ATEBRIOZ™ (ZILURGISERTIB) TABLETS 25 MG

PATIENT ENROLLMENT FORM GUIDE

Use this guide to help you accurately fill out the ATEBRIOZ Patient Enrollment Form (PEF) to ensure timely processing of your patient's prescription.

Fax completed ATEBRIOZ Enrollment Forms to 1-855-282-4884.

PATIENT INSURANCE INFORMATION

Your patient's insurance information is needed for Mirum Access Plus (MAP) to verify prescription benefits for ATEBRIOZ. If available, please provide copies of both sides of your patient's insurance card(s). Alternatively, please encourage your patient to go to mirumaccessplus.com to sign up for MAP.

REQUIRED FIELDS

1. All fields marked with a (*) are required and must be completed to prevent processing delays.

URGENT PATIENT ACCESS PROGRAM

2. Check this box to enroll in the Mirum Urgent Patient Access Program to expedite access to ATEBRIOZ for eligible patients if a pre-defined access barrier of ≥5 days is experienced.

DIAGNOSIS

3. Select the appropriate diagnosis box and provide the appropriate ICD-10-CM code and description.

PRESCRIPTION

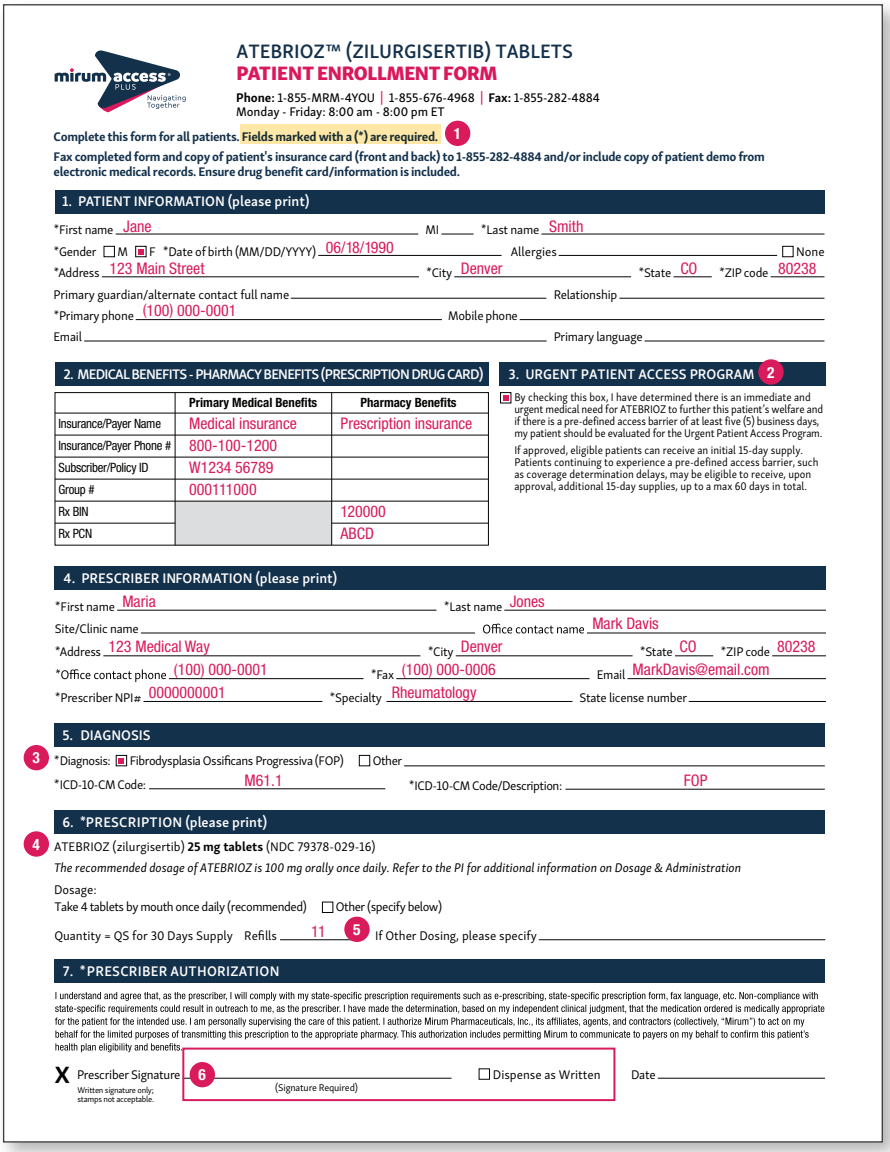
4. This section serves as the actual prescription for ATEBRIOZ and needs to be fully completed to prevent delays or additional outreach from the pharmacist.

   Reference the full Prescribing Information at ATEBRIOZHCP.com.

5. Specify the number of refills.

PRESCRIBER AUTHORIZATION

6. To honor your request for ATEBRIOZ, please sign and check box for Dispense as Written.



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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. 1

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 Jane MI *Last name Smith
*Gender ☐ M ☒ F *Date of birth (MM/DD/YYYY) 06/18/1990 Allergies ☐ None
*Address 123 Main Street *City Denver *State CO *ZIP code 80238
Primary guardian/alternate contact full name Relationship
*Primary phone (100) 000-0001 Mobile phone
Email Primary language

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

	Primary Medical Benefits	Pharmacy Benefits
Insurance/Payer Name	Medical insurance	Prescription insurance
Insurance/Payer Phone #	800-100-1200	
Subscriber/Policy ID	W1234 56789	
Group #	000111000	
Rx BIN		120000
Rx PCN		ABCD

3. URGENT PATIENT ACCESS PROGRAM 2

☒ 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 Maria *Last name Jones
Site/Clinic name Office contact name Mark Davis
*Address 123 Medical Way *City Denver *State CO *ZIP code 80238
*Office contact phone (100) 000-0001 *Fax (100) 000-0006 Email MarkDavis@email.com
*Prescriber NPI# 0000000001 *Specialty Rheumatology State license number

5. DIAGNOSIS

3 *Diagnosis: ☒ Fibrodysplasia Ossificans Progressiva (FOP) ☐ Other
*ICD-10-CM Code: M61.1 *ICD-10-CM Code/Description: FOP

6. *PRESCRIPTION (please print)

4 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 11 5 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 6 (Signature Required) ☐ Dispense as Written Date
Written signature only; stamps not acceptable.

Guide instructions continued on page 2

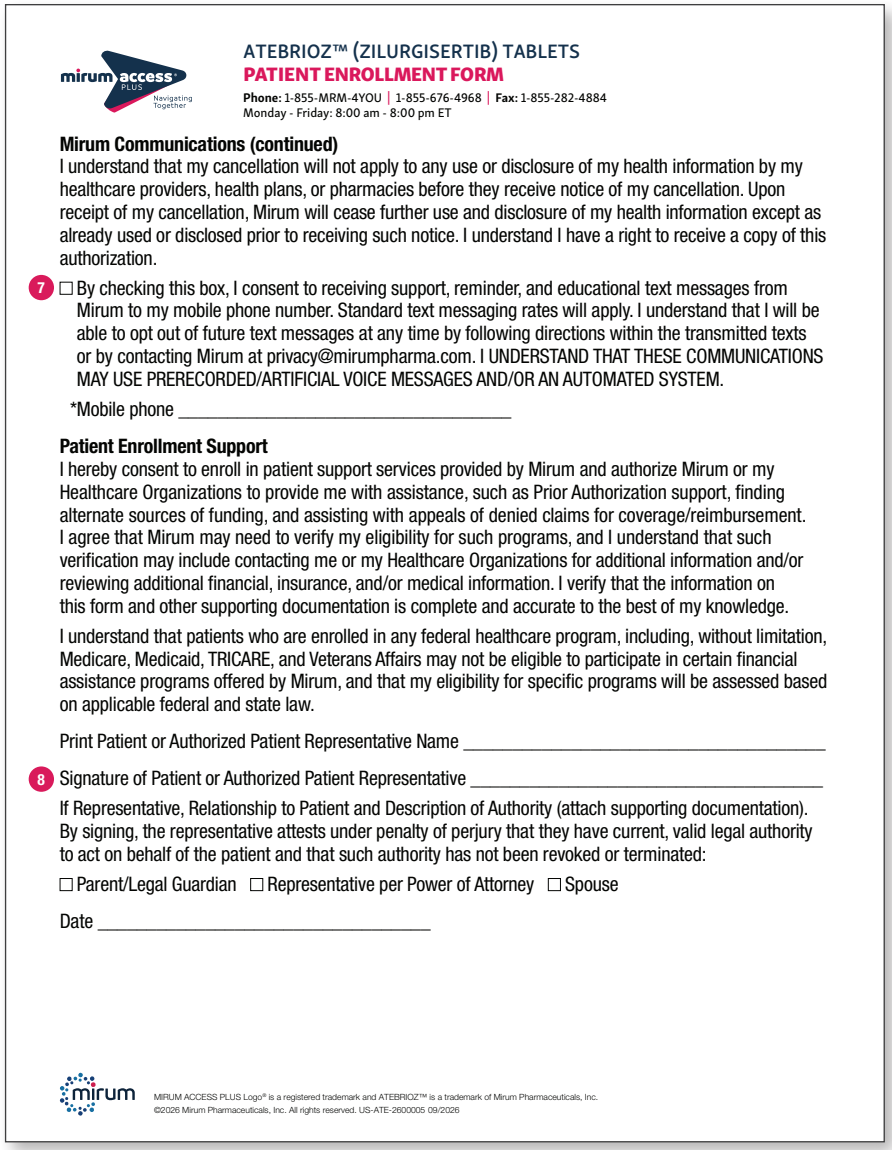
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PATIENT AUTHORIZATION

7 Patients who opt-in can receive additional, enhanced communications and resources from MAP to support them along their treatment journey.

8 The patient authorization is located on the third page of the PEF. The authorization is required for MAP to provide optional patient services. If the patient/authorized patient representative is not available to sign the form at your office, your patient can go to mirumaccessplus.com to sign up for MAP services.



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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.

7 ☐ 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 _____

8 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 _____

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INDICATION

ATEBRIOZ is indicated to reduce the volume of total new heterotopic ossification (HO) in adults and pediatric patients aged 12 years and older with fibrodysplasia ossificans progressiva (FOP).

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

ATEBRIOZ is contraindicated in pregnancy. ATEBRIOZ can cause fetal harm when administered to a pregnant woman.

WARNINGS AND PRECAUTIONS

Embryo-Fetal Toxicity: Based on its mechanism of action and findings from animal reproduction studies, ATEBRIOZ can cause fetal harm. Verify that females of reproductive potential are not pregnant prior to initiating treatment. Advise females of reproductive potential to use effective contraception during treatment and for one week after the final dose. Advise patients to discontinue ATEBRIOZ immediately if pregnancy occurs during treatment and to contact their healthcare provider.

ADVERSE REACTIONS

The most common adverse reactions (≥10%) are headache, arthralgia, upper respiratory tract infection, epistaxis, and nausea.

DRUG INTERACTIONS

CYP3A4 Inhibitors: Reduce the ATEBRIOZ dosage to 50 mg orally once daily when used concomitantly with a strong CYP3A4 inhibitor.

CYP3A4 Inducers: Avoid concomitant use of ATEBRIOZ with strong or moderate CYP3A4 inducers.

MATE1 and MATE2-K Substrates: Avoid concomitant use of ATEBRIOZ with MATE1 and MATE2-K substrates (e.g., metformin). If unavoidable, monitor for adverse reactions and consider dose reduction of the substrates if appropriate, according to their approved prescribing information.

USE IN SPECIFIC POPULATIONS

Lactation: Advise patients that breastfeeding is not recommended during treatment with ATEBRIOZ and for at least one week after the final dose.

DOSING INFORMATION

The recommended dosage of ATEBRIOZ is 100 mg orally once daily with or without food. ATEBRIOZ tablets may be administered whole or crushed. If crushed, mix 4 tablets (100 mg total) with four tablespoons of water, orange juice, apple sauce, or plain yogurt and administer immediately. Do not store the mixture for future use. Do not administer ATEBRIOZ with grapefruit, pomelo, or juices containing these fruits.

Please see full Prescribing Information, including the Medication Guide, for ATEBRIOZ.

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