



ATEBRIOZ™ (ZILURGISERTIB) TABLETS

PATIENT ENROLLMENT FORM

Phone: 1-855-MRM-4YOU | 1-855-676-4968 | Fax: 1-855-282-4884
Monday - Friday: 8:00 am - 8:00 pm ET

Complete this form for all patients. Fields marked with a (*) are required.

Fax completed form and copy of patient's insurance card (front and back) to 1-855-282-4884 and/or include copy of patient demo from electronic medical records. Ensure drug benefit card/information is included.

1. PATIENT INFORMATION (please print)

*First name _____ MI _____ *Last name _____
*Gender ☐ M ☐ F *Date of birth (MM/DD/YYYY) _____ Allergies _____ ☐ None
*Address _____ *City _____ *State _____ *ZIP code _____
Primary guardian/alternate contact full name _____ Relationship _____
*Primary phone _____ Mobile phone _____
Email _____ Primary language _____

2. MEDICAL BENEFITS - PHARMACY BENEFITS (PRESCRIPTION DRUG CARD)

	Primary Medical Benefits	Pharmacy Benefits
Insurance/Payer Name		
Insurance/Payer Phone #		
Subscriber/Policy ID		
Group #		
Rx BIN		
Rx PCN		

3. URGENT PATIENT ACCESS PROGRAM

☐ By checking this box, I have determined there is an immediate and urgent medical need for ATEBRIOZ to further this patient's welfare and if there is a pre-defined access barrier of at least five (5) business days, my patient should be evaluated for the Urgent Patient Access Program. If approved, eligible patients can receive an initial 15-day supply. Patients continuing to experience a pre-defined access barrier, such as coverage determination delays, may be eligible to receive, upon approval, additional 15-day supplies, up to a max 60 days in total.

4. PRESCRIBER INFORMATION (please print)

*First name _____ *Last name _____
Site/Clinic name _____ Office contact name _____
*Address _____ *City _____ *State _____ *ZIP code _____
*Office contact phone _____ *Fax _____ Email _____
*Prescriber NPI# _____ *Specialty _____ State license number _____

5. DIAGNOSIS

*Diagnosis: ☐ Fibrodysplasia Ossificans Progressiva (FOP) ☐ Other _____
*ICD-10-CM Code: _____ *ICD-10-CM Code/Description: _____

6. *PRESCRIPTION (please print)

ATEBRIOZ (zilurgisertib) **25 mg tablets** (NDC 79378-029-16)

The recommended dosage of ATEBRIOZ is 100 mg orally once daily. Refer to the PI for additional information on Dosage & Administration

Dosage:

Take 4 tablets by mouth once daily (recommended) ☐ Other (specify below)

Quantity = QS for 30 Days Supply Refills _____ If Other Dosing, please specify _____

7. *PRESCRIBER AUTHORIZATION

I understand and agree that, as the prescriber, I will comply with my state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to me, as the prescriber. I have made the determination, based on my independent clinical judgment, that the medication ordered is medically appropriate for the patient for the intended use. I am personally supervising the care of this patient. I authorize Mirum Pharmaceuticals, Inc., its affiliates, agents, and contractors (collectively, "Mirum") to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy. This authorization includes permitting Mirum to communicate to payers on my behalf to confirm this patient's health plan eligibility and benefits.

X Prescriber Signature _____
Written signature only;
stamps not acceptable.

(Signature Required)

☐ Dispense as Written Date _____



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8. PATIENT AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION AND MIRUM COMMUNICATIONS

Authorization to Share Protected Health Information

By signing this authorization, I (or my representative) authorize my healthcare providers, health plans, insurers, and Mirum product dispensing pharmacies (collectively, "Healthcare Organizations") to use, and disclose my personal and health information related to my medical condition, treatment, patient support, program enrollment and insurance claims and coverage (my "health information") with Mirum Pharmaceuticals, Inc., its affiliates, agents, and representatives (collectively "Mirum") (i) to contact me or my Healthcare Organizations, or others I have identified, about my disease or treatment, (ii) to work with my insurance carrier and other potential funding sources to try to help me get coverage, reimbursement, or payment for the medication ordered by my prescriber, (iii) to check eligibility and for referral to and or enrollment in patient support and/or financial assistance programs, (iv) to obtain prior authorization for coverage/reimbursement and to work with third parties to provide other community resources, alternate sources of funding, and referrals, (v) to assist with appeals of denied claims for coverage/reimbursement, (vi) for providing me with materials, information, and services related to my drug therapy and ways to help me maintain my prescribed treatment, (vii) for market research purposes, (viii) to improve, develop, and evaluate products, services, programs, or treatments related to my disease, (ix) to use aggregated, de-identified data for research or publications, or (x) as required by applicable law, regulation, or court order. I understand that Mirum is not a HIPAA covered entity and that my health information, once received by Mirum, will not be subject to HIPAA protections, but I understand that Mirum will safeguard my health information using administrative, technical, and physical safeguards consistent with industry standards and will not use or disclose it except for the purposes set forth in this authorization. I understand that my pharmacy may be paid to share my information with Mirum as allowed under this authorization.

Mirum Communications

I authorize Mirum to contact me by mail, telephone (including voicemail), or email for educational and marketing purposes, including contacting me for market research purposes about Mirum therapies or Mirum. I understand that Mirum may receive or provide remuneration in connection with these communications. I understand and agree that any information that I provide may be used by Mirum to help develop new products, services, and programs.

I agree and understand that my authorization is voluntary and that neither Mirum nor any of my healthcare providers, health plans, and pharmacies may condition my treatment, payment for treatment, enrollment or eligibility for benefits, including my eligibility to receive Mirum products, on whether I provide my authorization. However, if I do not provide authorization, I will not be able to receive certain optional Mirum services and support programs described above; my refusal will not affect my ability to obtain my prescribed medication through my healthcare provider or pharmacy. I understand that this authorization will remain valid for 10 years after the date set forth below or such earlier date as required by applicable law, unless I revoke it earlier by cancelling my enrollment in writing, which I may do at any time by contacting Mirum's representative at privacy@mirumpharma.com or by mailing a written revocation to Mirum Pharmaceuticals, Inc., P.O. Box 4089, Foster City, CA 94404.



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Mirum Communications (continued)

I understand that my cancellation will not apply to any use or disclosure of my health information by my healthcare providers, health plans, or pharmacies before they receive notice of my cancellation. Upon receipt of my cancellation, Mirum will cease further use and disclosure of my health information except as already used or disclosed prior to receiving such notice. I understand I have a right to receive a copy of this authorization.

☐ By checking this box, I consent to receiving support, reminder, and educational text messages from Mirum to my mobile phone number. Standard text messaging rates will apply. I understand that I will be able to opt out of future text messages at any time by following directions within the transmitted texts or by contacting Mirum at privacy@mirumpharma.com. I UNDERSTAND THAT THESE COMMUNICATIONS MAY USE PRERECORDED/ARTIFICIAL VOICE MESSAGES AND/OR AN AUTOMATED SYSTEM.

*Mobile phone _____

Patient Enrollment Support

I hereby consent to enroll in patient support services provided by Mirum and authorize Mirum or my Healthcare Organizations to provide me with assistance, such as Prior Authorization support, finding alternate sources of funding, and assisting with appeals of denied claims for coverage/reimbursement. I agree that Mirum may need to verify my eligibility for such programs, and I understand that such verification may include contacting me or my Healthcare Organizations for additional information and/or reviewing additional financial, insurance, and/or medical information. I verify that the information on this form and other supporting documentation is complete and accurate to the best of my knowledge.

I understand that patients who are enrolled in any federal healthcare program, including, without limitation, Medicare, Medicaid, TRICARE, and Veterans Affairs may not be eligible to participate in certain financial assistance programs offered by Mirum, and that my eligibility for specific programs will be assessed based on applicable federal and state law.

Print Patient or Authorized Patient Representative Name _____

Signature of Patient or Authorized Patient Representative _____

If Representative, Relationship to Patient and Description of Authority (attach supporting documentation). By signing, the representative attests under penalty of perjury that they have current, valid legal authority to act on behalf of the patient and that such authority has not been revoked or terminated:

☐ Parent/Legal Guardian ☐ Representative per Power of Attorney ☐ Spouse

Date _____

