G1 to One™ ENROLLMENT FORM FOR COSELA™ (trilaciclib)

Fax the completed three-page enrollment form to 1-833-FAX-G121 (1-833-329-4121)

Please check for the form of patient support being requested:

- ◯ Coverage Support (Benefits Investigation, Prior Authorization Assistance, and/or Appeals Support)
- ◯ Financial Assistance (Co-pay Assistance, Patient Assistance Program)

1. PATIENT INFORMATION

Patient First Name	Patient Last Name	Gender	Date of Birth
		◯ Male ◯ Female	
Height (in)	**Weight (lbs)**	**Street Address**	**City**
State	**ZIP Code**	**Phone #**	**Preferred Language**
Alt. Contact First Name	**Alt. Contact Last Name**	**Alt. Contact Relationship**	**Alt. Contact Phone #**

2. PRESCRIBER/TREATMENT SETTING (*REQUIRED FIELDS)

Prescriber First Name*	Prescriber Last Name*	State Where Licensed*	State License #*
Prescriber Type	**NPI #***	**Tax ID #***	**PTAN #***
Treatment Setting/Billing Entity	**Treatment Setting Address***	**City***	**State***
◯ Infusion Clinic/ Physician Office			
◯ Hospital Outpatient	**ZIP Code***	**Primary Contact Name**	**Title/Role**
◯ Hospital Inpatient			
	Primary Phone #	**Primary Fax #**	**Primary Email**

3. INSURANCE INFORMATION

◯ Medicare ◯ Medicaid ◯ Commercial/Private ◯ Other

Please attach a copy of both sides of the patient's insurance card.

Primary Insurance	Policy ID #	Group #	Phone #
Subscriber First Name	**Subscriber Last Name**	**Subscriber Date of Birth**	**Patient Relationship to Subscriber**
Secondary Insurance	**Policy ID #**	**Group #**	**Phone #**
Subscriber First Name	**Subscriber Last Name**	**Subscriber Date of Birth**	**Patient Relationship to Subscriber**

Call us at **1-833-G1toOne (1-833-418-6663)**
Monday–Friday (8 AM to 8 PM ET)

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Email us at **Enroll@G1toOne.com**

Visit us at **www.G1toOne.com**

4. CLINICAL INFORMATION (*REQUIRED FIELDS)

Primary Diagnosis ICD-10 Code*

Diagnosis of Small Cell Lung Cancer*

◯ Yes ◯ No

Treatment plan includes platinum/etoposide-containing regimen or topotecan-containing regimen*

◯ Yes ◯ No

Target Start Date*

5. PRESCRIPTION INFORMATION FOR PATIENT ASSISTANCE PROGRAM ONLY

Please complete the embedded prescription if you are seeking support from the G1 Patient Assistance Program (PAP) ONLY for patients who are uninsured or in financial need (for rules, call 1-833-418-6663). Alternatively, please attach a separate prescription if this section does not comply with your state's prescription law.

Medication: COSELA™ (trilaciclib) for injection, 300 mg per vial Route of Administration: IVPB

Instructions: Administer as a 30-minute intravenous infusion no more than 4 hours prior to chemotherapy on each day chemotherapy is administered.

BSA ____ m^2 Dosing: 240 mg/m^2 Dose ____ mg Days: ◯ 1–3 ◯ 1–5 ◯ Other ____ Total Vials per Cycle ____ Refills ____

Please list or attach a current list of medications

Known Drug Allergies

I authorize G1 Therapeutics, Inc. and the designated non-commercial pharmacy to dispense COSELA directly to the Treatment Setting address as part of the Patient Assistance Program.

Prescriber Name (Print) Signature (No Stamps) Date

6. PREFERRED SHIPPING LOCATION (IF DIFFERENT FROM TREATMENT SETTING ADDRESS)

Name Street Address City State ZIP Code

7. FINANCIAL ASSISTANCE

This section should only be completed for financial assistance or enrollment into the Patient Assistance Program (PAP). Patient financial information is required for financial assistance.

Annual Gross Household Income

$

Number of Persons in Household

8. REQUIRED: HEALTHCARE PROFESSIONAL CONSENT

G1 Therapeutics, Inc. and its contractors and agents (together "G1"), will use the information you provide to administer and improve the G1 to One Patient Support Program (the "Program"). By signing below, you represent, covenant, and certify as follows:

(i) My above referenced patient has provided all required written authorization(s), including HIPAA 164.508 and other federal or state laws to release to G1 and the Program all patient information needed for this application, including without limitation financial and personally identifiable information in order to (1) conduct coverage support services for COSELA and (2) determine eligibility and enroll patient for financial assistance; (ii) all of the information provided in this application is complete and accurate; (iii) COSELA was prescribed based on my independent medical judgment or the independent medical judgment of another healthcare professional in my office; (iv) I understand and have explained to my patient that G1 may modify or terminate the Program at any time without notice and that completion of this application does not guarantee enrollment in any particular part of the Program; (v) I understand and agree that any medications supplied by G1 under the Program are for use of the named patient only and shall not be sold, traded, bartered, transferred, returned for credit, submitted to any third-party payor (private or government) for reimbursement, or counted toward the patient's Medicare Part D out-of-pocket costs; (vi) I have not received nor will I seek or accept payment from my patient for any co-insurance amount paid for by the Program; (vii) I understand that I am under no obligation to prescribe any G1 drug and I have not received and will not receive any benefit from G1 for prescribing a G1 drug; (viii) if I become aware of any errors in the information provided, I will promptly notify G1 of those errors; and (ix) I agree to be contacted by telephone, fax, email, or other means by G1 and its contractors and agents for purposes of administration of the Program for my patient.

Healthcare Professional Name (Print) Signature (No Stamps) Date

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COSELA™
trilaciclib for injection 300 mg

9. REQUIRED: PATIENT CONSENT

By signing below, I am enrolling in the G1 to One Patient Support Program (the "Program"). I authorize G1 Therapeutics, Inc. and its affiliates, business partners, vendors, and other agents (collectively, "business partners" and together with G1 Therapeutics, Inc. "G1") to provide me with services for which I am eligible under the Program. Such services may include medication and adherence communications and support, insurance coverage and financial assistance support, disease and medication education, and other support services offered now or in the future. I agree to be contacted by telephone, fax, email or other means by G1 to determine my Program eligibility or otherwise with respect to the administration of the Program. As part of the Program offerings, I agree to my enrollment in the copay assistance program if I am eligible. If I am applying for patient assistance (no-cost medication), I authorize the Program to use my personal information to obtain a report on my individual credit history from consumer reporting agencies and use that report and other information collected from public and other sources to verify the information on this form and estimate my income to decide if I am eligible for free medication. Upon request, the Program will provide me the name and address of the consumer reporting agency that provides the consumer report. I understand that free product programs (Patient Assistance Program or other temporary supply offerings) are subject to eligibility criteria and that completing this application does not ensure that I will qualify for these programs or that G1 will not discontinue the Program, or any aspect of it, at any time. I certify that all the information provided in this application, including my household income and the members of my household, is complete and accurate. I understand that program assistance will terminate if the program becomes aware of any fraud and that I may be subject to other penalties of law. If I receive free product, I will not seek reimbursement for it from any insurer, health plan, or government program. If I receive free product, I will not seek to have this prescription, or any associated cost counted as part of my out-of-pocket cost for prescription drugs.

California Consumer Privacy Act

If I reside in California, I also have the right to request that G1 Therapeutics, Inc. and/or G1 to One Patient Support Program delete my personal information, although deletion is not required under certain circumstances. To cancel or request deletion, I must send a written notice to G1 Therapeutics, Inc. or G1 to One Patient Support Program. I know that if I do so that G1 Therapeutics, Inc. or G1 to One Patient Support Program will no longer be able to assist me with access to G1 Therapeutics, Inc. or G1 to One Patient Support Program services.

Patient Name (Please Print) _____ Patient Signature _____ Date _____

If signed by a patient representative:

Patient Representative Name (Please Print) _____ Patient Representatitve Signature _____

Date _____ Phone # _____

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