NuvationConnect™ Free Trial Request Form

Submit using online form or download and fax completed form to 1-877-NUV-CON4 (1-877-688-2664).
These requirements apply only to support through NuvationConnect™ and are not intended to limit any treatment, payment, or benefit activities with your pharmacy or other healthcare providers.

1 Patient Information

Patient Name (first, last):

Home Phone:

Date of Birth: / /

Cell Phone:

Gender: ☐ Male ☐ Female ☐ Other

Email:

Mailing Address:

PREFERRED CONTACT: ☐ Home ☐ Cell ☐ Email

City/State: ZIP:

BEST TIME TO CONTACT:

US Resident:
☐ Yes ☐ No

Consent to leave voice messages at the primary or alternative contact number: ☐ Yes ☐ No

Consent to receive text messages: ☐ Yes (cell phone is required) ☐ No

2 Alternate Contact/Caregiver Information (Optional)

Name (first, last):

PRIMARY CONTACT: ☐ Caregiver ☐ Patient

Phone:

BEST TIME TO CONTACT:

3 Healthcare Professional/Facility Information

Prescriber Name (first, last):

Facility Name:

Mailing Address:

Office Contact Name:

City/State: ZIP:

Office Contact Email:

NPI #:

Office Phone:

DEA #: Tax ID #:

Office Fax:

4 Clinical Information

Primary ICD-10 Code:

Secondary ICD-10 Code:

PRIOR TREATMENT:

☐ Chemotherapy ☐ Chemotherapy with IO/Immunotherapy

☐ IO/Immunotherapy ☐ ROS-1 TKI:

BIOMARKER STATUS/TEST RESULTS: (check all that apply)

☐ ROS-1 Positive ☐ G2032R-Positive

Most Recent Biomarker Test Date: / /

LINE OF THERAPY FOR IBTROZI™ (taletrectinib):

☐ First Line ☐ Second Line ☐ Third Line

Patient Name (first, last): _____ Date of Birth: / /

5 Prescribing IBTROZI™ (taletrectinib) (Restrictions and eligibility criteria apply)

DOSING:

IBTROZI 200 mg capsules;
3 capsules once daily
(30-day supply)

QUANTITY & REFILLS:

Quantity: 90 capsules
Refills: 0 refills

ADDITIONAL INSTRUCTIONS:

_____

_____

SHIP PRESCRIPTION TO: ☐ Patient ☐ HCP Shipping Address: _____

SIGN HERE Prescriber Signature: _____ Date: / /

Dispense as written

6 Healthcare Professional Certification

By signing below, I hereby represent, covenant, and certify as follows:

(1) The above therapy (or medicine) is medically necessary for this patient and that I, as the prescriber, have made the decision to prescribe IBTROZI (the "Product"); (2) I have obtained written consent from the patient (or from the patient's legal representative) as required by the Health Insurance Portability and Accountability Act (HIPAA) and other state and/or federal laws to release all of the patient's personal health information (PHI) needed for this form and such other PHI that Nuvation, NuvationConnect™, the contracted dispensing pharmacy, or other contractors and may be required to (a) perform a preliminary verification of the patient's insurance coverage for the Product and (b) assess the patient's eligibility for participation in the NuvationConnect Program; (3) 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 healthcare program. If I am or become in possession of such Product, I will not resell or attempt to resell the Product; (4) I have not received, nor will I seek or accept payment from my patient for any co-insurance amount paid for by the Product Copay Program for a Nuvation Bio product; (5) I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible under this program. I will notify NuvationConnect if I become aware of any such changes; (6) I understand that I am under no obligation to prescribe any Nuvation Bio drug, and I have not received and will not receive any benefit from Nuvation Bio for prescribing a Nuvation Bio drug; (7) The information contained in this form is complete and accurate to the best of my knowledge; (8) I agree to comply with the NuvationConnect guidelines and understand that Nuvation Bio, at its sole and absolute discretion, reserves the right to modify or discontinue patient support programs, including such programs provided through NuvationConnect, at any time; and (9) I will notify NuvationConnect of any errors regarding the foregoing, and will make every effort to correct those errors.

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

HCP Name (please print): _____

Designated Agent Name (please print): _____ Title: _____

SIGN HERE HCP Signature (no stamps, please): _____ Date: / /

Designated Agent Signature (no stamps, please): _____ Date: / /

Patient Name (first, last): _____ Date of Birth: / /

7 Patient Authorization

I hereby authorize my healthcare professionals, my health insurance company, and my pharmacy to disclose my protected health information (PHI) including, but not limited to, my name, address, telephone number, medical records, health insurance coverage, 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 NuvationConnect™ and any third parties engaged to assist Nuvation in administering NuvationConnect for the purposes described below. I understand that once my information has been disclosed to NuvationConnect, it could be subject to redisclosure and that federal privacy laws may no longer protect the information. I authorize the release and use of my Information for the purposes of: (1) verifying, investigating, coordinating, and resolving insurance coverage or reimbursement, or payment inquiries, including by communicating with my healthcare providers and insurance company to verify my coverage and/or my medical care; (2) determining my eligibility for IBTROZI™ (taletrectinib) (the "Product") and support through NuvationConnect; (3) enrolling me in and providing support through NuvationConnect, including facilitating the provision of the Product to me; (4) providing me with information regarding any independent patient assistance programs, patient advocacy organizations, or other alternate sources of funding, coverage, or support that may be available to provide assistance, including with out-of-pocket expenses; (5) coordinating my treatment with my healthcare professionals and specialty pharmacy; (6) providing me with information or materials related to NuvationConnect or the Product, including educational or promotional materials; (7) contacting me by phone, text, email or mail regarding this form or my use or potential use of the Product; (8) administering, evaluating, and improving NuvationConnect, the effectiveness of the Product, services, and programs, and helping to develop new products, services, and programs, and for other Nuvation general business and administrative purposes. I understand that if I refuse to sign this authorization, it will not affect my treatment by my healthcare professionals, or my payment, enrollment, or eligibility for benefits from my health plan. However, if I refuse to sign this authorization, or sign and then withdraw my authorization at a later date, it may affect my ability to participate in NuvationConnect. If I do not withdraw authorization, it will remain valid for 5 years (or at such lesser time as state law may require). I may withdraw this Authorization at any time by sending written notice to NuvationConnect at 13410 Eastpoint Centre Drive, Suite 150, Louisville, KY 40223. Withdrawal will stop further use or disclosure of my information, except as allowed by law or already relied upon. I am entitled to a copy of this signed Authorization, which expires 5 years after signing unless revoked earlier or otherwise specified by law.

By signing as the patient's representative or guardian, I confirm I am legally authorized to do so. Proof of this authority, such as a power of attorney or court order, may be requested.

Patient OR Legal Representative Name (please print): _____

SIGN HERE Patient OR Legal Representative Signature: _____ Date: / /

8 Free Trial Offer Terms & Conditions

A Free Trial of IBTROZI is available for all eligible patients who are 1) 18 years of age or older; 2) residents of the United States or its territories; 3) enrolled in NuvationConnect; and 4) new to IBTROZI; and 5) have a valid prescription for an FDA-approved indication. Eligible patients can receive a free 30-day supply of IBTROZI. This free trial is limited to one per patient and is not transferable. This free trial offer may not be transferred, sold, purchased, traded, or counterfeited. A completed free trial request form and a valid prescription must be presented to NuvationConnect. This free trial offer is only accepted by NuvationConnect's non-commercial pharmacy. Pharmacists, patients, or prescribers must not submit any claim for reimbursement for IBTROZI dispensed pursuant to this free trial to any third-party payor, including Medicare, Medicaid, or any other federal or state healthcare program. Patient cannot apply the value of the free product received through this free trial toward any government insurance benefit out-of-pocket spending calculations, such as Medicare Part D true out-of-pocket costs (TrOOP). The product may not be resold. Patient shall be responsible for any cost-sharing if product use continues beyond the free trial period. This Free Trial offer is not conditioned on any past, present, or future purchases, including refills. This free trial is not valid where prohibited by law. This free trial cannot be combined with any other savings, free supply or similar offer for the specified prescription. This free trial offer is not health insurance. This free trial offer may not be used to address delays or gaps in health insurance coverage. Offer good only in the United States and Puerto Rico. No purchase is necessary. Patients have no obligation to continue to use IBTROZI. Nuvation Bio reserves the right to rescind, revoke, or amend this offer without notice. This free trial offer expires 12/31/2025.

By signing as the patient's representative or guardian, I confirm I am legally authorized to do so. Proof of this authority, such as a power of attorney or court order, may be requested.

Patient OR Legal Representative Name (please print): _____

SIGN HERE Patient OR Legal Representative Signature: _____ Date: / /