KURA RxKONNECT

Patient Enrollment Form

- **Call 1-844-587-2777 or visit KuraRxKonnect.com**
- **Submit via fax at 1-844-587-2727 or submit online at KuraRxKonnect.com**

Support Requested: ❑ Benefits Investigation (BI) ❑ Prior Authorization (PA) ❑ Commercial Copay Assistance ❑ Temporary Assistance Program (TAP) ❑ Patient Assistance Program (PAP)

1 Patient Information — *Asterisk indicates required information.

First name*_____ Last name*_____
Date of birth* *(MM/DD/YYYY)* ____/____/_____ Gender* ❍ M ❍ F
Address*_____ Apt # _____
City*_____ State* _____ ZIP* _____
Phone*_____ ❍ Mobile Text ❍ Y ❍ N ❍ Home OK to leave detailed message? ❍ Y ❍ N
Legal representative (if any)_____ Phone _____

2 Patient Insurance Information (REQUIRED) — *Please include front and back copies of pharmacy cards or complete this section.*

Prescription insurance name_____ Policy#_____
Rx BIN _____ Rx Group _____ Rx PCN _____
Subscriber name_____ Subscriber DOB ____/____/_____ Insurance phone _____

3 Prescriber Information — *Asterisk indicates required 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 Clinical Diagnosis — *Asterisk indicates required information.

ICD-10* _____ Adult with R/R NPM1-m AML* ❍ Y ❍ N
Other _____ Date of last biomarker test ____/____/_____

5 Prescription (REQUIRED) — *Asterisk indicates required information.

	KOMZIFTI™ (ziftomenib) Pharmacy Prescription: *Rx will be triaged by Kura RxKonnect™ to an in-network pharmacy. See Prescriber Attestation below.*	**Temporary Assistance Program (TAP)**
Strength*	200-mg capsule	200-mg capsule
Prescribing directions	❑ Take 3 capsules daily by mouth fasted with water at least 1 hour before or 2 hours after a meal	❑ Take 3 capsules daily by mouth fasted with water at least 1 hour before or 2 hours after a meal
Other directions		
Quantity*	❑ 30 day supply (90 capsules)	❑ 15 day supply (45 capsules)
Refills*		Up to 3

❑ I authorize the dispensing of a limited supply of KOMZIFTI™ (ziftomenib) as indicated on this form to my patient until insurance coverage is approved. I authorize Kura RxKonnect to forward this prescription to the pharmacy dispensing free product under the Kura RxKonnect TAP Program to the patient named on this form. I agree to assist in efforts to secure access to KOMZIFTI™ (ziftomenib) for my patient. *For full eligibility criteria of the Kura RxKonnect TAP Program, please contact Kura RxKonnect Patient Support.*

Concurrent medications:

❑ NKDA ❑ Food/drug allergies:

Specialty Pharmacy: ❑ Biologics ❑ Onco360 ❑ Other: Medically Integrated Dispensary (MID)

MID contact name: MID phone:

6 Prescriber Attestation — *Asterisk indicates required information.

By signing this Prescriber Attestation Form (Form), I am attesting to the following:

(A) I have prescribed the medication listed above (Medication) based on my independent professional judgment of medical necessity for the above-named patient (Patient) and I will supervise the Patient's medical treatment. Further, I authorize the Program to provide the Medication for the Patient, based upon my medical order and within Program requirements.

(B) By completing and transmitting this Form, I am certifying that I have received, where and as required by law, authorization from the Patient or the Patient's authorized representative to release the Patient's identity and other protected health information (as defined by the Health Insurance Portability and Accountability Act [HIPAA]) to the Kura RxKonnect Patient Support Program (Program), the Program's affiliates, administrator(s), and their respective agents and service providers, for the purpose of securing access to the Medication, and related purposes;

(C) I will not seek reimbursement for free products provided to the Patient from the Program;

(D) I understand that Kura Oncology reserves the right to modify or discontinue the Program at any time and to verify the accuracy of information submitted;

(E) If the Patient is insured, I understand that the Program does not provide free drug in the instance of an administrative error or a coverage restriction, such as a step edit. For certain products where the step edit may not be medically appropriate, as confirmed by me, the Program may consider support following 2 levels of unsuccessful appeals;

(F) If I am in a state with electronic prescription requirements, such as New York, prescriptions must be submitted via e-prescription directly to the pharmacy along with this Form; and

(G) All information provided in this Form is complete and accurate to the best of my knowledge.

Prescriber Signature (REQUIRED)

SIGN HERE _____ ____/____/____ SIGN HERE _____ ____/____/____

Prescriber signature*: Dispense as written **Date*** **Prescriber signature: Substitution permitted** **Date**

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.

Please visit KOMZIFTI.com for full Prescribing Information, including Boxed WARNING and Medication Guide.

KURA RxKONNECT

Patient Enrollment Form

- Call 1-844-587-2777 or visit KuraRxKonnect.com
- Submit via fax at 1-844-587-2727 or submit online at KuraRxKonnect.com

*Asterisk indicates required information.

First name*_____ Last name*_____

Date of birth* *(MM/DD/YYYY)* ____/____/_____

Address*_____ Apt # _____

City*_____ State* _____ ZIP* _____

7 Patient Signatures — *Asterisk indicates required information.*

My signature below certifies that I have read, understand, and agree to the Patient Assistance Program Application Certification in section 8. (REQUIRED for Kura RxKonnect™ Patient Assistance Program)

SIGN HERE Patient or Authorized Representative signature _____ Date* **(REQUIRED IF SIGNED)** ____/____/_____

Print Authorized Representative: First name_____ Last name _____

Relationship to patient _____ Representative phone _____

If applying for Patient Assistance Program: Gross Household Income _____ Number of people in household _____

My signature below certifies that I have read, understand, and agree to the Health Insurance Portability and Accountability Act Patient Authorization in section 9.

SIGN HERE Patient or Authorized Representative signature _____ Date* **(REQUIRED IF SIGNED)** ____/____/_____

Print Authorized Representative: First name_____ Last name _____

Relationship to patient _____ Representative phone _____

8 Patient Assistance Program Application Certification

Patient Assistance Program Certifications

To be considered for Kura's Patient Assistance Program ("PAP") I must:

- Meet income criteria set by Kura
- Be uninsured or rendered uninsured
- Be prescribed a Kura product for a medically necessary treatment
- Be a US resident

I authorize Kura to verify my eligibility for the Kura 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 Kura 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 understand that Kura 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 my participation in the PAP is dependent on my ability to meet the eligibility criteria for the program as determined by Kura. Kura 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, among other names) may require 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 Kura products. Patients with insurance plans that otherwise deny, restrict, eliminate, delay, alter, or withhold 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 the Kura PAP. I agree to inform Kura 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 insurance plan, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale. If approved for the PAP I will not seek to have the value of any medication provided to me under this PAP 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 PAP. I will notify the PAP if my insurance or financial situation changes. The PAP may be changed or discontinued without notice.

Gross household income is the total income before income tax deductions from all people living in your household. Gross income refers not only to the salaries and benefits received but also includes, and is not limited to, the receipts from any personal business, investments, dividends and other income. If proof of income is needed, some acceptable forms may include: federal tax return, Social Security benefit statement, one month's worth of paycheck stubs or unemployment or disability statement.

I understand that I do not have to sign this certification, but I will not be able to enroll in the PAP if I do not sign.

❍ If approved for PAP, by choosing this option, I authorize Kura RxKonnect to share my name, phone number, diagnosis and fact that I am participating in PAP with Kura's designated research vendor so the vendor may contact me directly to administer surveys on Kura's behalf. I understand participation in the research surveys is voluntary and saying no (or not responding) will not affect my medical care, insurance status, or access to support services.

❍ I do not authorize Kura RxKonnect to share my name, phone number, diagnosis or fact that I am participating in PAP with Kura's designated research vendor.

9 Health Insurance Portability and Accountability Act Patient Authorization

Health Insurance Portability and Accountability Act ("HIPAA") Patient Authorization ("Authorization"):

What you are agreeing to provide and who may see it:

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 (together, my "Protected Health Information" or "PHI"), to Kura Oncology, Inc., the Kura RxKonnect™ Patient Support Program, and their respective partners, affiliates, contractors, and agents (together, "Kura").

The purposes my Healthcare Providers may share my PHI with Kura include:

- Working with my health insurance plan to understand or verify coverage for Kura products through Benefits Investigation
- Applying for the Kura Patient Assistance Program ("PAP") to receive Kura products at no cost
- Determining my eligibility for and facilitating enrollment into financial assistance services if I'm eligible, including the Kura PAP, copay assistance and other programs, foundations, or alternative sources of funding or coverage that may be available to provide assistance with the costs of Kura products
- 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 Kura products through prior authorization for coverage and assistance with appeals of denied claims for coverage
- Providing me with treatment reminders and educational materials and information about Kura products

Authorization:

By signing this Authorization, I acknowledge and agree for my Healthcare Providers, Health Insurers and Specialty Pharmacies to use and/or disclose my PHI to Kura for the purpose of delivering support to access Kura product(s) as prescribed by my Healthcare Provider.

Once disclosed to Kura, my PHI released under this Authorization may no longer be protected by state and federal law, including HIPAA. However, Kura will only use and share my PHI for the purposes stated on this Authorization or as otherwise permitted by law. For more information on Kura's privacy practices, I understand that I can learn more by visiting https://kuraoncology.com/privacy-policy.

I understand that:

- I do not have to sign this Authorization, but I will not be able to enroll in the Kura RxKonnect Patient Support Program, and the Kura RxKonnect Patient Support Program may not be able to provide assistance to me without it. A decision by me not to sign this Authorization will not affect my ability to obtain medical treatment, payment for treatment, insurance coverage, or access to health benefits.
- My pharmacy may receive payment or other remuneration for disclosing my PHI and distributing marketing material pursuant to this Authorization.
- This Authorization is valid for 18 months from the date I sign, or (if earlier) 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: Kura RxKonnect Patient Support, 13410 Eastpoint Centre Drive, Louisville, KY 40223. If I revoke this Authorization, I will no longer be eligible for the services described. My revocation will not impact uses and disclosures of my PHI that have already occurred in reliance on this Authorization.
- I have a right to receive a copy of this Authorization.

KURA® ONCOLOGY

US-KO539-2500074 08/25