KURA RxKONNECT

Patient Authorization 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* _____

1 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 2. (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 3.

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

Print Authorized Representative: First name_____ Last name _____

Relationship to patient _____ Representative phone _____

2 Patient Assistance Program Application Certification

Patient Assistance Program Certifications

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

- Meet eligibility 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.

KURA RxKONNECT

Patient Authorization Form

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

3 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-KO539-2500105 09/25