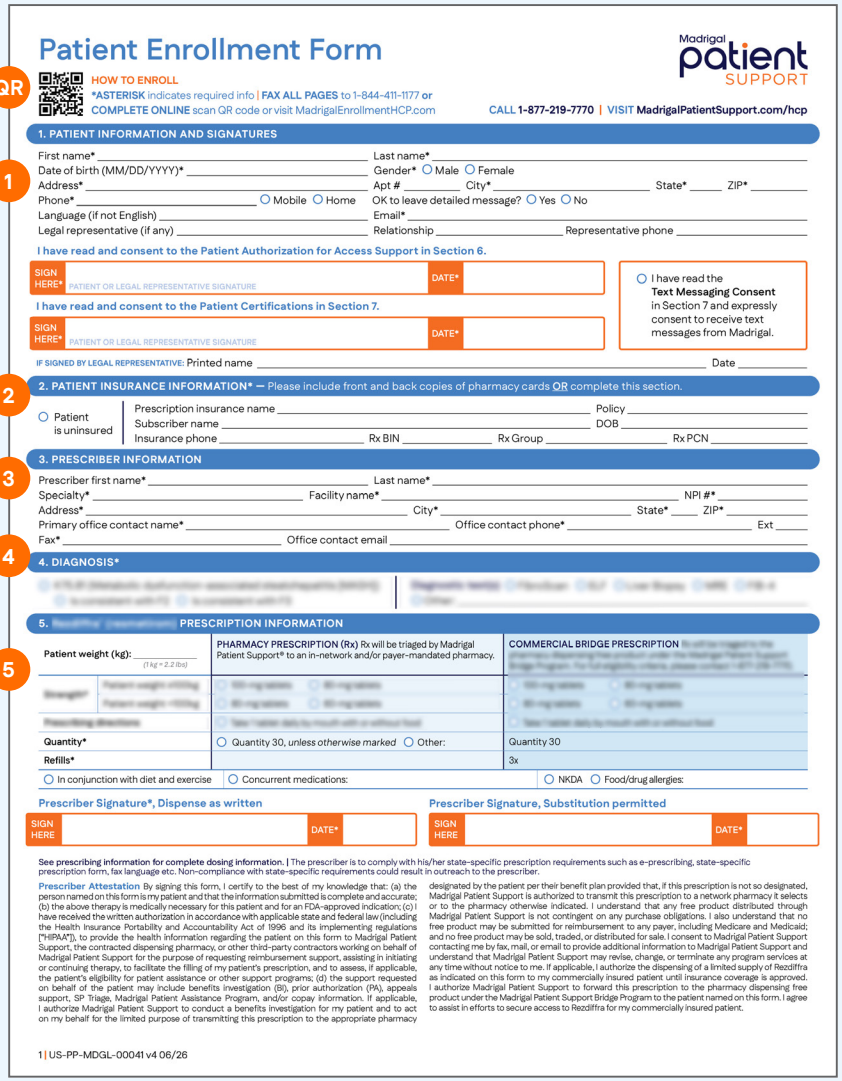
QR CODE

Scan the QR code to enroll your patients online.



Patient Enrollment Form

Madrigal patient SUPPORT

QR HOW TO ENROLL

*ASTERISK indicates required info | FAX ALL PAGES to 1-844-411-1177 or

COMPLETE ONLINE scan QR code or visit MadrigalEnrollmentHCP.com

CALL 1-877-219-7770 | VISIT MadrigalPatientSupport.com/hcp

1. PATIENT INFORMATION AND SIGNATURES

First name* Last name*

Date of birth (MM/DD/YYYY)* Gender* ○ Male ○ Female

Address* Apt # City* State* ZIP*

Phone* ○ Mobile ○ Home OK to leave detailed message? ○ Yes ○ No

Language (if not English) Email*

Legal representative (if any) Relationship Representative phone

I have read and consent to the Patient Authorization for Access Support in Section 6.

SIGN HERE* PATIENT OR LEGAL REPRESENTATIVE SIGNATURE DATE*

I have read and consent to the Patient Certifications in Section 7.

SIGN HERE* PATIENT OR LEGAL REPRESENTATIVE SIGNATURE DATE*

○ I have read the **Text Messaging Consent** in Section 7 and expressly consent to receive text messages from Madrigal.

IF SIGNED BY LEGAL REPRESENTATIVE: Printed name Date

2. PATIENT INSURANCE INFORMATION* — Please include front and back copies of pharmacy cards OR complete this section.

○ Patient is uninsured

Prescription insurance name Policy

Subscriber name DOB

Insurance phone Rx BIN Rx Group Rx PCN

3. PRESCRIBER INFORMATION

Prescriber first name* Last name*

Specialty* Facility name* NPI #*

Address* City* State* ZIP*

Primary office contact name* Office contact phone* Ext

Fax* Office contact email

4. DIAGNOSIS*

5. PRESCRIPTION INFORMATION

Patient weight (kg): _____ (1 kg = 2.2 lbs)	PHARMACY PRESCRIPTION (Rx) Rx will be triaged by Madrigal Patient Support® to an in-network and/or payer-mandated pharmacy.	COMMERCIAL BRIDGE PRESCRIPTION
Strength*		
Prescribing directions		
Quantity*	○ Quantity 30, *unless otherwise marked* ○ Other:	Quantity 30
Refills*		3x

○ In conjunction with diet and exercise ○ Concurrent medications: ○ NKDA ○ Food/drug allergies:

Prescriber Signature*, Dispense as written

SIGN HERE DATE*

Prescriber Signature, Substitution permitted

SIGN HERE DATE*

See prescribing information for complete dosing information. | The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Prescriber Attestation By signing 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 therapy is medically necessary for this patient and for an FDA-approved indication; (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, the contracted dispensing pharmacy, or other third-party contractors working on behalf of Madrigal Patient Support for the purpose of requesting reimbursement support, assisting in initiating or continuing therapy, to facilitate the filling of my patient's prescription, and to assess, if applicable, the patient's eligibility for patient assistance or other support programs; (d) the support requested on behalf of the patient may include benefits investigation (BI), prior authorization (PA), appeals support, SP Triage, Madrigal Patient Assistance Program, and/or copay information. If applicable, I authorize Madrigal Patient Support to conduct a benefits investigation for my patient and to act on my behalf for the limited purpose of transmitting this prescription to the appropriate pharmacy designated by the patient per their benefit plan provided that, if this prescription is not so designated, Madrigal Patient Support is authorized to transmit this prescription to a network pharmacy it selects or to the pharmacy otherwise indicated. I understand that any free product distributed through Madrigal Patient Support is not contingent on any purchase obligations. I also 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. 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. If applicable, I authorize the dispensing of a limited supply of Rezdiffra as indicated on this form to my commercially insured patient until insurance coverage is approved. I authorize Madrigal Patient Support to forward this prescription to the pharmacy dispensing free product under the Madrigal Patient Support Bridge Program to the patient named on this form. I agree to assist in efforts to secure access to Rezdiffra for my commercially insured patient.

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PAGE 2

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PAGE 3

Ready to submit?

Be sure faxed pages are legible.

Fax all three (3) pages to

1-844-411-1177

Enrollment Form Step-By-Step Guide

Madrigal patient SUPPORT

The Patient Enrollment Form serves as both prescription and consent to enroll in Madrigal Patient Support®. For commercially-insured patients, it also serves as a request for Bridge Support.

Follow this step-by-step guide for help completing required information (i.e., signatures, diagnosis, prescription, pages, etc.) to help minimize process delays.

1 PATIENT INFORMATION AND SIGNATURES

Two patient signatures are required. Be sure to have your patient or an authorized representative **sign and date twice** to consent to:

- Patient Authorization for Access Support (**Sec 6**)
- Patient Certifications (**Sec 7**)

Patients who opt in to text messaging can receive helpful updates and support from Madrigal Patient Support.

MISSING SIGNATURES WILL CAUSE DELAYS.

2 PATIENT INSURANCE INFORMATION

Attach front and back copies of your patient's pharmacy insurance card (preferred), or complete this section if it's unavailable. This information helps us determine coverage options.

3 PRESCRIBER INFORMATION

Your office contact details help us and/or the specialty pharmacy coordinate with your office to support benefits investigations and fulfillment.

4 DIAGNOSIS

Be sure to check all appropriate boxes, confirming:

- Diagnosis / ICD-10-CM code
- Stage
- Diagnostic test(s) used

5 PRESCRIPTION INFORMATION

Complete the Pharmacy Prescription section highlighted in light blue to support prescription triage and routing to the appropriate Specialty Pharmacy.

For commercially insured patients experiencing a coverage delay who may be eligible for the Bridge Program, also complete the additional prescription section highlighted in darker blue to request Bridge Program consideration.

One prescriber signature is required. The prescriber must sign and date once to validate the form. Stamp signatures are not allowed.

6 PATIENT AUTHORIZATION FOR ACCESS SUPPORT

7 PATIENT CERTIFICATIONS

Your patient will need to review these sections prior to signing their consent in **Sec 1**. You must include these pages when you submit the form.

Questions? CALL 1-877-219-7770

VISIT MadrigalPatientSupport.com/hcp

Madrigal