

Madrigal Patient Support Patient Enrollment Form (PEF) Guide

The prescription and enrollment form serves as a prescription and consent to enroll in Madrigal Patient Support (MPS). *This form is also used to request a patient's participation in the Bridge Program.*

INSTRUCTIONS

Complete all fields noted with an asterisk and have your patient sign **section 1** before submitting. **All 3 enrollment form pages must be submitted to the program or limited network specialty pharmacy.**

QR CODE

Scan to enroll your patients in MPS online.

SECTION 1 – PATIENT AUTHORIZATION/ CERTIFICATIONS

Patient Authorization provides permission to share health information for access support as outlined in **section 7**. Patient Certifications provides authorization to enroll in MPS and for Madrigal Pharmaceuticals to deliver a range of support services as outlined in **section 8**. **A patient or authorized representative's signature and the date are required if your patient enrolls in MPS.**

SECTION 2 – PATIENT INSURANCE INFORMATION

To determine your patient's coverage, please **fully** complete this section. Incomplete information may cause processing delays. Include copies of both sides of your patient's pharmacy insurance card(s).

SECTION 3 – PRESCRIBER INFORMATION

Provide all required information to avoid delays in investigating benefits for product fulfillment.

SECTION 4 – DIAGNOSIS

Confirm your patient's diagnosis and diagnostic tests in this **required** section.

SECTION 5 – RX, BRIDGE, SIGNATURE

Complete this section to write a prescription and, if applicable, check the box for the **Bridge Program**. Prescribers must sign at the bottom of **section 5** to complete the pharmacy prescription, authorize the Bridge Program, and/or enroll a patient in MPS. **No stamp signatures allowed.**

SECTION 6 – PRESCRIBER ATTESTATION

Attests to the validity of the information provided on the form. If applicable, the form authorizes MPS to conduct a benefits investigation and transmit the prescription to an appropriate pharmacy.

SECTION 7 – PATIENT AUTHORIZATION

HIPAA consent to share health information for access to therapy, services, and programs.

SECTION 8 – PATIENT CERTIFICATIONS

Patient consent to enroll in MPS support.

1 Patient Information and Authorizations – *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
 Email* OK to email? Y N Legal representative (if any) Representative phone

Patient Authorization for Access Support (REQUIRED for Madrigal Patient Support (MPS)) See section 7 on page 2 for details of authorization.
SIGN HERE Patient or authorized representative signature _____ Date* (REQUIRED IF SIGNED) / /
 Relationship to patient: First name _____ Last name _____
 Representative phone _____ Date _____

2 Patient Insurance Information (REQUIRED) – Please include front and back copies of pharmacy cards or complete this section.
 Prescription insurance name _____ Policy _____
 Subscriber name _____ Insurance phone _____
 Rx BIN _____ Rx Group _____ DOB / / _____
 Rx PCN _____

3 Prescriber Information – *Asterisk indicates required information.
 Prescriber first name* Last name*
 Specialty* Facility name* City* NPI #*
 Address* State* ZIP*
 Primary office contact name* Ext. Fax* Office contact email

4 Diagnosis (REQUIRED)

5 Prescription Information – *Asterisk indicates required information.
 Patient weight (kg) (1 kg = 2.2 lb) _____
 Pharmacy Prescription: Rx will be managed by MPS in an in-network and/or power-managed pharmacy. See Prescriber Attestation below.
 Commercial Bridge Prescription: _____
 Quantity* 30-day supply Other: _____ 30-day supply
 Refills* _____ 3x
 In conjunction with diet and exercise. Concurrent medications: _____
 NKDA Food/drug allergies: _____

6 Prescriber Signature (REQUIRED)
 Prescriber signature* Dispense as written _____ Date* _____
 Prescriber signature: Substitution permitted _____ Date _____
 See prescribing information for complete dosing information.

7 Prescriber Attestation
 By signing this form, I certify to the best of my knowledge that all the person named on this form is my patient and that the information submitted is complete and accurate. I, the above therapy is medically necessary for the patient and for the patient's safety. I understand that no free product may be sold, traded, or distributed for sale. I consent to Madrigal Patient Support conducting the in-the-mail, or email to provide additional information to Madrigal Patient Support and understand that Madrigal Patient Support may review, 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://hqwerty.com/terms>, which are specifically incorporated herein by reference, and acknowledge and consent to their application and enforceability in regards to this certification.

8 Patient Authorization for Access Support
 (HIPAA) Patient Authorization for Access 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"), and any specialty pharmacies ("Specialty Pharmacies") that dispense my medication, 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 herein, which may include the following:

8 Patient Certifications
 I am enrolling in the Madrigal Patient Support Program ("MPS") and authorize Madrigal Pharmaceuticals, Inc., its affiliates, agents and service providers ("Madrigal") to provide support under MPS, as described in this Enrollment Form and as may be added in the future. Such support includes medication and adherence communications and support, medication dispensing support, coverage and financial assistance support, disease and medication education, and other support services.
 If I sign up for Madrigal copay support, I understand that copy card information will be sent to my designated specialty pharmacy along with my prescription, and any assistance with my applicable cost-sharing or copayment for _____ will be made in accordance with the MPS terms and conditions.
 I authorize Madrigal to verify my eligibility for the Madrigal Patient Assistance Program ("MPAP"), and I understand that such verification may include contacting me or my designated specialty pharmacy for additional information and/or reviewing additional financial information for the Fair Credit Reporting Act.