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 **1 FREE month** 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

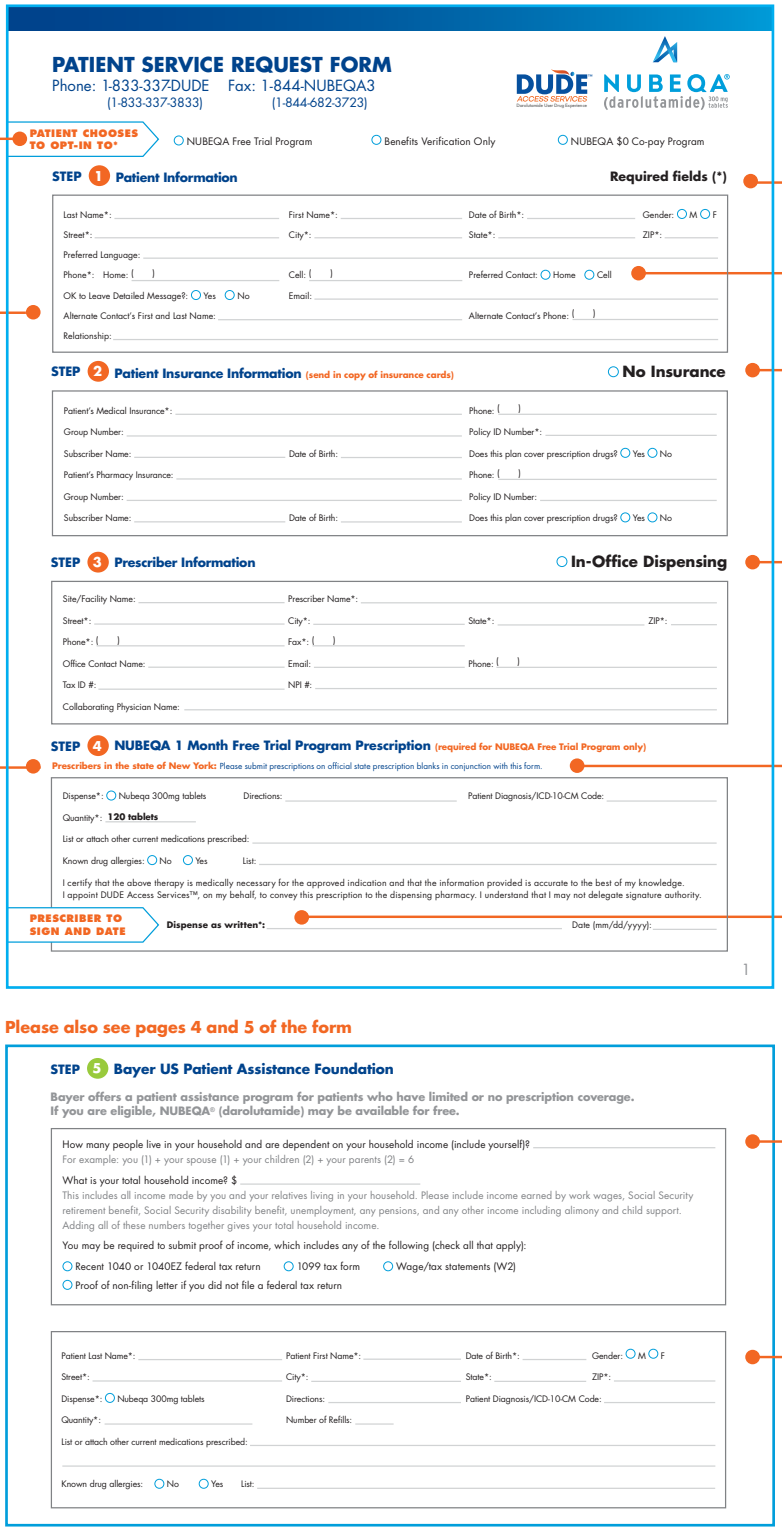
Bayer US Patient Assistance Foundation (complete steps 1-3 and 5)

- 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 1 FREE month 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 NUBEQA (darolutamide) 300 mg tablets

PATIENT CHOOSES TO OPT-IN TO* ○ NUBEQA Free Trial Program ○ Benefits Verification Only ○ NUBEQA $0 Co-pay Program

STEP 1 Patient Information — Required fields (*)

Last Name*: First Name*: Date of Birth*: Gender: ○ M ○ F
Street*: City*: State*: ZIP*:
Preferred Language:
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 1 Month 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.

Dispense*: ○ Nubeqa 300mg tablets Directions: Patient Diagnosis/ICD-10-CM Code:
Quantity*: 120 tablets
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 pages 4 and 5 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*:
Dispense*: ○ Nubeqa 300mg tablets Directions: Patient Diagnosis/ICD-10-CM Code:
Quantity*: 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

Please note: To complete Step 5, patients will have to initial and sign page 5 of the form

PATIENT SERVICE REQUEST FORM

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DUDE™ ACCESS SERVICES Darolutamide User Drug Experience

NUBEQA® (darolutamide) 300 mg tablets

PATIENT CHOOSES TO OPT-IN TO*

○ NUBEQA Free Trial Program ○ Benefits Verification Only ○ NUBEQA $0 Co-pay Program

STEP 1 Patient Information

Required fields (*)

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

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

Preferred Language: _____

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 1 Month 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.

Dispense*: ○ Nubeqa 300mg tablets Directions: _____ Patient Diagnosis/ICD-10-CM Code: _____

Quantity*: **120 tablets**

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): _____

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

PATIENT HIPAA AUTHORIZATION

I voluntarily provide this authorization for the use and disclosure of my Protected Health Information ("PHI"), as such term is defined by the Health Insurance Portability and Accountability Act of 1996 (as amended, "HIPAA"). I understand that PHI is health information that identifies me or that could reasonably be used to identify me.

I authorize my healthcare provider, including my physician and pharmacy, and my health plan, to disclose to Bayer and its contracted agents my name, address, telephone number, health insurance status and coverage and such medical information as may be necessary for me to enroll in DUDE Access Services. I understand this disclosure(s) will contain PHI, including information about my current medical condition, treatment, coordination of treatment and receipt of medication. I allow the use and disclosure of my PHI to Bayer its contracted agents for the following purposes:

- To verify my insurance information and coverage
- To ensure the accuracy and completeness of the DUDE Access Services Enrollment Form
- To help with my insurance coverage questions for Bayer medications
- To determine if I qualify for other Bayer patient support programs
- To determine my eligibility for other sources of prescription medication financial assistance
- To provide education, training, and ongoing support on the use of my Bayer medication
- To send me information on Bayer products and services related to my treatment
- To send me refill reminders for my Bayer prescription medication and to encourage its appropriate use
- To communicate with me, my healthcare providers and health plan about my medical care and treatment
- To contact me for market research feedback, sales support purposes, and as necessary to comply with applicable laws

I understand that:

- This Authorization will remain in effect until the end of my participation in DUDE Access Services or 5 years from the date of my signature on this Authorization, whichever occurs later.
- I may cancel this Authorization at any time by writing to: DUDE Access Services, PO Box 220724, Charlotte, NC 28222.
- If I cancel this Authorization my healthcare provider and health plan will stop sharing my PHI with Bayer and its contracted agents. However, the revocation will not affect prior use or disclosure of my PHI in reliance on this Authorization.
- That entities that receive my PHI in accordance with this Authorization may not be required by law to keep the information private and that it will no longer be protected by the HIPAA privacy law. It may become available in the public domain.
- I do not need to sign this Authorization to receive (i) medical treatment or medication or (ii) coverage, payment, enrollment in or eligibility for benefits from my health plan. However, if I do not sign this Authorization, I may not participate in DUDE Access Services or be eligible for other Bayer patient support programs.
- I understand that some of my health care providers, such as my pharmacies, may receive payment from Bayer in return for services that require use or disclosure of my PHI to Bayer and its contracted agents.

I have read and understand the terms of this Authorization and have had an opportunity to ask questions about the uses and disclosures of PHI. I understand that I am entitled to receive a signed copy of this Authorization and I can also get a copy by contacting DUDE Access Services at 1-833-337-DUDE (1-833-337-3833).

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

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

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 1 MONTH FREE TRIAL PROGRAM TERMS AND CONDITIONS

The NUBEQA Free Trial Program (FTP) provides a 1 month 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.

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*: _____

Dispense*: ◯ Nubeqa 300mg tablets Directions: _____ Patient Diagnosis/ICD-10-CM Code: _____

Quantity*: _____ 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): _____

Bayer US **Patient Assistance Foundation**

PROGRAM RULES AND 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; and (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 Bayer US Patient Assistance Foundation (the "Foundation"), including its agents, administrators, and service providers, authorizing the Foundation to obtain information from my credit profile and/or other information from Experian Health. I authorize the Foundation, including its agents, administrators, and service providers, to obtain such information solely to determine my eligibility to participate in the Foundation's free drug program.

PATIENT TO INITIAL HERE

Patient initial here _____ to confirm you and understand and consent to the above rules and instructions.

PATIENT HIPAA AUTHORIZATION

I agree to allow my healthcare providers and health insurers to use and disclose my Protected Health Information ("PHI"), as such term is defined by the Health Insurance Portability and Accountability Act of 1996 (as amended, "HIPAA"), including my name, address, telephone number, health insurance status and coverage and such medical and treatment information as may be necessary for me to enroll into the Bayer US Patient Assistance Foundation (the "Foundation"), Bayer and their agents for the following purposes: (1) to verify my insurance information and coverage; (2) to ensure the accuracy and completeness of my application to the Foundation's free drug program (the "Program"); (3) to determine if I am eligible for the Program and, if so, provide me with my prescribed Bayer medicine at no cost; (4) to contact me for feedback on the quality of customer service for the Program and to improve Program operations and administration; and (5) as required or permitted under applicable law. I understand that PHI is health information that will identify me, or that could reasonably be used to identify me. I understand that some of my health care providers, such as my pharmacies, may receive payment from Bayer in return for services that require use or disclosure of my PHI to Bayer and its contracted agents.

My application to the Foundation is entirely voluntary. I understand that I do not need to sign this Authorization to receive (i) medical treatment or medication from my healthcare providers or (ii) coverage, payment, enrollment in or eligibility for benefits from my health plan. However, if I do not sign this form, I will not be eligible to apply for free medicine through the Foundation's Program. This Authorization to share my PHI will continue until I am no longer enrolled in the Program or 5 years from the date of my signature on this Authorization, whichever occurs later. I may cancel this Authorization at any time by writing to the Bayer US Patient Assistance Foundation, PO Box 5670, Louisville, KY 40255. If I cancel this Authorization my healthcare provider and health plan will stop sharing my PHI with Bayer and its contracted agents. However, cancelling my consent will not have any effect on prior use or disclosure of my PHI in reliance on this Authorization. I understand that entities that receive my PHI in accordance with this Authorization may not be required by law to keep the information private and that it will no longer be protected by the HIPAA privacy law.

I have read and understand the terms of this Authorization and have had an opportunity to ask questions about the uses and disclosure of my PHI. I understand that I am entitled to receive a signed copy of Authorization consent and I can also get a copy by contacting the Program at 1-866-2BUSPAF (1-866-228-7723).

PATIENT TO SIGN AND DATE

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

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

MAC-NUB-US-0087-1 12/20