

Select all that apply:

- For benefits verification
- For Patient Assistance Program
- For commercially eligible patients, Copay Assistance Program enrollment (available through separate enrollment at COSELAcopy.com)

Fax the completed 3-page enrollment form to 1-833-329-4121

1 PATIENT INFORMATION (*REQUIRED FIELDS)

Patient First Name*		Patient Last Name*		Gender*		Date of Birth*	
<input type="text"/>		<input type="text"/>		<input type="radio"/> Male <input type="radio"/> Female		<input type="text"/>	
Height (in)*	Weight (lbs)*	Street Address				City	
<input type="text"/>	<input type="text"/>	<input type="text"/>				<input type="text"/>	
State		ZIP Code		Phone #*		Preferred Language	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
Alt. Contact First Name		Alt. Contact Last Name		Alt. Contact Relationship		Alt. Contact Phone #	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	

2 PRESCRIBER/FACILITY SETTING (*REQUIRED FIELDS)

Prescriber First Name*		Prescriber Last Name*		State Where Licensed*		State License #*			
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>			
Prescriber Type		NPI #*		Tax ID #*		PTAN #*			
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>			
Facility Setting/Billing Entity		Facility Setting Address*				City*		State*	
<input type="radio"/> Infusion Clinic/Physician Office <input type="radio"/> Hospital Outpatient <input type="radio"/> Hospital Inpatient		<input type="text"/>				<input type="text"/>		<input type="text"/>	
		ZIP Code*		Primary Contact Name		Title/Role			
		<input type="text"/>		<input type="text"/>		<input type="text"/>			
		Primary Phone #		Primary Fax #		Primary Email			
		<input type="text"/>		<input type="text"/>		<input type="text"/>			
Facility Name									
<input type="text"/>									

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 #	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
Subscriber First Name		Subscriber Last Name		Subscriber Date of Birth		Patient Relationship to Subscriber	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
Secondary Insurance		Policy ID #		Group #		Phone #	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
Subscriber First Name		Subscriber Last Name		Subscriber Date of Birth		Patient Relationship to Subscriber	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	



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 COSELA Cares™ 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: Intravenous piggyback

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

BSA m² Dosing: 240 mg/m² 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 HEALTHCARE PROFESSIONAL CERTIFICATION AND AUTHORIZATION

By completing and transmitting this form, I am certifying that I have received from our patient and have on file the patient's HIPAA consent and all other necessary permissions from my patient authorizing the release of the patient's identification and insurance information to Pharmacosmos Therapeutics Inc., its affiliates, its program administrator, and their respective agents and service providers for them to use in providing the patient with benefit verification and support services as described herein. I certify that I have read and agree to the terms, conditions, and authorizations listed on page 3 and that all information provided in this Enrollment Form is complete and accurate to the best of my knowledge.

Healthcare Professional Name (Print)

Signature (No Stamps)

Date



Visit us at

www.cosela.com/patient-support



Call us at

1-833-418-6663



Fax us the completed

enrollment form at

1-833-329-4121



Email us at

enroll@COSELAcares.com

COSELA[®]
trilaciclib for injection
300 mg

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® (trilaciclib), including my personal contact information on this form (collectively, my "Information"), to the patient support program called COSELA Cares™ ("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 healthcare. I also understand that if I sign, I may later withdraw this Authorization by sending written notice of my withdrawal from the Program to COSELA Cares, PO Box 2355, Morristown, NJ 07962, 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 COSELA Cares 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:

10 DISCLAIMERS

COSELA Cares™ provides informational support services only, including: benefits investigation guidance, payor-specific information, financial assistance resources, and reimbursement education. The program does not provide administrative services, submit claims, or guarantee insurance coverage, reimbursement, or product access. Eligibility requirements and program restrictions apply, and all coverage and reimbursement decisions are made solely by third-party payors. Any product provided through the Patient Assistance Program is supplied on a complimentary basis, and no claims for payment or reimbursement may be submitted to any third-party payor, including federal healthcare programs. Providers remain responsible for all coding, billing, and claim submission activities.



Visit us at
www.cosela.com/patient-support



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enrollment form at
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Email us at
enroll@COSELAcares.com