KRAZATI® (adagrasib)

Free Trial Offer Program

MIRATI&Me

Please fill out all fields in their entirety.

Eligibility Screening

1. Is the patient 18 years or older? ◯ Yes ◯ No

2. Does the patient reside in the United States or a US territory? ◯ Yes ◯ No

3. Please provide the patient's ICD-10 code: _____

4. Has the patient tested positive for the *KRAS G12C* biomarker? ◯ Yes ◯ No

5. Has the patient been prescribed KRAZATI® by a licensed US or US territory physician? ◯ Yes ◯ No

6. Does the patient currently have health insurance? ◯ Yes ◯ No
(This question does not affect patient eligibility for this offer program)

7. Does the patient currently have prescription insurance? ◯ Yes ◯ No
(This question does not affect patient eligibility for this offer program)

☐ By checking this box, I confirm that I am aware this program is for one free 30-day trial per patient (per lifetime)

Patient Information

Patient First Name _____ Patient Last Name _____

Street Address _____

City _____ State _____ ZIP Code _____

Phone Number _____ Date of Birth _____ Gender ◯ Male ◯ Female

Prescriber Information

Prescriber First Name _____ Prescriber Last Name _____

Site/Facility Name _____ Phone Number _____

Fax Number _____ Prescriber NPI Number _____ DEA Number _____

State License Number _____ Specialty ◯ Hematologist ◯ Oncologist ◯ Other _____

OFFICE CONTACT INFORMATION

Office Contact Name _____ Title _____

Office Contact Phone _____ Office Contact Fax _____

Email _____ Office Street Address _____

City _____ State _____ ZIP Code _____

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Please fill out all fields in their entirety.

Shipping Address Information

Please select an option

- ◯ Patient Address as provided in Patient Information section
- ◯ Site/Facility Address as provided in Prescriber Information section (KRAZATI® Free Trial Offer Program 30-day supply may be shipped to prescribing healthcare provider)

Terms and Conditions

By enrolling in the Free Trial Offer Program, you acknowledge that your patient currently meets the eligibility criteria and will comply with the terms and conditions described below:

The KRAZATI® Free Trial Offer Program provides eligible patients with a 30-day supply of KRAZATI® at no cost

The KRAZATI® Free Trial Offer Program is solely intended to allow new patients a free trial of KRAZATI® to determine, with you, whether KRAZATI® is right for them. This Free Trial Offer is valid for one time only with no refills. For any future use, you must write a new prescription for KRAZATI®

To be eligible, a patient must (1) have an on-label diagnosis, (2) be new to KRAZATI® treatment, (3) not have enrolled previously in the KRAZATI® Free Trial Offer Program, and (4) be 18 years of age or older

The KRAZATI® Free Trial Offer Program supply will be delivered to the patient's preferred address (no P.O. Boxes)

The KRAZATI® Free Trial Offer Program supply cannot be exported or transferred in exchange for money, other property, or services

No portion of the KRAZATI® Free Trial Offer Program may be submitted for reimbursement to any third-party payer, including Medicare or Medicaid, either directly or indirectly

The KRAZATI® Free Trial Offer Program is not health insurance. This free trial offer is not intended to address delays or gaps in health insurance coverage for the specified prescription

This program is for one free 30-day supply per patient (per lifetime)

This program is valid only for residents of the United States and US territories

The Mirati & Me Patient Support Program reserves the right to rescind, revoke, or amend this program at any time without notice

Void where prohibited by law. Void where use is prohibited by the patient's insurance provider

☐ I accept the Terms and Conditions

Free Trial Offer Prescription*

Patient First Name _____ Patient Last Name _____

Date of Birth _____

☐ KRAZATI® (adagrasib) 200 mg Quantity _____ Directions _____

_____

Future fills of KRAZATI will be dispensed by: ◯ Onco360 ◯ Biologics ◯ In-office Dispensing Pharmacy

Prescriber Signature† _____ Date _____

For any questions, call 1-844-647-2842 | Fax 1-844-647-2844
8 AM to 8 PM ET, Monday-Friday

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Prescriber Authorization*

By signing below, I certify that: (1) the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge; (2) I am the physician, or a designated agent of the healthcare provider/practice, who has prescribed KRAZATI® (the "Product"), which is medically necessary for this patient; (3) I have reviewed the current Product prescribing information before prescribing; and (4) I have received the necessary legal authorization from the patient named previously (or from the patient's legal representative) to release the patient's personal health information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder, as well as other state and/or federally protected personal information) both as provided on this form to Mirati Therapeutics, Mirati & Me, the contracted dispensing pharmacy, or other contractors may require (a) to perform a preliminary verification of the patient's insurance coverage for the Product and (b) to assess the patient's eligibility for participation in the Mirati & Me Free Trial Offer Program. I authorize to convey on my behalf the prescription I signed for the patient and the other information included on this form to the dispensing pharmacy chosen for the patient. I agree that Mirati & Me may contact me, including, without limitation, via email, fax, and telephone to seek additional information relating to the Product, or the prescription(s) contained on this form. I understand that any Product provided at no charge to the patient is provided on a complimentary basis. I will not submit or cause to be submitted any claims for payment or reimbursement for such Product to any third-party payer, including, without limitation, a federal healthcare program. If I am or become in possession of such Product, I will not resell or attempt to resell the Product. I agree to comply with the Mirati & Me guidelines and understand that Mirati Therapeutics, at its sole and absolute discretion, reserves the right to modify or discontinue patient support programs, including such programs provided through Mirati & Me, at any time.

Prescriber Signature† _____ Date _____

Designated Agent Name† _____ Title _____ Date _____

*Prescriber shall comply with applicable state prescribing requirements, such as e-prescribing, state-specific prescription form(s), fax language, etc. Noncompliance with applicable state prescribing requirements could result in additional communications from Mirati & Me or other contractors to the prescriber.

†Either the Prescriber Signature or the Designated Agent Name is required.

If you need additional assistance, please call Mirati & Me, available Monday-Friday, 8 AM to 8 PM ET.

Phone: 1-844-647-2842