Scholar Rock SUPPORTS™

Scholar Rock Supports™ Enrollment Form

Scholar Rock Supports offers coordinated resources and personalized support throughout the patient journey. Once enrolled, patients will be supported by an experienced and dedicated team, including an **Rx Onboarding and Care Coordinator (ROCC)** who helps guide the experience and coordinates the right resources based on the patient's needs—including education, insurance support, infusion logistics and more.

FOR HEALTHCARE PROVIDERS

Follow the instructions below to enroll your patient in Scholar Rock Supports and start treatment with ISEMBYLD™ (apitegromab-mstn).

All information, including an original prescriber signature and date, must be completed for the patient to receive support.

Please complete the following:

1. Complete the **healthcare provider** sections on pages **2** and **3**. Please be sure to sign the form before submission
2. ISEMBYLD is available through Accredo, CarePartners Pharmacy/Seven Bridges Specialty, CVS Specialty, Orsini and CuraScript SD. Please indicate preferred acquisition method and, if relevant, your specialty pharmacy preference on page **3**
3. Obtain the patient or patient legal representative signatures either on this form (page **4**) or electronically via the e-Consent Portal at **srrksupportsconsent.com**
4. Submit the completed form and any supporting documentation (copies of insurance cards, relevant chart notes, etc.) by fax to **877-219-0016**

HOW TO SUBMIT THIS FORM

This form must be signed and dated by a prescriber.
Once completed, please submit by fax to **877-219-0016**.

FOR PATIENT OR PATIENT LEGAL REPRESENTATIVE

Please complete the following:

1. Review, complete, and sign the **patient** sections on page **4**
2. Make sure the patient's healthcare provider has current insurance information and preferred contact information
3. If preferred, you can review, complete, and electronically sign the patient sections on our e-Consent Portal, which can be found by visiting **srrksupportsconsent.com**

Click here to visit the e-Consent Portal

If you have any questions or concerns,
please contact us at **1-833-777-5444 (1-833-SRRK-444)**
Monday through Friday 8 AM - 8 PM ET.

Scholar Rock®

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Complete all fields and submit this form by fax to **877-219-0016**.

FOR HEALTHCARE PROVIDER

All information must be completed for the patient to receive support. Fields marked with asterisk * are required. This form cannot be processed without an original prescriber signature and date.

Section 1: PATIENT INFORMATION

Patient First Name*: _____ **Last Name*:** _____ **Birth Date*:** _____

Sex*†: ☐ Male ☐ Female ☐ Other Preferred Language: _____ Translation services requested: ☐ Y ☐ N

Patient Address*: _____ **City*:** _____ **State*:** _____ **ZIP*:** _____

Primary Contact Name: _____ Relationship to Patient: _____

Email Address: _____ **Primary Contact Phone*:** _____ Other Phone: _____

Additional Contact Name: _____ Relationship to Patient: _____

Additional Contact Phone: _____

†Scholar Rock recognizes that patients may not identify as male or female. However, many insurance companies require this information to determine insurance benefits. Please indicate the sex on file with the insurance company

Section 2: INSURANCE INFORMATION – Please attach copies of the front and back of medical and prescription insurance cards

☐ Patient does not have insurance

Primary Medical Insurance: Plan name*: _____ **Policy ID*:** _____ **Group ID*:** _____

Policy holder (if not patient)*: _____ **Birth date*:** _____ **Insurance phone number*:** _____

Secondary Medical Insurance: Plan name: _____ Policy ID: _____ Group ID: _____

Policy holder (if not patient): _____ Birth date: _____ Insurance phone number: _____

Prescription Drug Coverage: Plan name: _____ RxBIN: _____ RxPCN: _____ RxGroup: _____

Policy holder (if not patient): _____ Birth date: _____ Insurance phone number: _____

Section 3: PATIENT CLINICAL INFORMATION

Diagnosis Code(s)*: ☐ G12.0 ☐ G12.1 ☐ Other: _____ *SMN2* Copy #: _____

Apitegromab Clinical Trial Participant: ☐ Yes ☐ No Apitegromab EAP Participant: ☐ Yes ☐ No Program ID: _____

Last Functional Assessment (include scale and date): _____

Please list any current or previous SMN targeted or gene therapy (include date of last dose)*: _____

_____

Drug and non-drug allergies (if any): _____ Patient Weight: ____kg Date Weighed: _____

Section 4: PRESCRIBER INFORMATION

Prescriber First Name*: _____ **Last Name*:** _____ **NPI #*:** _____

Practice/Facility Name*: _____ Office Contact Name: _____

Address*: _____ **City*:** _____ **State*:** _____ **ZIP*:** _____

Office Contact Email: _____ **Office Phone*:** _____ **Office Fax*:** _____

Office Tax ID #: _____ Office NPI #: _____ Prescriber Specialty: _____

State License #: _____ Exp Date: _____ PTAN: _____ Medicaid Provider #: _____

Section 5: INFUSION SITE INFORMATION

Site of care (select one)*:

☐ Hospital outpatient ☐ Infusion center ☐ Home infusion ☐ HCP office ☐ Other _____ ☐ Need to identify site of care

Site of care name: _____ Address: _____

Site of care Tax ID #: _____ NPI #: _____ City: _____ State: _____ ZIP: _____

Contact name for product shipping/receiving: _____ Contact phone number: _____

Maintenance plan: ☐ Continue at treatment site above ☐ Home infusion ☐ Other _____ ☐ Need to identify site of care

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FOR HEALTHCARE PROVIDER

All information must be completed for the patient to receive support. Fields marked with asterisk * are required. This form cannot be processed without an original prescriber signature and date.

PREFERRED PROCUREMENT METHOD

Please select a preferred procurement method:

☐ Specialty Pharmacy ☐ Buy and Bill (please order directly with CuraScript SD) ☐ Unknown

OPTIONAL SPECIALTY PHARMACY PRESCRIPTION†

Patient First Name: _____ Last Name: _____ Birth Date: _____

Dose: 10 mg/kg Q4W Directions: ISEMBYLD _____mg IV Q4W Dispense: 28 days Refills: _____

(Supplied as 150 mg/3 mL vials – 50 mg/mL concentration.)

Supplies (please strike through if not required): Dispense needles, syringes, ancillary supplies, and home medical equipment.

Skilled Nursing (please strike through if not required): Visit as needed to establish venous access, administer medication, and assess general status and response to therapy.

Other Instructions: _____

Please select your specialty pharmacy preference:

☐ Accredo ☐ CarePartners Pharmacy/Seven Bridges Specialty ☐ CVS Specialty ☐ Orsini

When a prior authorization is required, an expedited prior authorization review may be requested if the beneficiary's life, health, or ability to regain maximum function is in serious jeopardy and all payor criteria for expedited review are met. In this situation, you have the option to request an expedited prior authorization review by marking the appropriate checkbox where indicated below.

Prior Authorization Review Urgency: ☐ Standard Review ☐ Expedited Review/Urgent‡

‡By checking this box, I attest that (1) the beneficiary's life, health, or ability to regain maximum function is in serious jeopardy and (2) all payor criteria for expedited review have been met.

_____ _____

Prescriber name (print) Date

_____ _____ OR _____ _____

Prescriber signature (dispense as written) (Original signature required) Date

Prescriber signature (substitution permitted) (Original signature required) Date

†The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

REQUIRED PRESCRIBER AUTHORIZATION

By signing this form, I certify that I have prescribed ISEMBYLD for the patient identified on this form ("Patient") based on my independent professional judgment of medical necessity. I have received authorization to disclose the Patient's personally identifiable medical and insurance information to Scholar Rock, Inc. and its affiliates (collectively, "Scholar Rock") and other service providers or contractors for reimbursement support, for coordinating access to therapy, and for Scholar Rock to contact them about Scholar Rock Supports. I authorize Scholar Rock to contact me about the information provided on this form and to transmit this prescription to the specialty pharmacy designated by me, Patient, or Patient's health plan.

I will not submit or cause to be submitted any claims for any medication provided at no charge, including to any federal health care program or other third-party payor nor will I resell or attempt to resell such medication. I am under no obligation, and have received no compensation, to prescribe, purchase, or recommend ISEMBYLD or any other Scholar Rock medication. Completion of this form does not guarantee that support will be provided, and the full value of any support provided shall extend to the Patient.

I verify that the information provided on this form is complete and accurate to the best of my knowledge.

_____ _____ _____

Prescriber name (print)* **Prescriber signature*** **Date***

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If you have any questions, please contact us at 1-833-777-5444 (1-833-SRRK-444) Monday through Friday 8 AM – 8 PM ET.

FOR PATIENT OR PATIENT LEGAL REPRESENTATIVE†
Fields marked with asterisk * are required. There are 2 options to complete and sign the Enrollment Form:

OPTION 1 **Using the printed enrollment form:**
Complete and sign the patient sections and ask your healthcare provider to fax the completed form to: **877-219-0016**

OPTION 2 **Using the digital enrollment form:**
Complete and sign the patient sections using the e-Consent Portal by visiting **srrksupportsconsent.com** to sign electronically

†A legal representative is a person who has authority to make health care decisions on behalf of the patient. For patients who are children, this may be the patient's parent or legal guardian. For patients who are adults, this may be the patient's legal guardian or health care proxy.

Scholar Rock Supports™ ("Program") provides support to appropriate patients who have been prescribed a Scholar Rock medication ("Program Support"). Program Support includes: (1) reimbursement and financial support (for eligible patients), (2) working with you and your Health Team (defined below) to get you access to your medication (such as helping you identify an infusion site), and (3) providing you with disease-related and medication-related educational information and resources. In order for us to provide you with Program Support, we will need your consent to use electronic signatures and records, your authorization for use and disclosure of certain of your personal health information and your consent to enroll. Please read and sign the authorization and consents below if you wish to apply for Program Support.

Patient Name*: _____ **Date of Birth*:** _____

HIPAA AUTHORIZATION

By signing below, I authorize my health care providers, my pharmacy, and my health plan (collectively, my "Health Team") to use my personally identifiable medical and insurance information (collectively, my "Information") and to disclose my Information to Scholar Rock, Inc. and its affiliates (collectively, "Scholar Rock") and its service providers ("Service Providers"), so that Scholar Rock may enroll me in the Program, provide me with Program Support and administer the Program.

I understand that once my Information is disclosed, my Information may not be protected by certain federal privacy laws and could be re-disclosed; however, Scholar Rock will only use and disclose my Information as described in this form or otherwise if required by law. I understand that my pharmacy will receive payment from Scholar Rock for disclosing my Information to Scholar Rock. I understand that I can refuse to sign this authorization and that this will not affect my treatment, insurance coverage, or eligibility for benefits or Scholar Rock medication. However, if I do not sign this authorization, I will not be able to receive Program Support. This authorization will remain in effect for six (6) years from the date I sign it, unless I withdraw it or if a shorter effective period is required by law. I may withdraw this authorization at any time by sending a written notice to Scholar Rock at: Scholar Rock Supports, PO Box 592188, Orlando, FL 32859. I understand my withdrawal of this authorization will not invalidate uses or disclosures of my Information made prior to Scholar Rock's receipt of my notice of withdrawal. I understand I am entitled to a signed copy of this authorization.

_____ _____ _____
Signature of Patient or Legal Representative* **Printed Name of Signer*** **Date***

_____ _____
Printed Name of Patient* Relationship to Patient and Authority to Sign (if signed by legal representative)

CONSENT TO ENROLL IN SCHOLAR ROCK SUPPORTS

By signing below, I confirm I would like to enroll in the Program and receive Program Support from Scholar Rock and its Service Providers and that all information provided in this form is complete and accurate. I understand the Program is optional and I do not need to participate in the Program to receive Scholar Rock medication and that completing this form does not ensure that I will qualify for assistance or support. Moreover, if I receive free medication through the Program, I certify that I will not seek reimbursement or credit for this medication from any insurer, health plan, or government program. I understand that Scholar Rock reserves the right to modify or discontinue the Program, or to terminate assistance at any time. Scholar Rock and its Service Providers may use my Information and share it with each other and my Health Team in connection with providing the Program Support, administering the Program, or as otherwise required by Scholar Rock to meet its legal obligations.

Scholar Rock and its Service Providers may communicate with me (such as by mail, phone, email, and text message) to help me prepare for an infusion, to discuss my eligibility for copay assistance or free medication or to refer me to other programs or sources of financial support, or to see if I would like to respond to surveys or for other non-marketing purposes. I consent to Scholar Rock and its Service Providers sending text messages to me for these purposes at the phone numbers I provide.‡ I understand Scholar Rock and its Service Providers may de-identify my Information and use the resulting information for Scholar Rock's business purposes.

☐ **MARKETING CONSENT (OPTIONAL):** By checking this box, I authorize Scholar Rock and companies it works with to use and disclose my Information to send me marketing communications from Scholar Rock (such as by mail, phone, email, and text message) and for online targeted advertising, as further described in Scholar Rock's privacy policy at https://scholarrock.com/privacy-policy/. I also authorize Scholar Rock to share my Information with third parties for these purposes. I understand I can withdraw this consent any time by contacting Scholar Rock Supports.

_____ _____ _____
Signature of Patient or Legal Representative* **Printed Name of Signer*** **Date***

_____ _____
Printed Name of Patient* Relationship to Patient and Authority to Sign (if signed by patient legal representative)

‡I understand that I do not need to consent to receive text messages to participate in the Program or to receive Scholar Rock medication. I understand my telephone provider may charge me fees for receiving these text messages. I may revoke my consent to receive text messages at any time by replying STOP to any text message from Scholar Rock or contacting Scholar Rock at the address in the authorization above.

For details about how Scholar Rock collects and uses personally identifiable information more generally, please visit scholarrock.com/privacy-policy/.