Patient Authorization Form

Madrigal patient SUPPORT

By completing this form, you are enrolling in Madrigal Patient Support.
Through this program, eligible patients receive:

- Help identifying financial assistance options
- Support getting started and throughout treatment
- Education and tips from Nurse Navigators

We're here to help.

CALL
1-877-219-7770
Monday – Friday, 8 AM – 8 PM ET

VISIT
MadrigalPatientSupport.com

HOW TO ENROLL
FAX ALL PAGES to 1-844-411-1177 **or**
COMPLETE ONLINE scan QR code or visit MadrigalEnrollmentPatient.com

1. PATIENT INFORMATION AND SIGNATURE

* 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? ○ Yes ○ No

Email* _____ OK to email? ○ Yes ○ No

Legal representative (if any) _____

Relationship to patient _____ Representative phone _____

I have read and consent to the Patient Authorization for Access Support in Section 3.

SIGN HERE	PATIENT OR LEGAL REPRESENTATIVE SIGNATURE*	DATE	

I have read and consent to the Patient Certifications in Section 4.

○ **I have read the Text Messaging Consent in Section 4 and expressly consent to receive text messages from Madrigal.**

SIGN HERE	PATIENT OR LEGAL REPRESENTATIVE SIGNATURE*	DATE	

If signed by legal representative Printed name _____

2. PRESCRIBER AND PHARMACY INFORMATION

* Required information

Please provide the following information if known. We will follow up if additional details are needed to support your access to therapy.

Prescriber name* _____ Phone _____

Address _____

City _____ State _____ ZIP _____

Was your prescription sent to a pharmacy? ○ Yes ○ No

If yes, pharmacy name _____

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3. 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 on this form, which may include the following:

- Working with my health insurance plan to understand or verify coverage for Madrigal products
- Enrolling in the Madrigal Patient Assistance Program (PAP)
- Determining my eligibility for and facilitating enrollment into financial assistance services if I'm eligible, including copay assistance
- Coordinating my prescription through a pharmacy. This includes contacting me to discuss my coverage, costs and eligibility for assistance and other program administration purposes
- Facilitating my access to Madrigal products through prior authorization for coverage and assistance with appeals of denied claims for coverage
- Ensuring quality and safety and improving our products and services

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.

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3. PATIENT AUTHORIZATION FOR ACCESS SUPPORT (CONT.)

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.

4. PATIENT CERTIFICATIONS

I am enrolling in the Madrigal Patient Support Program and authorize Madrigal Pharmaceuticals, Inc., its affiliates, agents and service providers ("Madrigal") to provide support under Madrigal Patient Support, as described in this Patient Authorization 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.

I understand that copay 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 Rezdiffra™ (resmetirom) will be made in accordance with the Madrigal Patient Support terms and conditions.

I authorize Madrigal to verify my eligibility for the Madrigal Patient Assistance Program ("PAP"), and I understand that such verification may include contacting me or my Healthcare Provider for additional information and/or reviewing additional financial, insurance, and/or medical information. I authorize Madrigal under the Fair Credit Reporting Act to use my demographic information to access reports on my individual credit history from consumer reporting agencies, and that such access will not impact my credit score. I further understand and authorize Madrigal to use any consumer reports about me and information collected from me, along with other information they obtain from public and other sources, to estimate my income in conjunction with PAP eligibility, if necessary.

I understand that the Madrigal Patient Assistance Program (PAP) provides free medicine to qualifying patients. Participation in PAP is free and PAP does not collect any fees from people seeking assistance. I understand that PAP assistance is dependent on my ability to meet the eligibility criteria for the program as determined by PAP. PAP does not have any obligation to provide the program services to me and is not liable in the provision of these services.

I understand that patients with insurance plans or employers participating in an alternate funding program (also sometimes referred to as patient advocacy programs, specialty networks, SHARx, Paydhealth, or Payer Matrix, among other names) requiring them to apply to a manufacturer's patient assistance program or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of relevant Madrigal products, or that otherwise denies, restricts, eliminates, delays, alters, or withholds any insurance benefits or coverage contingent upon application to, or denial of eligibility for, specialty drug prescription coverage through the alternate funding program are not eligible for PAP. I agree to inform PAP if I am a member of such an insurance plan or if I am applying to PAP on behalf of a patient who is a member of such an insurance plan. I further understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale. If approved for PAP I will not seek to have the value of any medication provided to me under this program counted toward my true-out-of-pocket (TrOOP) cost for prescription drugs for my Medicare Part D Plan. I will not seek reimbursement for any products dispensed under the program. I will notify the program if my insurance or financial situation changes. The program may be changed or discontinued without notice.

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4. PATIENT CERTIFICATIONS (CONT.)

Text Messaging Consent: I acknowledge that by checking the Text Messaging Consent box in section 1, I expressly consent to receive text messages from or on behalf of Madrigal at the mobile telephone number(s) that I provide. I understand that my wireless service provider's message and data rates may apply. I understand that I can opt out of future text messages at any time by following the opt-out instructions contained in any text message communications, and that I can get help for text messages by texting HELP to the number provided in any text message communications. I also understand that additional text messaging terms and conditions may be provided to me in the future as part of an opt-in confirmation text message.

I agree to receive by mail, telephone, or email, or, if I indicate my agreement and consent above, by text, promotional marketing and communications and other information from Madrigal including health-related resources and therapy information (the "Communications"). I understand that Madrigal respects my personal information. Madrigal or third parties working on its behalf will not sell my personal information. If, in the future, I no longer want to receive the Communications, I may opt out at any time by contacting Madrigal in writing at the address in section 3 or by unsubscribing from Communications.

I understand that I may be contacted by Madrigal in the event that I report an adverse event. I understand that I do not have to enroll in Madrigal Patient Support to receive the Communications, and that I can still receive Rezdiffra™ (resmetirom) as prescribed by my Healthcare Provider. I may opt out of receiving Communications, individual support services offered by Madrigal Patient Support, including any copay support, or opt out of Madrigal Patient Support entirely at any time by notifying a Madrigal Patient Support representative by telephone at 1-877-219-7770 or by sending a letter to the address in section 3. I also understand that support provided by Madrigal Patient Support may be revised, changed, or terminated at any time.

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