Phone: 1-844-KADMON1 (523-6661)
Monday through Friday, 8:00 AM-8:00 PM ET

Fax: 1-833-635-1481
PO Box 5266, Louisville, KY 40255

Kadmon ASSIST™ Program Enrollment Form

Instructions and Description of Services

Note: If additional information or assistance is needed, please contact Kadmon ASSIST for an assessment of what services may be needed and the steps required.

DESCRIPTION OF SERVICES

Benefits Investigation: Kadmon ASSIST will contact the patient's insurance company to collect information on coverage, patient benefits and prior authorization (PA) requirements. *Please complete sections 1 to 3 and 5 to 8 when requesting this service and attach a copy of the patient's insurance/Medicare/Medicaid card (front and back).*

Prior Authorization Support: Kadmon ASSIST will contact the patient's insurance company to collect information and the PA requirements and follow up on the status of any provider/pharmacy-submitted PAs. *Please complete sections 1 to 3 and 5 to 8 when requesting this service.*

Patient Assistance Program (PAP): Kadmon ASSIST will provide free medication to patients who qualify. *Please complete sections 1 to 9, and section 10 as optional, when requesting this service.*

Commercial Co-Pay Savings Program: Co-pay savings for eligible commercially or privately insured patients. *Please complete sections 1 to 3 and 5 to 8 when requesting this service.*

Product Delivery Coordination: Kadmon ASSIST will help identify a specialty pharmacy within the REZUROCK™ (belumosudil) network and provide email and text message communication regarding product shipment.

Nurse Adherence Calls: Kadmon ASSIST Nurses can help patients understand more about their disease and their treatment with REZUROCK to help them off to a good start.

ENROLLMENT INSTRUCTIONS

1. Complete all applicable sections of the Kadmon ASSIST Program Enrollment Form.
2. Ensure all applicable provider and patient signature fields are complete.

a. The following fields are required for the Patient:

- Patient Full Name
- Patient Gender
- Patient Phone Number
- Patient Proof of Income (only applicable to PAP)
- Patient Insurance Information (if applicable)
- Patient Date of Birth
- Patient Home Address, City, State and Zip Code
- Patient Authorization Consent
- Patient Household Size (only applicable to PAP)

b. The following fields are required for the Prescriber:

- Prescriber Full Name
- Prescriber Fax Number
- Prescriber NPI Number
- Patient ICD-10 Code
- Prescriber Phone Number
- Prescriber Address, City, State and Zip Code
- Prescriber Declaration Signature & Date
- Patient Prescription and Clinical Information

3. Fax the completed Kadmon ASSIST Program Enrollment Form and all required documentation to Kadmon ASSIST at **1-833-635-1481**.

PATIENT CONFIDENTIALITY: Patient confidentiality is of primary importance to us. All patient information will remain confidential.

IMPORTANT REMINDER: Please be certain that all applicable pages of the Kadmon ASSIST Program Enrollment Form are completed and to include all appropriate documentation when submitting this form. Incomplete forms slow the review process and, in some cases, may require the health care provider to reapply for the program(s).

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1. REQUESTED SERVICES (Check all that apply. See page 1 for a description of available services.)

☐ Benefits Investigation ☐ Patient Assistance Program (PAP) ☐ Prior Authorization/Appeals Support ☐ Commercial Co-Pay Savings Program
☐ Product Delivery Coordination

Nurse Adherence Calls (SELECT ONE):

☐ **YES:** I would like to opt in to receive adherence calls from a program nurse.
☐ **NO:** I do not want to opt in to receive adherence calls from a program nurse.

If YES, please select your preferred method of contact. ☐ Patient Home Phone ☐ Patient Mobile Phone ☐ Authorized Representative Phone

2. PATIENT INFORMATION

Full Name (First and Last):		
Date of Birth (MM/DD/YYYY):	Gender: ☐ Male ☐ Female	
Home Address:		
City:	State:	Zip:
Patient Home Phone:	Patient Mobile Phone:	
Patient Work Phone:	Patient Email Address:	
Preferred Method of Contact: ☐ Home ☐ Mobile ☐ Work ☐ Text ☐ Email		
Authorized Representative:	Relationship to Patient: ☐ Patient ☐ Authorized Representative ☐ Caregiver	
Authorized Representative Phone:	Is the Patient a US or US Territory Resident?: ☐ Yes ☐ No	
Authorization Representative Email:		

3. PATIENT INSURANCE INFORMATION (Attach a copy of the patient's insurance/Medicare/Medicaid card, front and back, if available.)

Does the Patient Have Health Insurance?: ☐ Yes ☐ No	Insurance Type: ☐ Commercial ☐ Government ☐ Other	
Primary Medical Insurance Provider:		
ID #:	Group #:	
Beneficiary/Cardholder Name:	Insurance Phone:	
Secondary Medical Insurance Provider:		
ID #:	Group #:	
Beneficiary/Cardholder Name:	Insurance Phone:	
Prescription Insurance Provider:	ID #:	Group #:

4. PATIENT FINANCIAL INFORMATION [Required only if applying for the Patient Assistance Program (PAP)]

Employment Status: ☐ Employed ☐ Unemployed	
Current Annual Household Income: $	Number of People in Household:
If there is no household income, indicate how the patient/household is being supported:	

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5. PRESCRIBER INFORMATION

Prescriber Name (First and Last):		Prescriber NPI Number:
Address:		
City:	State:	Zip:
Primary Phone:	Secondary Phone:	
Fax:	Prescriber State License Number:	
Email Address:	Preferred Method of Contact: ☐ Phone ☐ Fax ☐ Email	
Office Contact Name:	Office Contact Phone:	
Supervising Physician (If Required):	Supervising Physician Phone (If Required):	

6. PRESCRIPTION AND CLINICAL INFORMATION (Please completely fill out the prescription information below to prevent any potential delays.)

Patient Full Name:	Patient Date of Birth (MM/DD/YYYY):
Primary Diagnosis (ICD-10 Code):	Secondary Diagnosis (ICD-10 Code):
Current Medications:	
Previous Therapy:	
Allergies:	
Anticipated Therapy Start Date (MM/DD/YYYY):	Preferred Distribution Method: ☐ Patient ☐ Prescriber's Office
Ship to Address:	

Preferred Specialty Pharmacy: ☐ McKesson Biologics ☐ Onco360 ☐ Amber Specialty Pharmacy ☐ No Preference

REZUROCK™ (belumosudil) 200 mg tablet

Directions: _____ Quantity: _____ Refills: _____

Prescriber Printed Full Name (First and Last):

Prescriber Signature:	**Date:**

7. PRESCRIBER DECLARATION (SIGNATURE REQUIRED)

I certify that the patient and physician information contained in this **Kadmon ASSIST** Program Enrollment Form is complete and accurate to the best of my knowledge. I have prescribed **REZUROCK** and certify that this prescription medication is medically necessary for the patient. I certify that I will be supervising the patient's treatments and verify that the information provided is complete and accurate to the best of my knowledge. I certify that I have received the appropriate permission from the patient and met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and/or state law needed to release the above information to **Kadmon ASSIST** for the purposes of verifying the patient's insurance coverage, seeking prior authorization, if needed, on my patient's behalf, and providing information on appeals for denials of claims.

I authorize the forwarding of this prescription to a dispensing specialty pharmacy on behalf of myself and the patient. I understand that neither I, nor the patient, can seek reimbursement for any free medicine received under the **Kadmon ASSIST** PAP and that my team has informed the patient of this requirement.

By signing below (required), I have read and agree to **Section 7. Prescriber Declaration.**

(NOTE: Kadmon ASSIST Program Enrollment Form requests cannot be processed without signed prescriber declaration. Prescriber actual signature required, no signature stamp.)

Prescriber Printed Full Name (First and Last):

Prescriber Signature:	**Date:**

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8. PATIENT PRIVACY AUTHORIZATION (SIGNATURE REQUIRED)

I understand that, before I may receive assistance from **Kadmon ASSIST**, sponsored by Kadmon Pharmaceuticals, LLC ("Kadmon"), the administrators of **Kadmon ASSIST**, including their contractors or other representatives, will need to obtain, review, use and disclose my personal health information ("PHI"), including information relating to my medical condition and prescription medications and the information included in this **Kadmon ASSIST** Program Enrollment Form. I therefore authorize each of my physicians, pharmacies and health plans to disclose my PHI, as necessary, to (i) the administrators of **Kadmon ASSIST** and their contractors or representatives, in order to verify my eligibility to enroll in **Kadmon ASSIST** and to enroll me in **Kadmon ASSIST** if I am eligible; and (ii) the administrators of **Kadmon ASSIST** and their contractors or representatives to investigate insurance coverage in connection with **Kadmon ASSIST**. I also authorize the administrators of **Kadmon ASSIST** and their respective contractors or representatives to (i) use my PHI to provide the services described in this enrollment form, including to communicate with me by US postal mail, telephone, text or email and to prepare summaries that do not include my PHI for statistical purposes; and (ii) share my PHI with one another and with my physicians and pharmacists, as well as with Medicare, my health plans and their administrators, contractors or representatives, in order for them to coordinate my benefits and investigate my insurance coverage. I also authorize the administrators of **Kadmon ASSIST** and their contractors, representatives and third-party services partners to disclose my PHI to authorized representatives of Kadmon as necessary to ensure compliance with the rules of **Kadmon ASSIST**. I also authorize authorized representatives of Kadmon to use my PHI to communicate with the administrators of **Kadmon ASSIST**, their contractors, representatives or third-party services partners, my physicians, pharmacies and me for compliance purposes. If I have designated an authorized representative, I authorize **Kadmon ASSIST**, its administrators and their third-party service partners to use my PHI to contact the person I have designated as my authorized representative for the purpose of verifying the information I have provided in this form and/or coordinating the provision of benefits that may be available to me under **Kadmon ASSIST** and to disclose my PHI, including information provided in this enrollment form, to my authorized representative for the purposes described in this paragraph. I understand that the PHI disclosed pursuant to this authorization, once disclosed, may not be governed by federal privacy law and may be subject to re-disclosure. I further understand that if I choose not to provide this authorization, it will not affect my eligibility for, or receipt of, treatment, including Kadmon products, or health care insurance benefits, but that I will not be able to receive any assistance from **Kadmon ASSIST**. I acknowledge that my PHI may be used for marketing purposes and that my health care providers (including my pharmacies) may receive payment for disclosing my PHI. I understand that I may cancel this authorization at any time by telephoning **Kadmon ASSIST** at **1-844-KADMON1 (523-6661)** or by mailing a written request for cancellation to **Kadmon ASSIST**, PO BOX 5266, Louisville, KY 40255. I understand that canceling my authorization will mean that my physicians, pharmacies and health plans, as well as **Kadmon ASSIST**, its administrators and contractors and representatives, may no longer rely on the authorization to use or disclose my PHI, but that any use or disclosure of such information that occurs before my cancellation is received will be unaffected by my cancellation.

I understand that if I do not cancel this authorization, the authorization will expire **18 months** from the date of signature (or the maximum period allowed by applicable state law, if less than 18 months). The administrators of **Kadmon ASSIST** will retain the information I have submitted in accordance with Kadmon's records retention policy. I understand that I am entitled to receive a copy of this authorization once it has been signed.

By signing, I certify that I have read and agree to the above Patient Privacy Authorization.

Patient Printed Name (First and Last):

Relationship to Patient: ☐ Patient ☐ Authorized Representative ☐ Caregiver

Patient/Legal Guardian/Caregiver Signature:	**Date:**

9. PAP SUPPORT SERVICES PATIENT CERTIFICATION (SIGNATURE REQUIRED FOR PAP)

I certify that all of the information provided in this application, including information about household income, is complete and accurate. I understand that **Kadmon ASSIST** Patient Assistance Program ("PAP") assistance will terminate if the PAP becomes aware of any fraud or if this medication is no longer prescribed for me. I understand that completing this application does not ensure that I will qualify for patient assistance. I certify that I will not seek reimbursement or credit for this prescription from any insurer, health plan or government program. If I am a member of a Medicare Part D plan, I will not seek to have the prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. I understand that if I qualify for free medicine, it will be for a **rolling year**, and should I require assistance in future years, I must reapply for **Kadmon ASSIST** PAP assistance. I understand that the **Kadmon ASSIST** PAP reserves the right to modify the application form, modify or discontinue this program or terminate assistance at any time and without notice. I authorize the **Kadmon ASSIST** PAP and its affiliates to forward the prescription to a dispensing pharmacy on my behalf. **Kadmon ASSIST** PAP is not responsible for verifying any information contained in the prescription forwarded as part of the enrollment process, including, without limitation, allergies, medical conditions or other medications being taken by me. I understand that I will notify the **Kadmon ASSIST** PAP immediately if anything changes with my prescription, income or my insurance coverage. I understand that the **Kadmon ASSIST** PAP reserves the right to request documentation to verify the information provided in this application for purposes of determining my eligibility for assistance and to conduct periodic audits of my enrollment, including the physician who will be supervising my treatment, to verify the information provided herein. I understand that I may opt out of receiving **Kadmon ASSIST** PAP assistance by notifying **Kadmon ASSIST** at **1-844-KADMON1 (523-6661)**. I understand that assistance received through the **Kadmon ASSIST** Patient Assistance Program is not insurance.

I understand that if I am eligible or enrolled in a Medicare plan, I will:

a) Receive the requested medication from the **Kadmon ASSIST** Patient Assistance Program (administered by RxCrossroads Pharmacy) for the remainder of the enrollment calendar year for which my application was approved, and I will not seek the requested medication from my Medicare plan for the remainder of the enrollment calendar year

b) Not seek true out-of-pocket (TrOOP) credit for any medication received from the Program because I understand that medication received from the Program will not count toward my TrOOP

c) Agree to notify my Medicare plan that I will receive my Kadmon medication for free until the end of the year through the Program

By signing, I certify that I am at least eighteen (18) years of age and that I have read and agree to the above Patient Certification and the terms and conditions of the **Kadmon ASSIST** Patient Assistance Program. By signing, I also certify that all information that I have provided in this application is complete and accurate.

Patient Printed Name (First and Last):

Relationship to Patient: ☐ Patient ☐ Authorized Representative ☐ Caregiver

Patient/Legal Guardian/Caregiver Signature:	**Date:**

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10. FAIR CREDIT REPORTING ACT PATIENT CONSENT (SIGNATURE OPTIONAL FOR PAP)

I am providing 'written instructions' under the Fair Credit Reporting Act to the program, including its agents, administrators and service providers, authorizing the program to obtain information from my credit profile and/or other information from Experian Health. I authorize **Kadmon ASSIST**, including its agents, administrators and service providers, to obtain such information solely to determine my eligibility to participate in the program.

Patient Printed Name (First and Last):

Relationship to Patient: ☐ Patient ☐ Authorized Representative ☐ Caregiver

Patient/Legal Guardian/Caregiver Signature:	**Date:**

11. TEXT MESSAGING AND EMAIL PATIENT OPT IN

By signing, I agree to be contacted by email at the address I have provided or to receive autodialed phone or text messages ("texts") at the mobile phone number I have provided for the purpose of helping me/the patient stay on therapy, which may promote or advertise **REZUROCK™ (belumosudil)**. I certify that the number I am providing belongs to me and not a family member or third party. I understand that I may opt out of individual communications of the program entirely at any time by calling **1-844-KADMON1** (523-6661), clicking the email link in a message received or by replying "STOP" by text to any text from **Kadmon ASSIST**. **Kadmon ASSIST** will not sell or rent this information and will use it only in accordance with this authorization and consent. Consent to being contacted by email, phone or text messages is not a condition of participation in the programs or the purchase of any products or services. I understand that my cellular service carrier's data and text messaging rates may apply. This authorization is valid for **18 months** from the date the form is signed. If I am providing this consent on behalf of another person, I certify that I am authorized to agree to every element of this consent on behalf of such other person, and I agree that I will be liable and will hold Kadmon Pharmaceuticals, LLC harmless in the event that such other person alleges that they did not give consent.

Patient Printed Name (First and Last):

Relationship to Patient: ☐ Patient ☐ Authorized Representative ☐ Caregiver

Patient/Legal Guardian/Caregiver Signature:	**Date:**

Fax completed form to **1-833-635-1481**. For complete program details, visit **KadmonASSIST.com** or call **1-844-KADMON1 (523-6661)**.

Please see full Prescribing Information at REZUROCK.com.

KAD25000064 07/21