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Patient Enrollment Form:
Check all requested support services that apply and note required sections

☐ Insurance Verification ☐ Rapid Start Program ☐ Patient Assistance Program

SECTION 1 PATIENT INFORMATION

Patient Name (First, M.I., Last)	**Date of Birth** (MM/DD/YYYY)	**Primary Language**
Street Address	**Gender** ☐ Male ☐ Female	
City / State / ZIP	**Email**	
Primary Phone (with area code) ☐ Home ☐ Mobile ☐ Work	**Best Time to Call** ☐ AM ☐ PM	
Secondary Phone (with area code) ☐ Home ☐ Mobile ☐ Work	**Best Time to Call** ☐ AM ☐ PM	
Alternate Contact/Caregiver Name	**Alternate Contact/Caregiver Phone** (with area code)	

Has Treatment With ORSERDU Been Started?
☐ Yes Date: _____ ☐ No

MANDATORY FIELDS

Diagnosis Code (ICD-10-CM Code)

ESR1 Positive ☐ Yes ☐ No

ER Positive/HER2 Negative ☐ Yes ☐ No

Prior Therapy
Please verify patient has received prior endocrine therapy:
☐ Yes ☐ No
If yes, please specify: _____

SECTION 2 PRESCRIBER INFORMATION

Physician Name (First, M.I., Last)		
NPI #		
Specialty ☐ Oncologist ☐ Hematologist ☐ Other: _____		
Site/Facility Name		
Street Address		
City / State / ZIP		
Office Contact	**Phone** (with area code)	**Best Time to Call** ☐ AM ☐ PM
Fax	**Office Contact Email**	

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PATIENT NAME (First, M.I., Last) _____ **DATE OF BIRTH** (MM/DD/YYYY) _____

PRESCRIBER NAME _____ **NPI** _____

SECTION 3 INSURANCE INFORMATION Please provide copy of front and back of insurance card

Plan or Policy Type: ☐ Commercial / Employer ☐ Medicare ☐ Medicaid ☐ None

If applicable, has a PA been submitted? ☐ Yes ☐ No **Date PA Submitted** (MM/DD/YYYY) _____

Primary Insurer	**Phone** (with area code)
Policy ID #	**Group #**
Subscriber Name (First, M.I., Last)	**Date of Birth** (MM/DD/YYYY)
Relationship to Subscriber	
Secondary Insurer	**Phone** (with area code)
Policy ID #	**Group #**
Subscriber Name (First, M.I., Last)	
Relationship to Subscriber	
Prescription Card Name	**Prescription Card Phone** (with area code)
Primary Policyholder Name (First, M.I., Last)	**Primary Policyholder Date of Birth** (MM/DD/YYYY)
Relationship to Patient (write "self" if you are the policyholder)	

Member ID	**RxBIN #**	**RxPCN #**	**RxGRP #**

SECTION 4 SPECIALTY PHARMACY*

☐ Onco360 ☐ Biologics ☐ In Office Dispense

Has the prescription been sent directly to the selected pharmacy? ☐ Yes ☐ No

Pharmacy Name	
Phone (with area code)	**Contact**

* Unless the patient requests otherwise or the patient's insurance provider requires the patient to use a specific pharmacy, the prescription will be directed to the authorized pharmacy providing the lowest cost sharing for the patient under the patient's insurance plan.

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PATIENT NAME (First, M.I., Last) _____ **DATE OF BIRTH** (MM/DD/YYYY) _____

PRESCRIBER NAME _____ **NPI** _____

SECTION 5

General Prescription	Rapid Start Prescription
☐ ORSERDU / 345 mg ☐ ORSERDU / 86 mg	☐ ORSERDU / 345 mg 15 day supply
Directions	**Directions**
Quantity	**Quantity**
Refills	**Refills**

Prescriber Signature*

x _____ OR x _____ _____

Prescriber Signature *(Dispense as written)* **Prescriber Signature** *(Substitution permitted)* **Date***

* Prescriber shall comply with applicable state prescribing requirements, such as e-prescribing, state-specific prescription form(s), fax language, etc. Non-compliance with applicable state prescribing requirements could result in additional communications from Stemline Therapeutics or other contractors to the prescriber.

Prescriber Certification and Authorization: By signing below, I certify that: (1) I have made the clinical judgment that the above therapy is medically necessary and appropriate for this patient and will be used only by this patient. I will not use any such Product or prescribe, provide, furnish, or dispense any portion thereof to any other person or patient. If I am or become in possession of such medications, I will not sell, resell, offer for sale, trade, or barter such Products; (2) I have reviewed the current Product prescribing information before prescribing; and (3) to the full extent required by applicable law, I have obtained written permission from the patient named above (or from the patient's legal representative) to release the patient's personal health information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder, as well as other state and/or federally protected personal information) both as provided on this form and such other PHI that Stemline Therapeutics, the contracted dispensing pharmacy, or other contractors may require (a) to perform a preliminary verification of the patient's insurance coverage for the Product and (b) to assess the patient's eligibility for participation in the Stemline Therapeutics program. I authorize and appoint Stemline Therapeutics 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 chosen by or for the patient. I agree that Stemline Therapeutics may contact me, including, without limitation, via email, fax, and telephone to seek additional information relating to Stemline Therapeutics, the Product, or the prescription(s) contained on this form. I further certify that (a) any reimbursement investigation support or assistance provided to patients through Stemline ARC is not made in exchange, directly or indirectly, for any past, present, or future recommendation, prescription, purchase, or use of the above therapy or any other product or service for or from anyone and (b) my decision to prescribe the Product was based solely on my determination of medical necessity as set forth herein. I understand that completing this form does not guarantee that assistance will be provided to my patient.

I understand that any Product 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 Product to any third-party payor, including, without limitation, 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. I agree to comply with the Stemline Therapeutics guidelines and understand that Stemline Therapeutics, at its sole and absolute discretion, reserves the right to modify or discontinue patient support programs, including such programs provided through Stemline Therapeutics, at any time. I certify that the information contained in this form is complete and accurate to the best of my knowledge.

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PATIENT NAME (First, M.I., Last) _____ **DATE OF BIRTH** (MM/DD/YYYY) _____

PRESCRIBER NAME _____ **NPI** _____

SECTION 6 PATIENT ASSISTANCE PROGRAM*

Patient Financial Information	
Current Annual Household Adjusted Gross Income $	**US Resident** ☐ Yes ☐ No
Household Size (including you)	

* Eligibility criteria apply.

Patient Certification: I certify that, as of the date of my signature, the information provided on this form is complete and accurate to the best of my knowledge and that all of the insurance plans and programs through which I obtain health care coverage are listed above or have been provided separately to Stemline Therapeutics. I further certify that I am a legal resident of the United States. In order to qualify to receive free Product through programs offered by or through Stemline, including the Patient Assistance Program (collectively, "Program"), I understand that certain eligibility criteria will apply. I will be ineligible to participate in the Program unless I provide proof of income within 30 days after this form is submitted. I also understand that: (1) Stemline Therapeutics may request documentation from me, my employer, my health care provider, or my insurance company to verify my financial or insurance information; (2) completion of this form and the provision of requested documentation does not guarantee that I will be approved to participate in the Program; (3) any free Product provided to me through the Program is contingent upon my meeting Stemline Therapeutics eligibility criteria; (4) if I am eligible to participate in the Program, there is no purchase requirement associated with such assistance; and (5) Stemline Therapeutics reserves the right to make an independent determination of my financial need. Stemline Therapeutics reserves the right at any time, and without notice, to modify or discontinue Stemline Therapeutics and any assistance provided to me. I will not submit or cause to be submitted any claims for payment or reimbursement from any third-party payer, including any federal health care program such as Medicare or Medicaid, or any private or other insurance plan, or from any other person or entity for a free supply of the Product supplied under this Program, regardless of whether a payer subsequently determines that it will cover such supply of ORSERDU. I will not sell, trade, or distribute or otherwise transfer the Product supplied under the Program. The cost of the Product provided under the Program will not count toward any Medicare true out-of-pocket ("TrOOP") costs. I agree to notify Stemline Therapeutics if: (1) I obtain coverage through another source (federal, state, or private program), (2) I no longer meet the income criteria for the Program, or (3) I find any errors in this application form. If I am approved, as required by my insurance or other benefit provider, I will notify such provider of my receipt of any free Product received through the Program. I understand that I must re-apply for the Program annually and there is no guarantee I will qualify at this time or in future periods.

Signature of Patient or Legal Representative†

Sign and Date Here

_____ Date _____

Name of Patient or Legal Representative _____

(If signed by representative, explain authority to act on behalf of patient and relationship)

†By signing on behalf of the patient, as representative or guardian, I attest that I am legally able to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such representative's or guardian's authority to act for the patient, such as power of attorney or legal court order, may be requested.

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PATIENT NAME (First, M.I., Last) _____ **DATE OF BIRTH** (MM/DD/YYYY) _____

PRESCRIBER NAME _____ **NPI** _____

SECTION 7 PATIENT AUTHORIZATION For release of information to Stemline Therapeutics

I authorize my health care providers (including pharmacy providers) and health plans to release or disclose, in electronic or other form, my personal health information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder, as well as other state and/or federally protected personal information), including my personal contact and other information on this form, all medical records and financial information, with respect to my treatment, my eligibility for assistance, the coordination of my treatment, and receipt of my medication (collectively, my "Information") to Stemline Therapeutics, including any third parties engaged to assist Stemline Therapeutics in administration, for the purposes of: (1) establishing my benefit eligibility for Elacestrant (the "Product"); (2) communicating with my health care providers and health plans about my eligibility for support through Stemline Therapeutics, my benefit and coverage status, and/or my medical care; (3) providing support through Stemline Therapeutics, including facilitating the provision of the Product to me, as well as any information or materials related to such support or Stemline Therapeutics products, including promotional or educational communications; (4) evaluating the effectiveness of Stemline Therapeutics; (5) reporting safety information, including communications with the U.S. Food and Drug Administration and other government authorities; (6) contacting me regarding this enrollment form or my use or potential use of the Product and providing me with related patient support communications, including through messages left for me that disclose that I take or may take the Product; (7) administering, evaluating, and improving Stemline Therapeutics, including by analyzing the usage patterns and the effectiveness of Stemline products, services, and programs and helping to develop new products, services, and programs, and for other Stemline general business and administrative purposes; and (8) disclosing my information to third parties if required by law.

I understand that my pharmacy provider(s) may receive remuneration for the use or disclosure of my Information, as authorized above, and that, once my Information has been disclosed to Stemline Therapeutics, my Information may not be subject to all of the protections and safeguards provided by HIPAA or other federal and state privacy laws. I also understand, however, that Stemline Therapeutics plans to use and disclose my Information only for the purposes described above or as required by law.

I understand that I may refuse to sign this Authorization and that my refusal to sign this Authorization will not affect my right to treatment or payment of benefits for health care. I understand that if I refuse to sign, I will not be eligible to receive assistance through Stemline Therapeutics. I may later withdraw this Authorization by sending written notice of my withdrawal from Stemline Therapeutics to PO Box 5490, Louisville, KY 40255. Withdrawal of this Authorization will end further uses and disclosures of my Information by Stemline Therapeutics, except to the extent those uses and disclosures have been made in reliance on this Authorization and as permitted by applicable law. I am entitled to receive a copy of this signed Authorization, which expires 5 years after the date it is signed by me unless otherwise specified by law or revoked earlier in writing.

Signature of Patient or Legal Representative*

Sign and Date Here

_____ **Date** _____

Name of Patient or Legal Representative _____

(If signed by representative, explain authority to act on behalf of patient and relationship)

* By signing on behalf of the patient, as representative or guardian, I attest that I am legally able to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient may be requested such as power of attorney or legal court order.