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

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

1. PATIENT INFORMATION

Patient First Name

Patient Last Name

Gender

◯ Male ◯ Female

Date of Birth

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/FACILITY SETTING (*REQUIRED FIELDS)

Prescriber First Name*

Prescriber Last Name*

State Where Licensed*

State License #*

Prescriber Type

NPI #*

Tax ID #*

PTAN #*

Facility Setting/Billing Entity

◯ Infusion Clinic/ Physician Office

◯ Hospital Outpatient

◯ Hospital Inpatient

Facility Setting Address*

City*

State*

ZIP Code*

Primary Contact Name

Title/Role

Primary Phone #

Primary Fax #

Primary Email

Facility Name

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)**

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COSELA® trilaciclib for injection 300 mg

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. 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

6. PRESCRIPTION INFORMATION FOR ELIGIBLE UNINSURED OR UNDERINSURED PATIENTS

Please complete the embedded prescription if you are seeking support from 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 Pharmacosmos Therapeutics Inc. and the designated non-commercial pharmacy to dispense COSELA directly to the Facility Setting address as part of the Patient Assistance Program.

Prescriber Name (Print) **Signature (No Stamps)** **Date**

7. PREFERRED SHIPPING LOCATION (IF DIFFERENT FROM Facility Setting ADDRESS)

Name | Street Address | City | State | ZIP Code

8. PRESCRIBER CERTIFICATION AND AUTHORIZATION

I certify that, to the full extent required by applicable law, I have obtained written permission from my patient named above (or from the patient's legal representative) to release to the patient support program, G1 to One ("the Program"), the patient's personal health information, both as provided on this form and such other personal health information as the Program may need (1) to perform a preliminary verification of the patient's insurance coverage for COSELA, (2) to assess the patient's eligibility for participation in the Program, (3) to enroll the patient in the Program, (4) to provide reimbursement support and other services to the patient in connection with the patient's prescription(s) on this form, and (5) for the other purposes identified on the Patient Authorization for Use and Disclosure of Personal Health Information. I authorize and appoint the Program to convey on my behalf the prescription(s) I signed for the patient and the other information included on this form to the dispensing pharmacy. I agree that the Program may contact me, including without limitation via email, fax, and telephone, to seek additional information relating to the Program, COSELA, or the prescription(s) contained on this form. I understand that any COSELA 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 products to any third-party payor, including a federal health care program. If I am or become in possession of such product, I will not resell or attempt to resell the product.

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

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9. HIPAA RELEASE PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I authorize my healthcare providers (including pharmacy providers) and health plans to disclose my personal health information related to this prescription form or my use or potential use of COSELA®, including my personal contact information on this form (collectively, my "Information"), to the patient support program called G1 to One (the "Program") so that the Program may use and disclose the Information in order to: (1) establish my benefit eligibility; (2) communicate with my healthcare providers and health plans about my benefit and coverage status and my medical care; (3) provide support services, including facilitating the provision of COSELA to me, as well as any information or materials related to such services or Pharmacosmos products, including promotional or educational communications; (4) evaluate the effectiveness of COSELA support programs; (5) report safety information, including in communications with the US Food and Drug Administration and other government authorities; (6) contact me regarding this prescription form or my use or potential use of COSELA and provide me with related patient support communications, including through messages left for me that disclose that I take or may take COSELA; and (7) allow Pharmacosmos to analyze the usage patterns and the effectiveness of Pharmacosmos products, services, and programs and help develop new products, services, and programs, and for other Pharmacosmos general business and administrative purposes. I understand that my provider(s) may receive remuneration in exchange for the provision of my Information as authorized above, and that once my Information has been disclosed to the Program, federal privacy law may no longer restrict its use or disclosure and that it may be redisclosed to others. I also understand, however, that the Program plans to use and disclose my Information only for the purposes described above or as required by law. I understand that if I refuse to sign this Authorization, that will not affect my right to treatment or payment benefits for health care. I also understand that if I sign, I may later withdraw this Authorization by sending written notice of my withdrawal from the Program to G1 to One, PO Box 5757, Louisville, KY 40255, and that such withdrawal will not affect any uses and disclosures of my Information prior to the Program's receipt of the notice. I am entitled to a copy of this signed Authorization, which expires 10 years from the date it is signed by me or such timeframe as allowed by law. Please note documentation proving Power of Attorney may be required.

Patient Name (Print)		Patient Signature		Date	

AUTHORIZED REPRESENTATIVE CONSENT (Optional)
I further authorize G1 to One to discuss my treatment with the following authorized representative(s).

Authorized Representative (1) Name (Print)		Relationship to Patient:	☐ Spouse	☐ Child	Other: ☐
Authorized Representative (2) Name (Print)		Relationship to Patient:	☐ Spouse	☐ Child	Other: ☐

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PHARMACOSMOS THERAPEUTICS

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