ArrayACTS™
Access | Coverage | Treatment Support

By submitting this form, the HCP is requesting benefit investigation, prior authorization, and/or appeals support on behalf of his/her patient. If applicable, please screen the patient for eligibility for the following services:

- ☐ Co-pay Program (Commercially-insured patients)
- ☐ Alternate Funding Options
- ☐ Array Patient Assistance Program (PAP)
- ☐ Array ACTS™ Patient Adherence Support

PRESCRIPTION AND ENROLLMENT FORM

STEP 1: PATIENT INFORMATION

First Name: ____________ Last Name: ____________

Gender: ☐ Male ☐ Female Date of Birth: ____/____/______

Address: ____________

City: ____________ State: ______ ZIP: ______

Home Phone: ____________ Cell Phone: ____________

Preferred Phone: ☐ Home ☐ Cell Best Time to Call: ☐ AM ☐ PM

Email: ____________

Caregiver/Alternate Contact Name: ____________

Relation to Patient: ____________ Contact Phone: ____________

Patient has received one of the following:

☐ Voucher Date Received: ____________

☐ Sample Date Received: ____________

☐ Does not apply

STEP 2: INSURANCE INFORMATION

(Complete or attach a copy of both sides of the patient's insurance card.)

☐ Patient has no insurance/Enroll in PAP (provide last 4 digits of SSN): ______

Medicare Eligible? ☐ Yes ☐ No

Primary Insurance: ____________

ID #: ________ Group #: ________ Phone: ________

Subscriber Name: ____________ DOB: ____/____/______

Subscriber Relationship to Patient: ____________

Secondary Insurance: ____________

ID #: ________ Group #: ________ Phone: ________

Subscriber Name: ____________ DOB: ____/____/______

Subscriber Relationship to Patient: ____________

Pharmacy Plan Name: ____________

Policy #: ________ Group #: ________ Phone: ________

Employer: ________ Rx BIN: ________ Rx PCN: ________

STEP 3: PATIENT SIGNATURE—Please see pages 2 and 3 for patient authorization for program(s) enrollment

STEP 4: PRESCRIBER INFORMATION

Prescriber Name (First and Last): ____________

Facility Name: ____________

Address: ____________

City: ____________ State: ______ ZIP: ______

Office Contact: ____________

Phone: ____________ Fax: ____________

Contact Email: ____________

NPI #: ____________ State License #: ____________

Tax ID #: ____________ DEA #: ____________

STEP 5: DISPENSING PHARMACY (select preferred pharmacy)

☐ Avella Specialty Pharmacy

☐ Biologics, Inc.

☐ Diplomat Pharmacy, Inc.

☐ ONCO360 Oncology Pharmacy

☐ US Bioservices

☐ In-office Dispensing Pharmacy Name: ____________

Pharmacy Phone: ____________ Fax: ____________

(Prescription may be triaged to another pharmacy based on payor requirements.)

STEP 6: CLINICAL INFORMATION

Primary Diagnosis Code (ICD-10): ____________ Primary Diagnosis Description: ____________

BRAF Unresectable/Metastatic Melanoma Mutations: ☐ V600K ☐ V600E ☐ Other ____________

Secondary Diagnosis Code (ICD-10): ____________ Secondary Diagnosis Description: ____________

STEP 7: PRESCRIPTION INFORMATION

Rx: BRAFTOVI™ (encorafenib) capsules

Dosing (select one)

☐ 450 mg once daily ☐ Other: ____________

Day(s) Supply (select one)

☐ 30-day supply ☐ Other: ____________

SIG: ____________

# of Refills: ____________

Rx: MEKTOVI® (binimetinib) tablets

Dosing (select one)

☐ 45 mg twice daily ☐ Other: ____________

Day(s) Supply (select one)

☐ 30-day supply ☐ Other: ____________

SIG: ____________

# of Refills: ____________

For any questions, please call 1-866-ARRAYCS (277-2927).
Please fax completed Prescription and Enrollment Form to Array ACTS™ at 1-877-299-9226.

STEP 8: PRESCRIBER AUTHORIZATION AND CONSENT—READ AND SIGN STATEMENT OF MEDICAL NECESSITY

Physician Certification: By signing this Prescription and Enrollment Form, I certify that the information provided is complete and accurate to the best of my knowledge. I also certify that I have prescribed BRAFTOVI™ (encorafenib) capsules and MEKTOVI® (binimetinib) tablets based on my professional judgment of medical necessity, and that I will supervise the patient's medical treatment. I have obtained written authorization from the identified patient to disclose the patient's Protected Health Information (PHI as defined by HIPAA) related to the patient's medical condition, therapy, and prescription medications, and the information disclosed in this enrollment form. I authorize the release of medical and/or other patient information relating to BRAFTOVI and MEKTOVI therapy to agents and service providers of Array BioPharma, Inc. to use and disclose as necessary for fulfillment of the prescription and to furnish any information on this form to the insurer of the above-named patient for the purpose of verifying benefit eligibility, coordinating and dispensing of BRAFTOVI and MEKTOVI, and obtaining coverage authorization.

Prescriber Signature: ______________________________ **Date:** ______________

(Original signature required—no stamps) (Dispense as written)

Array Patient Assistance Program Certification: To the best of my knowledge, the patient identified on this form does not have prescription drug insurance coverage (other than Medicare Part D, if applicable) for the medication(s) on the attached prescription. I will immediately notify the Array Patient Assistance Program if I become aware that this patient's insurance or income status has changed. I certify that I will not seek reimbursement for any medication dispensed to the patient through the Array Patient Assistance Program from any insurer, health plan, or government program, including Medicare and Medicaid. I understand that: (1) the Array Patient Assistance Program reserves the right to verify all information provided by the healthcare professional, suspend participation where inadequate information is provided, and limit enrollment based on available resources; (2) the Array Patient Assistance Program reserves the right to modify or terminate this program, or recall or discontinue medications, at any time without notice; (3) the Array Patient Assistance Program, and its agents and assignees, are relying on the certifications in this form.

Prescriber Signature: ______________________________ **Date:** ______________

PATIENT AUTHORIZATION

Patient Name (First and Last): ______________________________ **Date of Birth:**_____/____/_______

PATIENT AUTHORIZATION AND CONSENT TERMS:

Patient authorization is required for enrollment into the Array ACTS™ patient support services. Please read and sign the Patient Authorization terms below:

By signing this Authorization, I authorize each of my physicians, pharmacists, including any specialty pharmacy that receives my prescription for BRAFTOVI and MEKTOVI, and other healthcare providers (together, "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my Protected Health Information, including but not limited to medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security Number, insurance plan and/or group numbers (together, "PHI"), to Array BioPharma, Inc, its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Array BioPharma, Inc.") including providers of alternate sources of funding for prescription drug costs, and other service providers supporting access programs for Healthcare Providers and patients to provide me with support related to Array products.

Specifically, I authorize disclosure of my Protected Health Information in order to:

a. Enroll me in, and contact me about, Array ACTS™ Program services, including online support, financial assistance services, co-pay assistance, nurse services, and compliance and persistency services,
b. Verify, investigate, assist with, and coordinate my coverage for BRAFTOVI and MEKTOVI with my Insurers, and
c. Coordinate prescription fulfillment.

☐ **By checking this box, I agree to receive marketing information, offers, and educational materials related to my treatment experience with BRAFTOVI™ (encorafenib) and MEKTOVI® (binimetinib), and to allow the use of my PHI to conduct surveys, data analytics, market research, and other internal business activities.**

I understand that, in cases when an Authorized Personal Representative must sign this Authorization in place of the patient, Array BioPharma, Inc. may use the patient's PHI to contact the Authorized Personal Representative for the purpose of verifying the information in the enrollment form and/or coordinating the provision of benefits that may be available to the patient under the programs, and to disclose PHI to the Authorized Personal Representative solely for the aforementioned purposes.

I understand that pharmacies that ship my medication may be paid to share this information with Array ACTS™ to help provide the offerings requested for me. Once my PHI has been disclosed to Array ACTS™, I understand that federal privacy laws no longer protect the information. However, Array BioPharma agrees to protect my PHI by using and disclosing it only for the purposes described in this Authorization or as permitted by law.

I understand that I may refuse to sign this Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me. I understand that I do not have to agree to receive these services and communications and that I can still receive my prescribed medication without signing this Authorization. If I refuse to sign the Authorization, or revoke my Authorization later, I understand that this means I will not be able to participate or receive assistance from Array ACTS™.

This Authorization will last until three years from the date this form is signed, unless a shorter period is required by law. I understand that I may cancel this Authorization at any time by mailing a request to Array ACTS™ Program, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560; or by calling 866-ARRAYCS (277-2927).

I understand that revoking this Authorization will end further uses and disclosure of my PHI by the parties identified above except to the extent those uses and disclosures have already been made in reliance upon this Authorization as permitted by applicable law. I am entitled to receive a copy of this Authorization.

Patient or Patient's Representative Signature: ______________________________ **Date:** ______________

For any questions, please call 1-866-ARRAYCS (277-2927).
Please fax completed Prescription and Enrollment Form to Array ACTS™ at 1-877-299-9226.

PATIENT ASSISTANCE PROGRAM—PATIENT AUTHORIZATION

Patient Name (First and Last): ______________________________ **Date of Birth:** ____/____/______

PATIENT ASSISTANCE PROGRAM AUTHORIZATION AND CONSENT TERMS:

Patient authorization is required for enrollment into the Array Patient Assistance Program. Please read and sign the patient authorization terms below:

I certify:

1. I do not have any assistance or insurance that would pay for the medication(s) requested by my Healthcare Provider on the attached prescription(s) (other than Medicare Part D, if applicable), nor do I have the ability to pay for the medication(s).
2. I will notify the Array Patient Assistance Program within thirty (30) days if my financial status or health insurance coverage changes.
3. I will not sell, trade, or distribute any products given to me via the Array PAP.
4. I will verify my Patient Assistance Program application status and receipt of the indicated medication(s) upon request by the Array Patient Assistance Program.
5. If I receive free product through the Array Patient Assistance Program, I certify that I will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program, including Medicare and Medicaid.
6. If I am a member of a Medicare Part D plan, I will not seek to have this prescription, or any cost associated with it, counted as part of my True Out-of-Pocket (TrOOP) cost for prescription drugs.
7. All of the information provided in this application, including household income, is complete and accurate.

I understand and agree:

1. That program assistance will terminate if the Array Patient Assistance Program becomes aware of any fraud or if this medication is no longer prescribed for me.
2. That completing this application does not ensure that I will qualify for patient assistance, and that my eligibility to participate in the Array Patient Assistance Program is subject to the decision of Array.
3. That I may be required to provide proof of ineligibility for certain other prescription coverage programs in order to meet the eligibility requirements for the Array Patient Assistance Program.
4. That the Array Patient Assistance Program reserves the right to modify the application form, modify or discontinue this program, or terminate assistance at any time and without notice.
5. That I may choose to opt out of the Array Patient Assistance Program at any time by notifying a representative at 1-866-ARRAYCS (277-2927) or by notifying the program in writing at the address listed above.

Patient or Patient's Representative Signature: ______________________________ **Date:** ______________

PATIENT AUTHORIZATION FOR ELECTRONIC INCOME VERIFICATION

I, the applicant named below, understand that I am providing "written instructions" to Array BioPharma, Inc. and its vendor TrialCard, Inc under the Fair Credit Reporting Act authorizing TrialCard, Inc on behalf of Array BioPharma, Inc. to obtain information from my credit profile or other information from Experian Health. I authorize Array BioPharma, Inc. and its partnered provider TrialCard, Inc to obtain such information solely for the purpose of determining financial qualifications for the Array Patient Assistance Program. I also agree to provide additional financial documentation in a timely manner, if so requested. I understand that I must affirmatively agree to the terms in this notice by signing below in order to proceed in the Array Patient Assistance Program financial screening process.

I understand that I am entitled to a copy of this Authorization upon request. This Authorization shall be valid for two (2) years from the date of the signature of this form (unless a shorter period is prescribed by law). I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to Array ACTS™ Program, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560, but that this cancellation will not apply to any information already used or disclosed through this Authorization.

Patient Authorization for Financial Screening: My signature certifies that I have read and understand the above statements, and agree to the outlined terms.

Patient or Patient's Representative Signature: ______________________________ **Date:** ______________

For any questions, please call 1-866-ARRAYCS (277-2927).
Please fax completed Prescription and Enrollment Form to Array ACTS™ at 1-877-299-9226.

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