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other:

6. PATIENT CERTIFICATIONS AND AGREEMENT

I CERTIFY that the information that I provide to Geron is true and complete. I understand that, at any time during my participation in the Program, Geron may request additional documentation to verify my information and that, if there is missing information or I do not respond to requests for additional documents, my participation may be delayed or I may no longer be able to participate. If I qualify for and receive copay assistance from Geron, I agree to comply with all Program terms and conditions. If I qualify for free medication, I agree that I will not seek or accept coverage or reimbursement for the medication from anyone else, including an insurance program or a health savings, flexible spending, or other healthcare reimbursement account. If I qualify for and receive free medication assistance from Geron, I agree to comply with the Program terms and conditions, including that I will not accept coverage for the medication from anyone else, including an insurance program or a health savings, flexible spending, or other healthcare reimbursement account. If I have Medicare Part D, I will not count any free medication I receive toward my true out-of-pocket costs (TrOOP). I understand that assistance from the Program may be temporary and that I may be required to apply every year. I understand that if I receive free medication for more than a year, I must reapply at least every year, sign an authorization for the Program, and be accepted. I will contact REACH4RYTELO at 1-844-4RYTELO if my insurance or treatment changes in any way.

I UNDERSTAND that Geron may need proof of my income in order to evaluate my eligibility for financial assistance and, by signing below, I am consenting to Geron obtaining information regarding my income from credit reporting agencies such as TransUnion or Experian.

I UNDERSTAND that, if I am receiving free medication assistance, my medication will be shipped directly to the prescriber's office address listed on this form (Section 8). I authorize the prescriber on this form, as my agent, to receive my medication on my behalf. My prescriber, as my agent, will receive and then provide me with my prescription medication.

I UNDERSTAND that any Program assistance will terminate if REACH4RYTELO becomes aware of any false or inaccurate information or if my medication is no longer prescribed for me.

I CERTIFY that, to the best of my knowledge: (1) my insurance plan did not require me to apply to the Program and/or change or hide my insurance coverage to make me appear to be underinsured and eligible for the Program; and (2) the Alternate Contact listed on my application (if any) is not associated with or a representative of my insurance company or any of its business partners. I agree to contact REACH4RYTELO at 1-844-4RYTELO immediately if my insurance, treatment, or financial situation changes in any way. I understand that Geron's patient assistance programs may be discontinued or the rules for participation may change at any time, without notice to me.

I UNDERSTAND that completing this enrollment form does not guarantee or ensure that I will qualify for patient assistance.

X **SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE UNDER FEDERAL OR STATE LAW** (REQUIRED):		**DATE:** / /
PATIENT REPRESENTATIVE'S NAME (IF SIGNING FOR THE PATIENT):	**PATIENT REPRESENTATIVE'S RELATIONSHIP TO PATIENT:**	**PHONE #:** ( ) -

7. HELPER INFORMATION

If someone helped you with this application and you want them to answer questions for you, please provide their name and phone number.

Helper's Name:	Helper's Phone #: ( ) -

REACH4RYTELO™ Enrollment Form

PHONE: **1-844-4RYTELO** | FAX: **1-888-224-2518**

Patient Name: **Date of Birth:** / /

8. PRESCRIBER INFORMATION

Prescriber name:		Facility name:	
Office contact:		Phone #: ( ) -	Ext:	Fax #: ( ) -
Address:		City:	State:	ZIP code:
Alternate office contact:	Alternate phone #: ( ) -	Ext:	Alternate email:
Days your office is unable to accept product delivery (if any):		State license #:	
Tax ID #:	PTAN #:	NPI #:	Group NPI #:
Medicaid provider ID #:	Expiration:	Other provider ID (if applicable):	

FACILITY ADDRESS WHERE PRODUCT SHOULD BE SHIPPED

☐ Same address as above

Required if applying for PAP or TPAP

Facility name:		Office contact:	Place of service code:
Address 1:		Phone #: ( ) -	Ext:	Fax #: ( ) -
Address 2:		Attention (Unit/Department):	
City:	State:	ZIP code:	Days your office is unable to accept product delivery (if any):
Alternate office contact:	Alternate phone #: ( ) -	Ext:	Alternate email:

9. DIAGNOSIS

Must be completed by a healthcare provider.

Diagnosis (Please check appropriate *ICD-10-CM* codes[s]): ☐ D46.0 ☐ D46.1 ☐ D46.A ☐ D46.B ☐ D46.4 ☐ D46.9 ☐ Other:

10. INITIAL PRESCRIPTION INFORMATION

Required if applying for PAP or TPAP

Prescriber name:	NPI #:
Medication: **RYTELO (imetelstat) injection for intravenous use. Available as 47-mg lyophilized powder in a single dose for reconstitution and 188-mg lyophilized powder in a single dose for reconstitution.**	**CHECK BOTH VIAL SIZES TO ENABLE PHARMACY TO OPTIMIZE WEIGHT-BASED DOSE** Vial size: ☐ 47-mg single-dose vial ☐ 188-mg single-dose vial

PRESCRIBER MUST CHECK ONE BOX

Dosage and directions: ☐ 7.1 mg/kg administered as an intravenous infusion over 2 hours every 4 weeks
☐ Other:

Patient weight (kg):	Quantity: **Sufficient for 28 days.**
Patient allergies:	
Concurrent medications:	

X **PRESCRIBER SIGNATURE:** **DISPENSE AS WRITTEN** **NO STAMP ALLOWED**	**PRESCRIBER SIGNATURE:** **SUBSTITUTION PERMITTED** **NO STAMP ALLOWED**	**DATE:** / /

11. PRESCRIBER CERTIFICATION

I CERTIFY to the following:

1. To the best of my knowledge, the patient and physician information in this form is complete and accurate;
2. I have prescribed the medication to this patient based on my professional judgment of medical necessity;
3. I certify that, if the patient is insured through a government healthcare program (eg, Medicaid, Medicare, VA, TRICARE), I have checked the corresponding box under "Primary Insurance";
4. I will immediately notify REACH4RYTELO if my patient is enrolled in the REACH4RYTELO Patient Assistance Program or Temporary Patient Assistance Program and I become aware that his/her insurance, treatment, or income status has changed;
5. I will not submit an insurance claim or other claim for payment to anyone else, including third-party payer (private or government) or the patient, for free medication provided to the patient. I forego any appeal of any denial of insurance coverage, for free medication provided by Geron for this patient, I will inform the patient not to count the free medication toward true out-of-pocket costs (TrOOP); and
6. Any medication provided by Geron for this patient will be used only for this patient and will not be resold, nor offered for sale, trade, or barter, or returned for credit.

I CERTIFY, if the patient enrolls in the REACH4RYTELO Copay Assistance Program for a physician-administered product, to the following:

1. I have read and will comply with the Program Terms and Conditions at www.reach4rytelo.com/termsandconditions.
2. To the best of my knowledge, this patient satisfies the Patient Eligibility requirements, and I will notify the Program immediately if the patient's insurance status changes.
3. The patient is not enrolled in Medicare, Medicaid, VA, TRICARE, or any other government healthcare program.
4. To the best of my knowledge, participation in this Program is not inconsistent with any contract or arrangement with any third-party payer to which this office/site will submit a bill or claim for reimbursement for the covered Geron medication(s) administered to the patient.
5. The bill or claim that this office/site will submit to the insurer or patient for payment for Geron medication(s) will have the Geron medication(s) listed separately from any bill or claim for drug administration, or any other items or services provided to the patient.
6. I will not submit an insurance claim or other claim for payment to any third-party payer (private or government) for the amount of assistance that my patient receives from the Program.
7. If this office/site receives payment directly from the Program for this patient, the office/site will not accept payment from the patient for the amount received from the Program.

I understand that Geron:

1. May verify all information provided, and not allow or suspend participation if inadequate information is received;
2. May modify, limit, or terminate these programs, or recall or discontinue medications, at any time without notice;
3. Is relying on my certification herein that my patient has given me consent to receive their Geron medication on their behalf; and
4. Is relying on these certifications, including that all of the information I have provided is complete and accurate.

SPECIAL NOTE: New York prescribers, please submit prescription on an original NY State prescription blank. For all other states, if not faxed, prescription must be on state-specific blank, if applicable for your state.

X **PRESCRIBER SIGNATURE** (REQUIRED): **NO STAMP ALLOWED**	**DATE:** / /

ICD-10-CM=International Classification of Diseases, Tenth Revision, Clinical Modification; NPI=National Provider Identifier; PTAN=Provider Transaction Access Number.

PRINT FORM **SIGN AND FAX COMPLETED FORM TO REACH4RYTELO AT 1-888-224-2518**