Margenza® (margetuximab-cmkb) 250 mg/10 mL injection for intravenous use

Access Support

Copay Assistance Program

ENROLLMENT FORM AND COPAY ASSISTANCE PROGRAM

By enrolling in MARGENZA Access Support, patients may receive various forms of support and information to help access MARGENZA, which may include insurance verification/prior authorization/appeals support, copay assistance and other financial support.

The MARGENZA Access Support Program, including the Copay Assistance Program, is not health insurance or a benefit plan. MacroGenics, Inc. ("MacroGenics") reserves the right to modify or discontinue the program at any time and to verify the accuracy of information submitted. Please carefully read all Terms and Conditions on pages 6-7. Please complete and fax this form to 1-844-256-5226.

PATIENT ENROLLMENT INSTRUCTIONS:

To have an insurance verification completed to understand your cost share/responsibility under your insurance coverage for MARGENZA,

- Complete part 1 on page 2 in the Patient Enrollment section including all insurance information or provide copies of your insurance and prescription card(s)
- Read the Patient HIPAA Authorization on page 4, **AND sign and date page 4 where "Signature of Patient" is located**
  - To enroll in the optional additional MARGENZA Patient Support Services, **sign and date PATIENT ENROLLMENT PART 3 on page 3**

If you are a commercially insured patient and would like to apply Copay Assistance to offset your cost share for MARGENZA,

- Ensure all the sections needed for an insurance verification are completed in addition to part 2 of the patient enrollment section **AND sign and date PATIENT ENROLLMENT PART 2 on page 2**

PRESCRIBER ENROLLMENT INSTRUCTIONS:

To process the requested services, MARGENZA Access Support will require one prescriber signature.

- **On page 5**, complete all sections in the Prescriber Enrollment section
  - The prescriber must manually sign and date the form
- Complete and fax this form to 1-844-256-5226

If you have any questions, please call MARGENZA Access Support at 1-844-MED-MGNX (1-844-633-6469), Monday-Friday 9 AM to 7 PM ET.

Please see Important Safety Information on page 8 and visit www.MARGENZA.com for full Prescribing Information, including Boxed Warning.

Hours of Operation:
Monday-Friday
9 AM to 7 PM ET

Address:
MARGENZA Access Support
PO Box 3795
Chesterfield, MO 63006

Phone: 1-844-MED-MGNX (1-844-633-6469)
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PART 1 PATIENT ENROLLMENT

PATIENT ENROLLMENT SECTION - MARGENZA

Patient Name (First, MI, Last) _____

Date of Birth (MM/DD/YYYY) _____ Gender ☐ Male ☐ Female

Address _____

City _____ State _____ Zip _____

Preferred Phone (Home or Mobile) _____ If Mobile, Ok to Text? ☐ Yes ☐ No

Best Time to Call _____ Email _____

Preferred Language ☐ English ☐ Spanish ☐ Other _____

Alternative Contact Name _____ Relationship to Patient _____

Phone _____

Must select one of the following:

☐ **No insurance coverage**

☐ **Copy of Policyholder's insurance cards (front and back) are attached**

☐ **Fill in information below**

	Primary Medical Insurance	Secondary Medical Insurance
Insurance Provider		
Insurance Phone #		
Policyholder Name		
Policyholder DOB		
Policy #		
Group #		

PART 2 COPAY PATIENT ENROLLMENT

☐ **No** ☐ **Yes** Do you use state or federal government-funded insurance to fill your prescriptions? Examples include Medicaid, Medicare, Medicare Part D, Medigap, CHAMPUS, Veteran's Affairs (VA), Department of Defense (DOD), TRICARE®, and others, **or any state patient, or pharmaceutical assistance program.**

☐ **I would like to apply to enroll in the MARGENZA Copay Assistance Program and agree to the Terms and Conditions on pages 6-7.**

Signature of Patient _____ **Date (MM/DD/YYYY)** _____

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Copay Assistance Program

PART 3 PATIENT ENROLLMENT

About MARGENZA Access Support:
Your healthcare provider has talked with you about using MARGENZA. MARGENZA Access Support was created to offer personalized support to patients and their caregivers at no charge.

Services Include:
Contacting you by email, mail, or telephone to provide personalized services, delivered by your MARGENZA Access Support team, such as information and marketing materials; responding to customer service requests and/or questions about your treatment; requesting feedback on your experience with the related products, services, and programs, including market research and medical research; disclosing your enrollment and use of these services to your doctors and insurers; analyzing and/or measuring program performance and program effectiveness for future enhancements; and other activities related to your condition and therapy that are not part of MARGENZA Access Support. These activities include opportunities to share your story and participate in studies about products and services. To cancel your participation in the program, please contact us at 1-844-MED-MGNX (1-844-633-6469), Monday-Friday 9 AM to 7 PM ET.

☐ **I would like to enroll in these OPTIONAL additional MARGENZA Access Support Services and agree to the Terms and Conditions on pages 6-7. I understand that my Protected Health Information (PHI, defined on page 4) may be used in connection with my participation in these programs.**

Signature of Patient _____ **Date (MM/DD/YYYY)** _____

To cancel your participation in any portion of MARGENZA Access Support, please contact us at 1-844-MED-MGNX (1-844-633-6469).

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Copay Assistance Program

PATIENT HIPAA AUTHORIZATION

Before MARGENZA Access Support can start helping you, we will need some information about you and your health. This is known as your Protected Health Information, or PHI. By signing this form, you understand and agree that your PHI may be shared with and used by MacroGenics as explained below.

PHI includes information like:

- Your health insurance or benefits, including how much coverage you have
- All records about your treatment
- Whether you're staying on your medicine or treatment
- Anything that affects your health

If you agree, your PHI may be shared by your doctors and other healthcare providers, your healthcare plan or health insurance company, clearinghouses or other agents, your pharmacy, and others who might have your PHI.

Your PHI is used in ways such as these:

- To learn how much of your treatment is covered by your insurance
- To help you find other ways to afford your treatment
- To track your use of your treatment
- To share information with your healthcare provider
- To make sure that you receive high-quality services from the program
- To measure program performance and make program improvements

Other things you should know about sharing and using your PHI:

- We only ask for and share the PHI that we need to provide the copay assistance you have requested and the optional Access Support Services if you have requested those. We do not ask for any PHI that we do not need, but we may receive some in the health records sent to us. Your PHI will be released to MacroGenics and its affiliates, agents, representatives, and service providers
- You don't have to give permission to share your PHI with MacroGenics to receive treatment from your healthcare providers, your prescription from your pharmacy, or benefits from your healthcare plan, but MARGENZA Access Support may not be able to help you without it
- After your PHI has been shared, it may no longer be covered by federal and state privacy laws (such as HIPAA), and it may be shared again
- Your signed permission to share and use your PHI lasts for three years from the date of your signature unless you are a resident of Maryland, Maine, or Montana, in which case the permission will last for one year from the date of your signature. In either case, you may revoke your permission before then by writing to MARGENZA Access Support, PO Box 3795, Chesterfield, MO 63006, which will preclude reliance on the authorization after the date your written revocation is received, **although it will not affect disclosures made before your revocation is received. You have the right to receive a copy of this form**

If you would like to opt out of the program or make changes to your enrollment:
You can stop sharing your PHI with us or change what you share by calling us at 1-844-MED-MGNX (1-844-633-6469), or by writing us at PO Box 3795, Chesterfield, MO 63006.

I have read and agree to the Patient HIPAA Authorization

Print Patient or Patient Representative Name _____

Signature of Patient or Patient Representative Name _____

Relationship to Patient _____ **Patient Social Security Number** _____

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Access Support

Copay Assistance Program

PRESCRIBER ENROLLMENT SECTION - MARGENZA

Name (First, Last) _____ Specialty _____ NPI # _____

Practice Name _____ Phone _____ Fax _____

Email _____

Address _____

City _____ State _____ Zip _____

Group Tax ID _____ Office Contact Name _____ Office Contact Phone _____

Collaborating Physician _____ NPI # _____

PATIENT INFORMATION

Patient Name (First, MI, Last) _____

Date of Birth (MM/DD/YYYY) _____

Address _____

City _____ State _____ Zip _____

Is the patient 18 years of age or older? ☐ Yes ☐ No

Is the patient being treated for HER2+ metastatic breast cancer? ☐ Yes ☐ No

Is the patient going to be treated concomitantly with chemotherapy? ☐ Yes ☐ No

Has the patient received two or more prior anti-HER2 regimens, at least one of which was for metastatic disease? ☐ Yes ☐ No

Valid enrollment includes: Treatment Setting and Diagnosis Code

Treatment Setting: ☐ **Physician's Office** ☐ **Hospital/Clinic Outpatient**

Name and Address of Facility (if applicable) _____

Facility NPI # (if applicable) _____ **Facility Tax ID #** (if applicable) _____

Diagnosis Code (ICD-10) _____

☐ **MARGENZA Copay Assistance Program** – For Qualified, Commercially Insured Patients Only (FDA-Approved Use Only).
IF CHECKED, PATIENT MUST PROVIDE THEIR SIGNATURE ON PAGE 2.

By signing below, I certify: 1) The therapy is medically necessary and that this information is accurate to the best of my knowledge; 2) I am disclosing this information to MacroGenics, Inc. ("MacroGenics"), as well as its affiliates, agents, representatives, business partners, and service providers to help enable copay assistance as requested by this Patient; 3) The Patient is aware of, has consented to, and has directed my disclosure of their information to MacroGenics so that MacroGenics may contact the Patient to further enable services for those purposes and that such consent and direction applies to disclosures made through the duration of the Patient's therapy; 4) I will not seek reimbursement from any third party for the support MacroGenics provides; 5) I am licensed to prescribe the prescription medication identified in this form; 6) Treatment for Patients enrolled in the MARGENZA Copay Assistance Program is for an FDA-approved indication; and 7) To the best of my knowledge, the Patient meets the insurance and residency requirements (for those applying for the MARGENZA Copay Assistance Program). **PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN AND DATE.** Rubber stamps, signature by other office personnel for the Prescriber, and computer-generated signatures will not be accepted.

Prescriber Signature _____ **Date (MM/DD/YYYY)** _____

Not signing this form will result in an incomplete submission and a delay in requested services.

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Copay Assistance Program

MARGENZA ACCESS SUPPORT AND COPAY ASSISTANCE PROGRAM TERMS AND CONDITIONS

MARGENZA Access Support, including the Copay Assistance Program, is not health insurance or a benefit plan. MacroGenics reserves the right to modify or discontinue the program at any time and to verify the accuracy of information submitted. By using the MARGENZA Copay Assistance Program, you confirm that the information you are providing is correct, that you meet the eligibility criteria set forth below, and you agree to and will comply with the terms and conditions described below. I understand that I am not required to sign these authorization forms or participate in MARGENZA Access Support and Copay Assistance Program. If I refuse, my eligibility for benefits under my insurance and the treatment by my healthcare provider will not change, although I will not be enrolled in the program. I understand and agree that any information provided to me regarding insurance coverage or estimates of my financial responsibility for MARGENZA are for informational purposes and that my insurance plan will make the ultimate and final determination regarding coverage and my financial responsibility and that I am personally responsible for any such payments, not MacroGenics.

Eligibility:
You have been prescribed MARGENZA. You have commercial insurance that covers your prescribed medicine, but your insurance does not cover the full cost; that is, you have a copay or coinsurance obligation. **The brand and the prescription being filled must be covered by the patient's commercial insurance plan. Offer excludes full cash-paying patients. This offer may not be redeemed for cash. You are not participating in any state or federal healthcare program, including, without limitation, Medicaid, Medicare, Medicare Part D, Medigap, Veteran's Affairs (VA), CHAMPUS, Department of Defense (DoD), TRICARE®, or any state patient, or pharmaceutical assistance program, or wherever prohibited by law. Patients who move from commercial insurance to a state or federal healthcare program will no longer be eligible.** Patients who start utilizing their government coverage during their enrollment period will no longer be eligible for the program. Uninsured and cash-paying patients are NOT eligible for this program. Cash Discount Cards and other non-insurance plans are not valid as primary insurance under this offer. If the patient is eligible for drug benefits under any such program, the patient cannot use this offer. This program cannot be combined with any coupon, certificate, voucher, or similar offer.

You are 18 years of age or older and are receiving MARGENZA for an FDA-approved use. Please ask your doctor for information about FDA-approved uses. Also see your doctor for the full US Prescribing Information for MARGENZA. You are a resident of the United States or Puerto Rico.

Patient is responsible for complying with any insurance carrier copayment disclosure requirements, including disclosing any savings received from this Program. It is illegal to (or offer to) sell, purchase, or trade this offer.

I understand that if I begin to have coverage under any government program or if my state prohibits the redemption of manufacturer copay assistance (coupons) at any time, I will no longer be eligible to receive benefits under the Copay Assistance Program. If I am enrolled in a qualified health plan (QHP) purchased through a health insurance exchange established by a state government or the federal government, I understand that if the federal government or my state government prohibits the redemption of manufacturer copay assistance (coupons) by enrollees in QHPs at any time, I will no longer be eligible to receive benefits under the Copay Assistance Program. I certify that my insurance company has not prohibited the redemption of manufacturer copay assistance (coupons) for the program product, and I understand that if at any time my insurance company prohibits the redemption of manufacturer copay assistance (coupons) for the program product, I will no longer be eligible to receive benefits under the Copay Assistance Program. I understand that I am responsible for reporting receipt of Copay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Copay Assistance Program, as may be required. I agree not to seek reimbursement for all or any part of the benefit I receive through the Copay Assistance Program. I understand that my provider will submit a claim to my private insurance company for the program product administered to me.

(Terms and Conditions are continued on the next page)

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Copay Assistance Program

MARGENZA ACCESS SUPPORT AND COPAY ASSISTANCE PROGRAM TERMS AND CONDITIONS (cont'd)

Program Payments:
The MARGENZA Copay Program will pay for the entirety of the commercial patient's remaining cost share, including coinsurance and copays for MARGENZA medicine up to a maximum of $26,000 during a 12-month period. To receive payments under the program, the patient or healthcare provider must submit a completed claim (CMS 1500 or UB04) and an Explanation of Payment (EOP) form. The submitted form must include the name of the insurer and plan, and show that MARGENZA was the medication that was administered to the patient. For patients enrolled into the MARGENZA Copay Program, the form requesting payment must be submitted within 180 days of the infusion service/administration date to receive program benefits. Program payments are limited to the copay or coinsurance costs for MARGENZA medicine only—the program doesn't cover costs associated with healthcare provider administration, other medications, treatments or therapies, bloodwork, transportation or any other costs associated with a patient's hospital stay or treatment. MARGENZA Access Support, including the Copay Assistance Program, is not health insurance or a benefit plan.

Program Timing and Limitations:
Enrollment in the program lasts for one year from the date of approval. Patients are eligible for savings for up to 12 months of therapy, provided they continue to meet program terms and conditions. If you live in California, the MARGENZA Copay Assistance Program expires on the earlier of: (i) the expiration date of program copay card; or (ii) the date an FDA-approved therapeutically equivalent becomes available and is covered under the Patient's health insurance plan on a lower cost-sharing tier, or when an over-the-counter product with the same active ingredients becomes available.

MacroGenics reserves the right to modify or discontinue the program at any time without notice and to verify the accuracy of information submitted. Void where taxed, restricted or prohibited by law. This offer is not transferable and is limited to one offer per person. Not valid if reproduced.

PRIVACY NOTICE AND CONSENT TO CONTACT BY PHONE OR TEXT:

MARGENZA Access Support is governed by the MacroGenics Privacy Policy. For more information, please visit www.MacroGenics.com/privacy/.

By enrolling in the MARGENZA Patient Assistance Program, I agree to receive non-marketing calls and texts by or on behalf of MacroGenics, including through an autodialer or prerecorded voice, at the number(s) I provided. If I have provided a caregiver phone number, I certify on my caregiver's behalf that my caregiver has agreed to receive these calls and texts. Message and data rates may apply. Recurring texts; reply STOP to end texts.

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Copay Assistance Program

What does MARGENZA treat?

MARGENZA is a prescription medicine approved for use in combination with chemotherapy for the treatment of adult patients with metastatic HER2-positive breast cancer who have received two or more prior anti-HER2 regimens, at least one of which was for metastatic disease.

IMPORTANT SAFETY INFORMATION

What is the most important information I should know about MARGENZA?

MARGENZA can cause serious side effects, including:

- **Heart problems that may affect your heart's ability to pump blood.** Your doctor will run tests to monitor your heart function before and during treatment with MARGENZA. Based on test results, your doctor may hold or discontinue treatment with MARGENZA.
  - Tell your healthcare provider right away if you get any of the following signs and symptoms: new or worsening shortness of breath, coughing, feeling tired, swelling of the ankles or legs, swelling of the face, irregular heart beat or palpitations, sudden weight gain of more than 5 pounds in 24 hours, dizziness or feeling light-headed, or loss of consciousness.
- **Harm to your unborn baby.** Tell your healthcare provider right away if you become pregnant or think you might be pregnant during treatment with MARGENZA. Exposure to MARGENZA during pregnancy or within 4 months prior to conception can result in fetal harm.
  - If you are able to become pregnant, your healthcare provider should do a pregnancy test before you start treatment with MARGENZA.
  - Birth control should be used while receiving MARGENZA and for 4 months after your last dose of MARGENZA.

What are other possible serious side effects of MARGENZA?

Infusion-related reactions. MARGENZA is a medicine that is delivered into a vein through a needle as an infusion. MARGENZA has been associated with infusion-related reactions which can include fever, chills, joint pain, cough, dizziness, tiredness, nausea, vomiting, headache, sweating, fast heart rate, low blood pressure, itching, rash, hives, and shortness of breath. Your healthcare team will monitor you during treatment with MARGENZA and may slow or stop your infusion if you have side effects. You may need to permanently stop MARGENZA if you have a severe infusion reaction.

Before you receive MARGENZA, tell your doctor if you are breastfeeding. It is not known if MARGENZA could pass into breast milk and harm your baby.

What are the most common side effects of MARGENZA in combination with chemotherapy?

The most common side effects with MARGENZA in combination with chemotherapy are fatigue/weakness, nausea, diarrhea, vomiting, constipation, headache, fever, hair loss, abdominal pain, peripheral neuropathy (weakness, numbness, pain, and/or tingling in hands and feet), joint and muscle pain, cough, decreased appetite, shortness of breath, infusion-related reactions, redness/swelling and pain on the palms of the hands and soles of the feet (hand-foot syndrome), and pain in arms and legs.

You are encouraged to report side effects to the FDA at (800) FDA-1088 or www.fda.gov/medwatch or to MacroGenics at (844)-MED-MGNX (844-633-6469).

These are not all the possible side effects of MARGENZA. Your doctor may stop treatment if serious side effects happen. Be sure to contact your healthcare team right away if you have questions or are worried about any side effects.

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