UROVANT SCIENCES

INSTRUCTIONS FOR ENROLLMENT

Patient Assistance Program Application

HOW TO APPLY

Fill out and follow the instructions in the application below.

- Complete the following sections:
  - Part 1: Patient Information
  - Part 2: Patient Certification and Authorization
  - Part 3: Healthcare Insurance Information
  - Part 4: Patient Declaration/Authorization to Assign Representative for Program Enrollment

Gather proof of income.

- Make a copy of one of the following items to show your adjusted gross annual household income:
  - Two of the most current paycheck stubs or earning statements for all working members of your household.
  - Last year's federal Individual Income Tax Return (1040)
  - Social Security income, pension, unemployment benefit statement, or other income statement(s).
  - W-2 or 1099 forms

Take the application and proof of income to your health care provider.

- Your health care provider must:
  - Complete the "To Be Completed By The Prescriber" section of the application, including "Order information".
  - Sign and date the application
  - Fax the completed application and proof of income to 1-866-889-0117, or mail them to 951 Yamato Rd, Suite 160 Boca Raton, FL. Faxes must be sent from your health care provider's office.

Note: Please allow up to 10 business days for processing. After the application is reviewed, you and your health care provider will be informed of the decision. If approved, your medicine will be sent to you. Urovant Sciences reserves the right to modify or cancel this program at any time without notice.

PATIENT CHECKLIST FOR SUBMITTING AN APPLICATION

☐ Read the Patient Declaration and Patient Authorization to Share Health Information on page 4, then complete all relevant patient information on page 2, and **sign and date** as required

☐ Submit completed pages with documentation to:

Mail: UROVANT SCIENCES
Patient Assistance Program
951 Yamato Rd Suite 160 Boca Raton,
FL 33431

Fax: 1-866-889-0117

☐ Ask your Healthcare Professional (HCP) to complete, and **sign and date** page 3

☐ Include a copy of the **front and back** of your insurance card

☐ Include a copy of your most recent 1040 or 1040 EZ Federal Tax Return

or one of the following:

☐ Two of the most current paycheck stubs or earning statements for all working members of your household.

☐ Social Security income, pension, unemployment benefit statement, or other income statement(s).

☐ W-2 or 1099 forms

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SUBMIT THIS PAGE

Fax the completed application and proof of income to 1-866-889-0117, or mail them to 951 Yamato Rd, Suite 160 Boca Raton, FL. Faxes must be sent from your health care provider's office.

Missing information and/or required documents may delay processing of application.

If you have questions about Urovant Patient Assistance Program or how to complete this form, please contact us at 866-842-3476, Monday-Friday 8am-8pm EST and Saturday 9am-5pm EST.

MEDICATIONS AVAILABLE THROUGH THE UROVANT PATIENT ASSISTANCE PROGRAM

GEMTESA® (vibegron) 75 mg Tablets

†May be distributed via pharmacy or shipped to HCP

TO BE COMPLETED BY THE PATIENT See checklist on page 1—all information is required.

1 Patient Information

Name: _____ Phone: _____

Email: _____ Date of Birth: _____ Gender: ____Male ____ Female

Address (Street, City, State, ZIP): _____

2 Financial Information

Federal Taxes *(Select one of the options below.)*

Total Gross Yearly Income

☐ Entire household Income: _____

Include a copy of most recent 1040 or 1040EZ Federal tax return or *two of the most current paycheck stubs or earning statements for all working members of your household, Social Security income, pension, and other income statements, W-2 or 1099 forms, Unemployment benefit statements. Any additional supplemental income such as alimony and child support should be included in "Entire household income."*

Household Size: _____

☐ I do not file Federal taxes. Including yourself, the number of people who live in your home and are dependent on your household income:
(Tax returns may be reviewed and additional documentation requested.)

3 Healthcare Insurance Information *(Select all that apply.)* **Please attach a copy of your insurance card.**

Subscriber Name: _____ Date of Birth: _____ Relationship to Patient: _____

Primary Plan Name: _____ Secondary Plan Name: _____

☐ Check if no insurance	ID/Policy #	Group #	Phone
☐ Prescription Insurance/Medicare Part D Plan Plan Name: _____ Fax: _____ Rx BIN #: _____ Rx PCN: _____	_____	_____	_____
☐ Private/Commercial Insurance			
☐ Medicaid			
☐ Medicare Part B			
☐ Medicare Advantage			
☐ Veterans Administration			
☐ ADAP AIDS			
☐ SPAP State Patient Assistance Program			
☐ Other:			

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SUBMIT THIS PAGE

4 Patient Declaration/Authorization to Assign Representative for Program Enrollment

Signature and date required before submission.

My signature below indicates that I have read, understand, and agree to the Patient Declaration and Patient Authorization to Share Health Information on page 4.

If I have listed an authorized representative below, I permit the administrators of the Urovant Patient Assistance Program to discuss my application with this person. This includes the status of my application, insurance and financial questions, any missing documentation, and other issues related to my application and participation, throughout my enrollment period in the program. By signing below, this representative is allowed to speak on my behalf regarding my application with UROVANT SCIENCES PATIENT ASSISTANT PROGRAM.

CHECK THE BOX: ☐ I also understand that Urovant Sciences and the vendors associated with administrating the Program (collectively the "Program Administrators") may obtain a credit report or investigative credit report about me which may contain information as to my income, credit standing, credit worthiness, credit capacity, character, or personal characteristics. I hereby consent to such credit report and acknowledge that such consent extends to consumer reporting agencies and to subsequent reports in connection with the Urovant Assistance Program.

PLEASE SIGN & DATE

Patient Name *(print)*_____ Date:_____

Authorized Representative *(print if applicable)* _____ Phone Number:_____

_____ _____

Patient Signature/Authorized Representative **Date**

TO BE COMPLETED BY THE PRESCRIBER See checklist on page 1—all information is required.

1 Prescription *(If requesting more than 1 product, attach additional prescription information.)*

Patient Name: _____ Date of Birth: _____

GEMTESA (vibegron) 75 mg Tablets

Sig Code:_____

Day Supply: _____

Quantity: _____

Number of Refills *(Maximum 12):* _____

List patient's current medications:

_____

2 HCP Information

Name: _____ Site Name: _____

Fax: _____ Business Hours: _____

Address *(City, State, ZIP)*: _____

NPI # *(required)* : _____ Email: _____

State License # *(required)* _____ Expiration *(mm/yyyy)* : DEA # *(required)* : _____

Collaborating MD *(for mid-level providers)* : _____ Collaborating MD NPI # *(required)* :_____

Phone: Fax:

3 HCP Authorization

My signature below indicates that I have read, understand, and agree to the Urovant Patient Assistance Program policy and the terms of Program participation on page 5.

HCP SIGN & DATE: Healthcare Professional Signature_____ Date: _____

Fax the completed application and proof of income to 1-866-889-0117, or mail them to 951 Yamato Rd, Suite 160 Boca Raton, FL. Faxes must be sent from your health care provider's office

Patient Assistance Program Application

PATIENT DECLARATION AND PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

Please read, sign and date on page 3, Patient Section 4.

I promise:

- I cannot afford my prescription medication, and the information on this form is correct and complete including all copies of documents proving my income to the best of my knowledge.
- The product(s) provided under this patient assistance program will not be sold, traded, bartered, or transferred.
- I will notify the administrators of the Urovant Patient Assistance Program ("Program") within thirty (30) days if there is any change in the status of my eligibility (related to changes in income or health coverage) to receive products through this program. This includes a change in my eligibility to participate in the Medicare program due to changes in my age or disability status or my enrollment in Medicare Part D.
- If, at any time during my participation in the Program, Program Administrators request additional documentation to verify the accuracy of information I have or am providing, I will provide such documentation in order to continue in the Program.
- Not to attempt to claim or submit any costs associated with the medicine(s) I receive under the Urovant Patient Assistance Program to any person or entity, including to any insurance plan (including Medicare Part D plans), health savings and flexible spending accounts, or any other healthcare reimbursement account.
- Not to seek true out-of-pocket (TrOOP) credit under the Medicare Part D program for the cost of the medicine(s) I receive under this program.

I understand:

- I will not be charged any fee, or required to purchase any Urovant product in order to enroll and participate in the Program.
- Program assistance may be temporary, and I may be required to reapply.
- This Program is not insurance.
- Urovant reserves the right to modify or discontinue the Program or terminate assistance at any time without notice.
- Completing and signing this form does not guarantee my eligibility for the Program.

I authorize the following communications:

- Specifically, I authorize UROVANT SCIENCES AND ITS PROGRAM ADMINISTRATORS to contact me to request my assistance with analysis related to the quality and efficacy of the Urovant Patient Assistance Program.
- When signing this application, I am agreeing to allow Urovant or its agent to contact me or my healthcare provider for additional information, if needed, to evaluate any adverse event or product complaint I or my provider reported on my behalf.
- The Program to contact my insurer, other potential funding sources, including the Centers for Medicare and Medicaid Services, social workers, or patient advocacy organizations on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my Urovant Program application or information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider, or pharmacist.

I understand that Urovant Sciences and the vendors associated with administrating the Program (collectively the "Program Administrators"):

- Reserve the right without notice to change the application form, change the Program or Program criteria, or terminate my enrollment at any time, without notice.
- May request and obtain information about my or my family's income, including verification of my income through third-party sources.

Patient Authorization To Share Health Information: By signing on page 3, I hereby authorize:

- My doctor(s), pharmacy and other healthcare providers, and my health plan or insurers ("Entities") to disclose to and share with Urovant Sciences, the Program Administrators and their affiliates, agents, contractors, representatives, service providers, and assignees ("Patient Assistance Program Recipients"), my individually identifiable health information, which may include my full name, demographic information, financial information, and information related to medical condition, treatment, care management, health insurance and benefits, medication history, and prescriptions (collectively, "Health Information"), whether in written or verbal form, including portions of my medical record.
- The Urovant Sciences Patient Assistant Program Administrators agree to access, obtain, use, disclose, receive, and maintain my Health Information for purposes of processing this Application, verifying the information provided in this Application, assisting in the identification of or determining eligibility under the Program and other patient assistance resources, investigating and verifying my insurance benefits, coordinating the dispensing and delivery of medication, and conducting the additional services described above and to run the Program, including internal business purposes. **In addition, by signing on page 3, I understand and agree that:**

- I may refuse to sign the form on page 2. This authorization is voluntary, but if I refuse to sign this form, I know that this means that I may no longer be eligible to receive assistance from the Program. I understand that my doctor(s), pharmacy and other healthcare providers, and my health plan or insurers may not condition the provision of my treatment, or coverage of my benefits, on my signing this authorization.
- Health Information released under this authorization may no longer be protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA).
- The information provided in this application may be subject to random audits and verification, and that during such audits and verification processes, I may be asked for additional supporting documentation and will comply with such requests.
- I may withdraw my authorization at any time by mailing a written withdrawal to Urovant Sciences Patient Assistant Program Administrators at 951 Yamato Rd Suite 160 Boca Raton, FL 33431, however, such withdrawal will not have an impact on any actions that have already been taken in reliance on this authorization.
- This authorization will last until I am no longer participating in the Program or sooner as limited by applicable state law.
- I have a right to receive a copy of this authorization.

HEALTHCARE PROFESSIONAL AUTHORIZATION: UROVANT SCIENCES PATIENT ASSISTANT PROGRAM POLICY AND TERMS & CONDITIONS AGREEMENT

Please read, sign and date on page 3, HCP Section 3.

Indicate your agreement to the terms of the Urovant Patient Assistance Program participation by signing on page 3. Your signature is intended to confirm to Urovant and its vendor VITACARE PRESCRIPTION SERVICES your understanding of the following:

- **Urovant's Patient Assistance Program administered by VITACARE PRESCRIPTION SERVICES prohibits Healthcare Professionals (HCPs) from charging patients any fee for enrollment or other activities associated solely with the patient's participation in the Urovant Patient Assistance Program ("Program").**
- Urovant requires that HCPs not charge the patient for those professional services associated with this regimen not covered by the patient's health insurer.
- Completing this enrollment form does not guarantee that Program assistance will be provided to my patient.
- No claim may be made to any third-party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment for product provided under the Program.
- The products(s) provided under the Program are for the use of the patient named in this form only, and may not be sold, traded, bartered, transferred, or returned for credit.
- The Program is limited to patients being treated on an outpatient basis.
- UROVANT SCIENCES and the vendors associated with administrating the Program (collectively, the "Program Administrators") reserve the right to request additional information if needed and to change or terminate the Program at any time, without notice.
- UROVANT SCIENCES reserve the right to modify or discontinue the Program, or refuse to distribute the medications under this program to any patient or facility at any time, without notice.

Indicate your agreement to the terms of the Program participation by signing on page 3. Your signature is intended to confirm to Urovant and its program administrators:

- The information on this form is correct and accurate to the best of my knowledge.
- There is a valid medical need for this patient's prescription, and I, or a healthcare provider in my practice, will be supervising the patient's treatment.
- I authorize UROVANT SCIENCES AND ITS PROGRAM ADMINISTRATORS or its affiliated companies or subcontractors to forward the patient's prescription to a dispensing pharmacy on behalf of the patient.
- I authorize UROVANT SCIENCES AND ITS PROGRAM ADMINISTRATORS to use my provider information, including National Provider ID # to determine a patient's eligibility in the Program.
- That to the best of my knowledge this patient does not have prescription drug insurance coverage for, or cannot afford, the product(s) listed above.
- I am not prohibited from participating in Federally funded healthcare programs nor am I on the List of Excluded Individuals/ Entities maintained by the HHS Office of Inspector General.
- When applicable, I will store any Program medication I receive for this patient separate from commercially purchased medication that is used for the treatment of other patients have a signed copy on file of my patient's current and completed patient authorization to share health information in accordance with HIPAA, or any other authorization or consent required by law, so that you may share patient health information with the Program, including the UROVANT SCIENCES PROGRAM PATIENT ASSISTANCE Recipients.
- I understand that the information provided in this application may be subject to random audits and verification and that, during such audits and verification processes, I may be asked for additional supporting documentation and will comply with such requests.