Madrigal Patient Support

Noninvasive Test Support Request

- Call **1-877-219-7770**
- Submit via fax at **1-844-411-1177**

Support needed ❑ Benefit investigation for noninvasive test coverage for suspected NASH

1 Patient Information — *Asterisk indicates required information.

First name* _____ Last name* _____

Date of birth* *(MM/DD/YYYY)* ____/____/_____ Gender* ❍ M ❍ F

Address* _____ Apt # _____

City* _____ State* _____ ZIP* _____

Phone* _____ ❍ Mobile ❍ Home OK to leave detailed message? ❍ Y ❍ N OK to text? ❍ Y ❍ N

Caregiver name _____ Caregiver phone _____

Patient Authorization for Noninvasive Test Support (REQUIRED FOR MPS SUPPORT) *(See section 6 for details of authorization.)*

Patient or authorized representative signature* X _____ Date* ____/____/_____

Print authorized representative: First name _____ Last name _____

Relationship to patient _____ Representative phone _____ Date ____/____/_____

2 Patient Insurance Information — *Attach a copy of insurance card(s).*

❍ Patient does not have insurance ❍ Commercial insurance ❍ Medicare ❍ Medicaid ❍ Other

Insurance name:	Policy #:
Subscriber name: DOB: / /	Group #:

3 Prescriber Information — *Asterisk indicates required information.

First name* _____ Last name* _____

Specialty* _____ NPI #* _____

Address* _____ City* _____ State* _____ ZIP* _____

Phone* _____ Ext _____ Fax* _____ Email _____

Primary office contact name* _____

Phone _____ Ext _____ Fax _____ Email _____

4 Request for Support

❑ I am seeking support to confirm my patient's insurance coverage of available noninvasive tests to confirm the presence of NASH and severity of liver fibrosis.

NIT(s) to be used: _____

5 Prescriber Attestation — *Asterisk indicates required information.

Madrigal Noninvasive Test Support Request: Prescriber Attestation (REQUIRED)

X _____ Date* ____/____/_____

Prescriber signature*

By submitting this form, I certify to the best of my knowledge that: (a) the person named on this form is my patient and that the information submitted is complete and accurate; (b) the above-referenced testing is necessary for this patient; (c) I have received the written authorization in accordance with applicable state and federal law (including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ["HIPAA"]), to provide the health information regarding the patient on this form to Madrigal Patient Support, or other third-party contractors working on behalf of Madrigal Patient Support for the purpose of requesting reimbursement support and information and to assess, if applicable, the patient's eligibility for patient assistance or other support programs related to the above-referenced testing; (d) the support requested on behalf of the patient may include benefits investigation (BI) and/or copay information. If applicable, I authorize Madrigal Patient Support to conduct a benefits investigation for my patient.

I consent to Madrigal Patient Support contacting me by fax, mail, or email to provide additional information to Madrigal Patient Support and understand that Madrigal Patient Support may revise, change, or terminate any program services at any time without notice to me.

I certify that I have reviewed the additional terms available at https://hcpverify.com/terms, which are specifically incorporated herein by reference, and acknowledge and consent to their application and enforceability in regards to this certification.

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6 Patient Authorization for Noninvasive Test Support

I authorize my physician(s) and their staff (together, "Healthcare Providers"), my health insurer, health plan or programs that provide me healthcare benefits (together, "Health Insurers"), to disclose my personal or other health information, which may include contact information, demographic information, financial information, and information related to my medical condition, treatments, and health insurance and benefits, to Madrigal Patient Support, and their respective partners, affiliates, subcontractors, and agents (together, "Madrigal"). I authorize Madrigal to receive, use, and share my information in order to provide me with access to the product, services, and programs described on this form, which may include the following:

- Working with my health insurance plan to understand or verify medical coverage for tests identified by my Healthcare Providers;
- Determining my eligibility for and facilitating enrollment into financial assistance services if I'm eligible, including copay assistance related to tests identified by my Healthcare Providers;

I understand that Madrigal may de-identify my information and use it in performing research, education, business analytics, marketing studies, or for other commercial purposes, including linkage with other de-identified information Madrigal receives from other sources. I understand that Madrigal may share my information, including identifiable health information, in order to de-identify it for these purposes and as needed to communicate with me by mail, telephone, or email, or, if I indicate my agreement and consent, by text.

Once disclosed to Madrigal, my personal information released under this authorization may no longer be protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA). However, Madrigal will only use and share my personal information for the purposes stated on this authorization or as otherwise permitted by law.

I understand that I do not have to sign this Authorization, but Madrigal will not be able to provide the services to me without it and I will not be able to enroll in Madrigal Patient Support. A decision by me not to sign this Authorization will not affect my ability to obtain medical treatment, payment for treatment, insurance coverage, access to health benefits or Madrigal products. However, I understand that my pharmacy may receive payment or other remuneration for disclosing my personal information and distributing marketing material pursuant to this authorization.

This authorization is valid for 18 months from the date support is last provided, or until my local state law requires expiration, or I revoke it earlier. I have the right to revoke (cancel) this authorization at any time by submitting a written notice to: Madrigal Patient Support, P.O. Box 7613, Overland Park, KS 66207. If I revoke this authorization, I will no longer be eligible for the services described. If a healthcare provider, health insurer, or specialty pharmacy is disclosing my personal information to Madrigal on an authorized, ongoing basis, my revocation will be effective with respect to such disclosing party when they receive notice of my revocation. My revocation will not impact uses and disclosures of my personal information that have already occurred in reliance on this authorization.

More information on my privacy rights, including specific rights I may have as a resident of certain states can be found in Madrigal's privacy policy (www.madrigalpharma.com/privacy).

I have a right to request a copy of this authorization.