DUDE™ ACCESS SERVICES
Darolutamide User Drug Experience

NUBEQA® (darolutamide) 300 mg tablets

Instructions for completing the Patient Service Request Form

NUBEQA Free Trial Program (complete steps 1-4)

- **Eligible** patients will receive **2 FREE months** of NUBEQA® (darolutamide)
- Verify patient benefits

Benefits Verification Only (complete steps 1-3)

- Check patient's insurance to determine coverage

Note: Eligible patients will be automatically enrolled in the NUBEQA $0 Co-pay Program

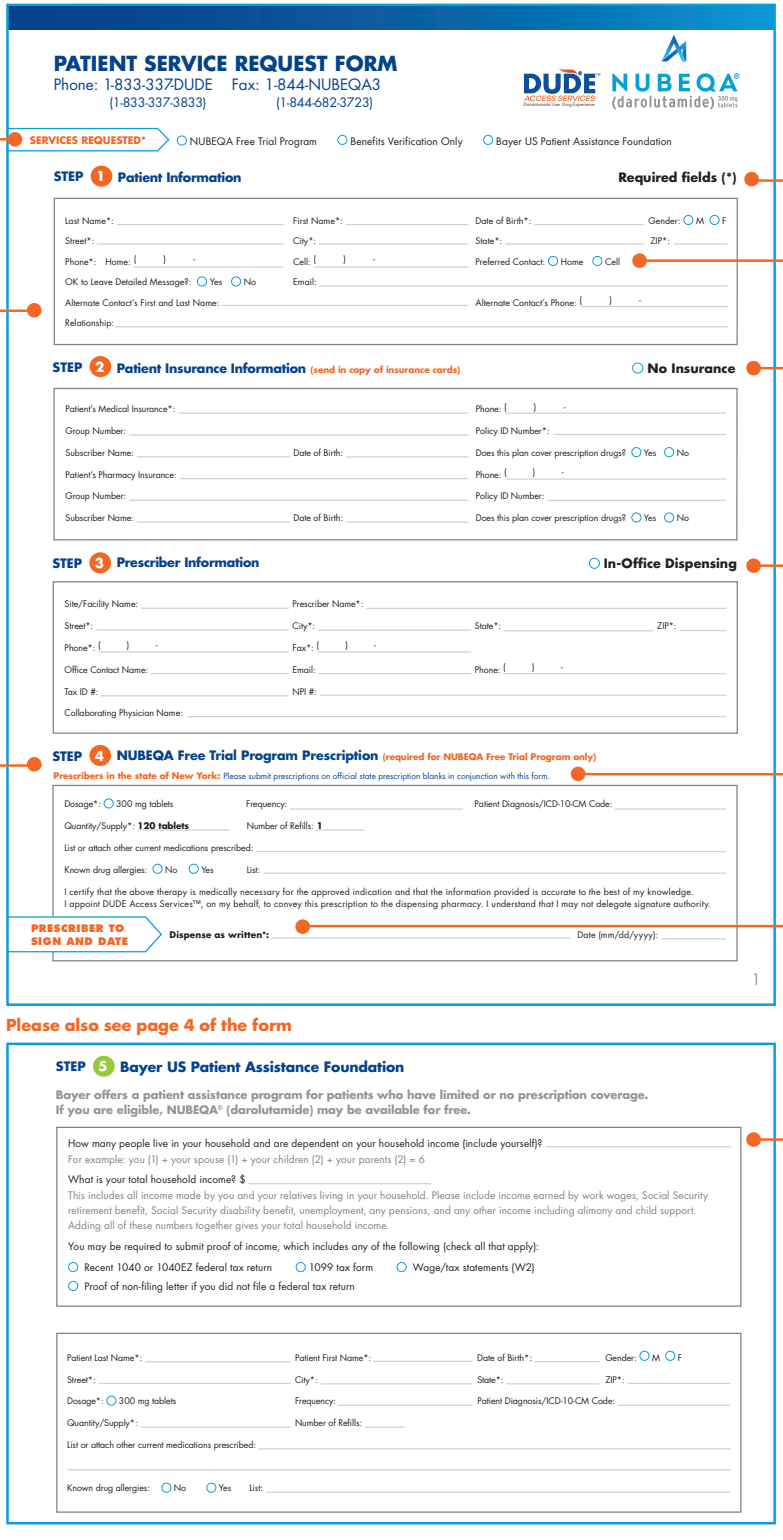
Bayer US Patient Assistance Foundation (complete steps 1-3 and 5)

- For eligible patients who need additional financial assistance

Alternate contacts may include family members to whom the patient has given permission to speak with DUDE Access Services™ on their behalf

NUBEQA Free Trial Program

- Complete the prescription section for 2 FREE months of NUBEQA
- At the end of the NUBEQA Free Trial Program, DUDE Access Services will contact you for a new prescription



PATIENT SERVICE REQUEST FORM
Phone: 1-833-337-DUDE (1-833-337-3833) Fax: 1-844-NUBEQA3 (1-844-682-3723)

DUDE ACCESS SERVICES Darolutamide User Drug Experience — NUBEQA® (darolutamide) 300 mg tablets

SERVICES REQUESTED* ○ NUBEQA Free Trial Program ○ Benefits Verification Only ○ Bayer US Patient Assistance Foundation

STEP 1 Patient Information — Required fields (*)

Last Name*: First Name*: Date of Birth*: Gender: ○ M ○ F
Street*: City*: State*: ZIP*:
Phone*: Home: ( ) - Cell: ( ) - Preferred Contact: ○ Home ○ Cell
OK to Leave Detailed Message?: ○ Yes ○ No Email:
Alternate Contact's First and Last Name: Alternate Contact's Phone: ( ) -
Relationship:

STEP 2 Patient Insurance Information (send in copy of insurance cards) ○ No Insurance

Patient's Medical Insurance*: Phone: ( ) -
Group Number: Policy ID Number*:
Subscriber Name: Date of Birth: Does this plan cover prescription drugs? ○ Yes ○ No
Patient's Pharmacy Insurance: Phone: ( ) -
Group Number: Policy ID Number:
Subscriber Name: Date of Birth: Does this plan cover prescription drugs? ○ Yes ○ No

STEP 3 Prescriber Information ○ In-Office Dispensing

Site/Facility Name: Prescriber Name*:
Street*: City*: State*: ZIP*:
Phone*: ( ) - Fax*: ( ) -
Office Contact Name: Email: Phone: ( ) -
Tax ID #: NPI #:
Collaborating Physician Name:

STEP 4 NUBEQA Free Trial Program Prescription (required for NUBEQA Free Trial Program only)
Prescribers in the state of New York: Please submit prescriptions on official state prescription blanks in conjunction with this form.

Dosage*: ○ 300 mg tablets Frequency: Patient Diagnosis/ICD-10-CM Code:
Quantity/Supply*: 120 tablets Number of Refills: 1
List or attach other current medications prescribed:
Known drug allergies: ○ No ○ Yes List:
I certify that the above therapy is medically necessary for the approved indication and that the information provided is accurate to the best of my knowledge.
I appoint DUDE Access Services™, on my behalf, to convey this prescription to the dispensing pharmacy. I understand that I may not delegate signature authority.

PRESCRIBER TO SIGN AND DATE — Dispense as written*: Date (mm/dd/yyyy):

1

Please also see page 4 of the form

STEP 5 Bayer US Patient Assistance Foundation

Bayer offers a patient assistance program for patients who have limited or no prescription coverage.
If you are eligible, NUBEQA® (darolutamide) may be available for free.

How many people live in your household and are dependent on your household income (include yourself)?
For example: you (1) + your spouse (1) + your children (2) + your parents (2) = 6
What is your total household income? $
This includes all income made by you and your relatives living in your household. Please include income earned by work wages, Social Security retirement benefit, Social Security disability benefit, unemployment, any pensions, and any other income including alimony and child support. Adding all of these numbers together gives your total household income.
You may be required to submit proof of income, which includes any of the following (check all that apply):
○ Recent 1040 or 1040EZ federal tax return ○ 1099 tax form ○ Wage/tax statements (W2)
○ Proof of non-filing letter if you did not file a federal tax return

Patient Last Name*: Patient First Name*: Date of Birth*: Gender: ○ M ○ F
Street*: City*: State*: ZIP*:
Dosage*: ○ 300 mg tablets Frequency: Patient Diagnosis/ICD-10-CM Code:
Quantity/Supply*: Number of Refills:
List or attach other current medications prescribed:
Known drug allergies: ○ No ○ Yes List:

COMPLETE ALL REQUIRED FIELDS, INCLUDING PATIENT SIGNATURES, TO AVOID DELAYS IN TREATMENT

At least 1 phone number is required

Check this circle if the patient does not have health insurance. **Complete Step 5 on page 4.**

Please check this circle for **In-Office Dispensing**

This informs DUDE Access Services to refer your patient back to your site after completing the NUBEQA Free Trial Program

Prescribers in NY must submit prescriptions on official state prescription blanks with this form

Missing signatures **WILL** cause a delay in processing

Financial information will help determine if your patient is eligible for additional financial assistance

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DUDE™ ACCESS SERVICES Darolutamide User Drug Experience

NUBEQA® (darolutamide) 300 mg tablets

SERVICES REQUESTED* ◯ NUBEQA Free Trial Program ◯ Benefits Verification Only ◯ Bayer US Patient Assistance Foundation

STEP 1 Patient Information

Required fields (*)

Last Name*: _____ First Name*: _____ Date of Birth*: _____ Gender: ◯ M ◯ F

Street*: _____ City*: _____ State*: _____ ZIP*: _____

Phone*: Home: ( ) - _____ Cell: ( ) - _____ Preferred Contact: ◯ Home ◯ Cell

OK to Leave Detailed Message?: ◯ Yes ◯ No Email: _____

Alternate Contact's First and Last Name: _____ Alternate Contact's Phone: ( ) - _____

Relationship: _____

STEP 2 Patient Insurance Information (send in copy of insurance cards)

◯ **No Insurance**

Patient's Medical Insurance*: _____ Phone: ( ) - _____

Group Number: _____ Policy ID Number*: _____

Subscriber Name: _____ Date of Birth: _____ Does this plan cover prescription drugs? ◯ Yes ◯ No

Patient's Pharmacy Insurance: _____ Phone: ( ) - _____

Group Number: _____ Policy ID Number: _____

Subscriber Name: _____ Date of Birth: _____ Does this plan cover prescription drugs? ◯ Yes ◯ No

STEP 3 Prescriber Information

◯ **In-Office Dispensing**

Site/Facility Name: _____ Prescriber Name*: _____

Street*: _____ City*: _____ State*: _____ ZIP*: _____

Phone*: ( ) - _____ Fax*: ( ) - _____

Office Contact Name: _____ Email: _____ Phone: ( ) - _____

Tax ID #: _____ NPI #: _____

Collaborating Physician Name: _____

STEP 4 NUBEQA Free Trial Program Prescription (required for NUBEQA Free Trial Program only)

Prescribers in the state of New York: Please submit prescriptions on official state prescription blanks in conjunction with this form.

Dosage*: ◯ 300 mg tablets Frequency: _____ Patient Diagnosis/ICD-10-CM Code: _____

Quantity/Supply*: **120 tablets** Number of Refills: **1**

List or attach other current medications prescribed: _____

Known drug allergies: ◯ No ◯ Yes List: _____

I certify that the above therapy is medically necessary for the approved indication and that the information provided is accurate to the best of my knowledge. I appoint DUDE Access Services™, on my behalf, to convey this prescription to the dispensing pharmacy. I understand that I may not delegate signature authority.

PRESCRIBER TO SIGN AND DATE

Dispense as written*: _____ Date (mm/dd/yyyy): _____

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DUDE™ ACCESS SERVICES Darolutamide User Drug Experience

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WRITTEN PERMISSION TO SHARE PROTECTED HEALTH INFORMATION

I authorize the use and disclosure of my Protected Health Information ("PHI") as defined by the Health Insurance Portability and Accountability Act of 1996, which was amended by the Health Information Technology for Economic and Clinical Health Act (as amended, "HIPAA"). I understand that Protected Health Information is health information that identifies me or that could reasonably be used to identify me and that this authorization to release my information is voluntary.

I authorize my healthcare provider, including my physician, pharmacies and my health plan, to disclose my name, address, and telephone number along with certain medical information including my treatment, my eligibility for assistance, the coordination of my treatment, the receipt of my medication and my participation in the Patient Support Program, DUDE Access Services™, to Bayer and its agents.

I allow the use and disclosure of my PHI for the following purposes: (1) To verify my insurance information; (2) to ensure the accuracy and completeness of the DUDE Access Services Patient Service Request Form; (3) to help with my reimbursement questions; (4) to determine if I qualify for patient assistance; (5) to determine my eligibility for other sources of funding; (6) to provide education, training, and ongoing support on the use of my medication; (7) to send me information on related products and services related to my treatment; (8) to send me refill reminders for my prescription and to encourage appropriate use; (9) to communicate with me, my healthcare providers and health plan insurers about my medical care and treatment; (10) to contact me for market research feedback; (11) for sales support purposes and (12) to comply with applicable law.

This authorization shall be in effect for 5 years from the date of my signature, or the date of last enrollment, whichever comes first, unless a shorter period is required by law. If I (or my representative) revoke this authorization, healthcare providers will stop using my PHI for the purposes outlined in this authorization, but the revocation will not affect prior use or disclosure of my PHI in reliance on this authorization. I (or my representative) may revoke this authorization at any time by calling 1-833-337-3833 or writing to: DUDE Access Services, PO Box 220724, Charlotte, NC 28222.

I also understand that, under this authorization, entities that receive my PHI may not be required by law to keep the information private and it will no longer be protected by the privacy law. It may become available in the public domain.

I understand that I do not need to sign this form to receive medical treatment or medication. I (or my representative) have read and understand the terms of this authorization form, and have had an opportunity to ask questions about the uses and disclosures of PHI described above. All of my questions have been answered to my satisfaction. I authorize the use and disclosure of my information as described in this form.

I (or my representative) have the right to receive a copy of this authorization upon request. I understand that my healthcare providers, insurers, and health plans may receive remuneration (payment) from Bayer in exchange for disclosing my PHI to Bayer.

○ I have read and agree to the NUBEQA $0 Co-Pay Program, and the NUBEQA Free Trial Program Terms and Conditions on page 3.

PATIENT TO SIGN AND DATE

Patient signature: _____ Date (mm/dd/yyyy): _____

If signed by a legal representative: Print Name: _____ Relationship to patient: _____

PATIENT SERVICE REQUEST FORM

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DUDE™ ACCESS SERVICES Darolutamide User Drug Experience

NUBEQA® (darolutamide) 300 mg tablets

NUBEQA $0 CO-PAY PROGRAM TERMS AND CONDITIONS

Patient must meet eligibility requirements of the NUBEQA $0 Co-pay Program; for example, only commercially insured patients are eligible: (i) Patient must inform NUBEQA $0 Co-pay Program of change in insurance status; (ii) it is required that the patient understand, accept and meet the terms of all the NUBEQA $0 Co-pay Program requirements; (iii) use of the NUBEQA $0 Co-pay Program must be consistent with and not prohibited by the requirements of the patient's health insurance; (iv) the NUBEQA $0 Co-pay Program benefit has a maximum amount of $25,000 per year, per patient; (v) the NUBEQA $0 Co-pay Program is for commercially insured patients using NUBEQA® (darolutamide) for an approved FDA indication; (vi) the NUBEQA $0 Co-pay Program does not cover costs for changes associated with administering NUBEQA or patient visits; (vii) offer valid only for patients treated in the USA, including Puerto Rico, Guam and US Territories; (viii) Bayer reserves the right to determine eligibility, monitor participation, fairly distribute product and may change or end the NUBEQA $0 Co-pay Program at any time with or without notice; (ix) patient agrees to provide necessary health information to the administration of the NUBEQA $0 Co-pay Program.

For questions about the NUBEQA $0 Co-pay Program, please call us at 1-833-337-DUDE (1-833-337-3833).

NUBEQA FREE TRIAL PROGRAM TERMS AND CONDITIONS

The NUBEQA Free Trial Program (FTP) provides 2 months' supply of NUBEQA at no cost to patients who meet FTP eligibility requirements and who agree to the FTP terms and conditions by submitting a signed FTP enrollment form. (i) FTP is a free trial offer, intended solely to allow new patients to try NUBEQA and to determine with their healthcare provider whether NUBEQA is right for them. There is no obligation to continue use of NUBEQA after the free trial has been completed; (ii) to be eligible, patient must: (1) reside in the United States or Puerto Rico and (2) be a new patient not currently using NUBEQA or who previously received NUBEQA through the FTP; (iii) NUBEQA supplied through the FTP will be dispensed only through a pharmacy designated by Bayer up to the limits above; (iv) product may only be delivered to the patient's home address (no P.O. boxes) or the prescribing healthcare provider's office; (v) it is unlawful for any person to sell, purchase, trade, barter or export NUBEQA supplied through the FTP or make an offer to do so; (vi) NUBEQA supplied through the FTP may not be billed (in whole or part, directly or indirectly) to any patient or third-party payer, including Medicare, Medicaid and commercial insurance plans; (vii) Bayer reserves the right to change or discontinue the FTP at any time without notice; (viii) the FTP is not health insurance; (ix) the FTP is not a discount, rebate, coupon, cost-sharing program or other form of financial assistance and no portion of the value of the FTP product may count as a patient out-of-pocket expense under any health insurance program; (x) NUBEQA supplied free of charge through the FTP is not contingent on continued use of NUBEQA or any other prescriptions or use of Bayer products. To continue a patient on therapy, a separate prescription must be written by the healthcare provider and filled at the patient's specialty pharmacy of choice; (xi) the FTP is void where prohibited by law and where use is prohibited by the patient's insurance provider.

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Bayer US Patient Assistance Foundation

Complete Step 5 for additional financial assistance

STEP 5 Bayer US Patient Assistance Foundation

Bayer offers a patient assistance program for patients who have limited or no prescription coverage. If you are eligible, NUBEQA® (darolutamide) may be available for free.

How many people live in your household and are dependent on your household income (include yourself)? _____

For example: you (1) + your spouse (1) + your children (2) + your parents (2) = 6

What is your total household income? $ _____

This includes all income made by you and your relatives living in your household. Please include income earned by work wages, Social Security retirement benefit, Social Security disability benefit, unemployment, any pensions, and any other income including alimony and child support. Adding all of these numbers together gives your total household income.

You may be required to submit proof of income, which includes any of the following (check all that apply):

- ◯ Recent 1040 or 1040EZ federal tax return
- ◯ 1099 tax form
- ◯ Wage/tax statements (W2)
- ◯ Proof of non-filing letter if you did not file a federal tax return

Patient Last Name*: _____ Patient First Name*: _____ Date of Birth*: _____ Gender: ◯ M ◯ F

Street*: _____ City*: _____ State*: _____ ZIP*: _____

Dosage*: ◯ 300 mg tablets Frequency: _____ Patient Diagnosis/ICD-10-CM Code: _____

Quantity/Supply*: _____ Number of Refills: _____

List or attach other current medications prescribed: _____

Known drug allergies: ◯ No ◯ Yes List: _____

Healthcare Professional Authorization

I certify that I am the healthcare professional who prescribed the medication requested in this application for the sole benefit of the named patient, and that my decision to prescribe was based on my independent professional judgment. I authorize the Bayer US Patient Assistance Foundation free drug program (the "Program"), and agents acting on its behalf to use my provider information, including National Provider ID, in the eligibility assessment process, and to forward this prescription, as necessary, to a dispensing pharmacy. In addition to the above, my signature below certifies the following: (i) I will not charge patients any fee for, or related to, their application, enrollment in the Program, any co-payment, or other cost-sharing amount related to free drug provided under the Program; (ii) no claim for payment for any product provided through the Program may be submitted to any third-party payer, including private insurers, Medicaid or Medicare; (iii) this medication provided by the Program will only be utilized by the patient named on this form, and will not be offered for sale, trade, barter, or returned for credit; (iv) the patient applying for assistance through the Program is being treated in an outpatient setting; (v) to the best of my knowledge, the information provided on this form is current, complete and accurate.

I understand and acknowledge that (i) submission of the application does not guarantee the patient's eligibility in the Program; (ii) the Program has the right to discontinue the Program at any time; and (iii) medication provided through the Program for enrolled patients is not contingent on any past, present or future prescriptions for this or any other Bayer product.

PRESCRIBER TO SIGN AND DATE

Prescriber's Signature (Required): _____ Date (mm/dd/yyyy): _____

PATIENT SERVICE REQUEST FORM

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Bayer US **Patient Assistance Foundation**

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

I agree to allow my healthcare providers and health insurers to give the Bayer US Patient Assistance Foundation free drug program, Bayer and its agents, my personal and medical information, including healthcare condition, diagnosis and medicines, for the following purposes: (1) (i) Determine if I am eligible for the program, (ii) provide me with free medicine through the Bayer US Patient Assistance Foundation free drug program if I am eligible to participate, and (iii) comply with any laws that may require the use or disclosure of my information. (2) Contact me or my healthcare provider for additional information to evaluate any adverse event or product complaint that I report or that my provider reports on my behalf. (3) Contact me to ask for feedback on the quality or customer service of the program. (4) Proper management and administration of the program and as permitted or required by applicable law.

I UNDERSTAND:

(1) Application to Bayer US Patient Assistance Foundation is entirely voluntary and I may choose to not complete or sign this form. My decision will not change the way my healthcare providers or health insurers treat me. However, if I do not complete and sign this application, I will not be able to participate in the Bayer US Patient Assistance Foundation free drug program. (2) Privacy laws may not prevent further disclosure of my information after it has been provided to the program, Bayer, their agents, or third-party providers authorized to administer the program. (3) This consent to provide my personal and medical information will continue until I am no longer enrolled in the program or until I choose to cancel my consent, which I may do at any time. (4) I can cancel my authorization at any time by writing to the Bayer US Patient Assistance Foundation, PO Box 5670, Louisville, KY 40255. Cancelling my consent will not have any effect on information given to or used by the program or its agents before the program received my written notice to cancel the consent. (5) I should keep a copy of this form. I also can get a copy by contacting the program at 1-866-2BUSPAF (1-866-228-7723).

INCOME VERIFICATION CONSENT

By applying for the Bayer US Patient Assistance Foundation free drug program, I understand and agree that: (i) there is no charge to participate and my participation in the program is not contingent on any requirement to purchase or use any Bayer product; (ii) completing and signing the program application does not guarantee my eligibility; (iii) the program may change or end at any time; (iv) I will not sell or trade any medicine that I get through this program; (v) I will notify the program within thirty (30) days if there is any change in my income, health insurance, eligibility to enroll in Medicare Part D, or any other reason that may affect my eligibility; (vi) I will not seek to be reimbursed or receive credit from my insurance provider, including Medicare Part D plans, for medicine I receive through the program; (vii) I will not seek credit for medicine from the program toward my true out-of-pocket expenses under Medicare Part D; (viii) the information I provided in this application is correct and complete.

I am providing 'written instructions' under the Fair Credit Reporting Act to the program, including its agents, administrators, and service providers, authorizing the program to obtain information from my credit profile and/or other information from Experian Health. I authorize the Bayer US Patient Assistance Foundation, including its agents, administrators, and service providers, to obtain such information solely to determine my eligibility to participate in the program.

PATIENT TO SIGN AND DATE

Patient signature: _____ Date (mm/dd/yyyy): _____

If signed by a legal representative: Print Name: _____ Relationship to patient: _____

MAC-DAR-US-0016-1 07/19