SpringWorks CareConnections®

GOMEKLI® (mirdametinib) ENROLLMENT FORM

PLEASE COMPLETE THE ENTIRE FORM, SIGN, AND FAX IT TO 844-227-3747.

Access a digital enrollment form at springworkstxcares.com/gomekli/hcp, e-prescribe directly to PharmaCord Pharmacy (NCPDP Number 1836191) or email the enrollment form to info@springworkstxcares.com.

For assistance, please call SpringWorks CareConnections at 844-CARES-55 (844-227-3755), Monday – Friday, 8 AM – 8 PM ET.

Services requested (check all that apply): ◯ Benefits Verification ◯ Nursing Support ◯ Financial Assistance

PATIENT TO COMPLETE

1 | Patient Information

First Name: _____ Last Name: _____ Date of Birth: ____/____/____ (MM/DD/YYYY) Gender: ◯ M ◯ F

Street Address: _____ Apt: _____ City: _____

State: _____ ZIP: _____ Preferred Phone #: (____) _____ Email: _____

Primary Language: _____ Preferred Contact Method: ◯ Call ◯ Text (opt-in below) ◯ Email

2 | Patient Financial Information (required to verify eligibility for Patient Assistance Program)

Number of Household Members (Including Patient): _____ Annual Gross Household Income: $ _____

3 | Patient Authorization

3A | I have read and understand the **Authorization to Use and Disclose Health and Other Personal Information** and agree to the terms on page 3.

SIGN HERE

_____ ____/____/____ (MM/DD/YYYY)
Patient or Personal Representative Signature

_____
Personal Representative Full Name (if applicable)

Authority/relationship of personal representative (if applicable):
◯ Legal Guardian ◯ Power of Attorney

NOTE: Please add any Power of Attorney information if applicable.

3B | ◯ **FOR CALIFORNIA PATIENTS ONLY:** By checking this box, I request that my **Authorization to Use and Disclose Health and Other Personal Information and Marketing Consent (if selected below)** remain valid for ten (10) years from the date of my signature. If not, such consent will expire in one (1) year from the date of my signature.

3C | ◯ **Marketing Consent (optional):** By checking this box, I authorize EMD Serono, Inc. and SpringWorks Therapeutics, Inc., which are healthcare companies of Merck KGaA, Darmstadt, Germany, to use my Health Information for marketing and market research purposes, including, but not limited to, providing education and promotional materials, information, offers, and services related to my therapy or medical condition and contacting me to participate in focus groups, surveys, or interviews funded or sent by SpringWorks Therapeutics, Inc., SpringWorks CareConnections Patient Support Program, or SpringWorks Therapeutics, Inc. affiliates. I understand I may withdraw my consent as described in this form.

3D | ◯ By selecting this option, I confirm that I have read and understand the **Opt-in for Text Messages Communication** related to the Patient Support Program and agree to the terms on page 3.

Upon enrollment, expect a welcome call from a SpringWorks CareConnections Nurse Advocate to explain the program and what you can expect next. The call will come from EMD Serono Patient Support (781-261-5400). Please add this number to your contact list so you recognize the call.

4 | Patient Insurance Information (NOTE: You may attach a copy of both sides of the patient's insurance card(s) instead of, or in addition to, the below)

Coverage: ◯ Commercial/Private ◯ Medicare ◯ Medicaid ◯ VA/DoD/TRICARE ◯ Other ◯ Uninsured

Primary Insurance: _____

ID #: _____

Group #: _____ Phone #: (____) _____

Medicare Part A/B ID #: _____

Cardholder Name (if different than patient): _____

Prescription Insurance: _____

ID #: _____

Rx BIN #: _____ Rx PCN: _____ Rx GRP: _____

SpringWorks CareConnections will verify your patient's insurance coverage. Please share any coverage information you've already obtained.

Has a Prior Authorization (PA) Been Initiated? ◯ Yes ◯ No
If "Yes," PA Status: ◯ Approved ◯ Denied ◯ Pending

Has an Appeal Been Initiated? ◯ Yes ◯ No
If "Yes," Appeal Status: ◯ Approved ◯ Denied ◯ Pending

NOTE: Please attach any relevant insurer approval or denial letters.

PRESCRIBER TO COMPLETE

5 | Patient Clinical Information

NOTE: Please attach any clinical notes or laboratory results relevant to therapy

Select ICD-10-CM code: ◯ **Q85.01** Neurofibromatosis, type 1

Select the appropriate location-based code for NF1-associated PN(s) (select all that apply):

◯ D33.3 Benign neoplasm of cranial nerves
◯ D36.10 Benign neoplasm of peripheral nerves and autonomic nervous system, unspecified
◯ D36.11 Benign neoplasm of peripheral nerves and autonomic nervous system of face, head, and neck
◯ D36.12 Benign neoplasm of peripheral nerves and autonomic nervous system, upper limb, including shoulder
◯ D36.13 Benign neoplasm of peripheral nerves and autonomic nervous system of lower limb, including hip
◯ D36.14 Benign neoplasm of peripheral nerves and autonomic nervous system of thorax
◯ D36.15 Benign neoplasm of peripheral nerves and autonomic nervous system of abdomen
◯ D36.16 Benign neoplasm of peripheral nerves and autonomic nervous system of pelvis
◯ D36.17 Benign neoplasm of peripheral nerves and autonomic nervous system of trunk, unspecified
◯ Other: _____

Clinical Notes Attached? ◯ Yes ◯ No

Allergies: _____ Current Medication(s): _____

Received Prior Treatment: ◯ Yes ◯ No, Treatment Naive

If "Yes," Select All That Apply:
◯ Surgery (description) _____ Date of Surgery ____/____ (MM/YYYY)
◯ Medication Name _____ Start Date ____/____ (MM/YYYY) Stop Date ____/____ (MM/YYYY)
◯ Other (description) _____

Please see full Prescribing Information at springworkstx.com/gomekli-prescribing-info.

SpringWorks CareConnections

PLEASE COMPLETE THE ENTIRE FORM, SIGN, AND FAX IT TO 844-227-3747.

PRESCRIBER TO COMPLETE

6 | Prescriber Information

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

NPI #: _____ Tax ID #: _____

State License # (PR only): _____

Office/Clinic/Institution Name: _____

Office Contact Name: _____

Office Contact Phone: (_____) _____ Office Ext: _____

Office Fax: _____

Office Contact Email: _____

7 | Preferred Specialty Pharmacy

◯ No Preference ◯ Biologics by McKesson ◯ Onco360 ◯ In-Office Medically Integrated Dispensing Pharmacy

If Preferred Pharmacy Is an Eligible Medically Integrated Dispensing Site:

Pharmacy NPI: _____ Contact Name: _____ Phone: (_____) _____ Fax: (_____) _____

Has a Prescription for GOMEKLI Already Been Sent to a Pharmacy?

◯ Yes ◯ No If "Yes," Date Prescribed: _____ /_____ /_____
MM DD YYYY

Pharmacy Name: _____

8 | Prescription for GOMEKLI® (mirdametinib)

NOTE: Complete GOMEKLI Prescription Information section AND either section 8, 8A , 8B, or 8C (if applicable).

GOMEKLI PRESCRIPTION INFORMATION

The recommended dosage of GOMEKLI is 2 mg/m^2 orally twice daily (approximately every 12 hours) with or without food for the first 21 days of each 28-day cycle. The maximum dose is 4 mg twice daily. Continue treatment with GOMEKLI until disease progression or unacceptable toxicity. The recommended dosage is based on body surface area (BSA). Please see US Prescribing Information for recommended and modified dosage.

Patient Name: _____ **Date of Birth:** _____ /_____ /_____
MM DD YYYY

National Drug Code (NDC): Capsules: 1 mg (NDC: 82448-130-42) 42 per bottle | 2 mg (NDC: 82448-260-42) 42 per bottle | 2 mg (NDC: 82448-260-84) 84 per bottle
Tablets: 1 mg (NDC: 82448-134-42) 42 per bottle | 1 mg (NDC: 82448-134-84) 84 per bottle

Medication	Dosage Strength and Form	Dosage Instructions	Quantity	Refills
◯ **8. GOMEKLI** PRESCRIPTION	◯ 1 mg capsules (21-day supply) ◯ 2 mg capsules (21-day supply) ◯ 1 mg tablets (21-day supply)	◯ Capsules: ___mg orally twice daily for _____ days ◯ Tablets: ___mg swallowed whole or dispersed and administered orally or by feeding tube (via a nasogastric or gastric tube) suspension twice daily for _____ days	◯ _____ capsules ◯ _____ capsules ◯ _____ tablets	_____
◯ **8A. GOMEKLI** QUICK START PROGRAM (NEW PATIENT)	◯ 1 mg capsules (21-day supply) ◯ 2 mg capsules (21-day supply) ◯ 1 mg tablets (21-day supply)	◯ Capsules: ___mg orally twice daily for _____ days ◯ Tablets: ___mg swallowed whole or dispersed and administered orally or by feeding tube (via a nasogastric or gastric tube) suspension twice daily for _____ days	◯ _____ capsules ◯ _____ capsules ◯ _____ tablets	Up to 5
I approve the dispense of GOMEKLI as shown above to my patient if they experience a qualified delay in obtaining insurance coverage. I certify that my patient has not previously been treated with GOMEKLI, has an immediate medical need for GOMEKLI, and meets all eligibility criteria found at springworkstxcares.com/gomekli/hcp/about.				
◯ **8B. GOMEKLI** BRIDGE PROGRAM (EXISTING PATIENT)	◯ 1 mg capsules (21-day supply) ◯ 2 mg capsules (21-day supply) ◯ 1 mg tablets (21-day supply)	◯ Capsules: ___mg orally twice daily for _____ days ◯ Tablets: ___mg swallowed whole or dispersed and administered orally or by feeding tube (via a nasogastric or gastric tube) suspension twice daily for _____ days	◯ _____ capsules ◯ _____ capsules ◯ _____ tablets	Up to 2
◯ **8C. GOMEKLI** PATIENT ASSISTANCE PROGRAM (NEW OR EXISTING PATIENT)	◯ 1 mg capsules (21-day supply) ◯ 2 mg capsules (21-day supply) ◯ 1 mg tablets (21-day supply)	◯ Capsules: ___mg orally twice daily for _____ days ◯ Tablets: ___mg swallowed whole or dispersed and administered orally or by feeding tube (via a nasogastric or gastric tube) suspension twice daily for _____ days	◯ _____ capsules ◯ _____ capsules ◯ _____ tablets	_____
I approve the dispense of GOMEKLI as shown above to my patient if they experience a qualified lapse in insurance coverage. I certify that my patient meets all eligibility criteria found at springworkstxcares.com/gomekli/hcp/about.				

9 | Prescriber Authorization

PRESCRIBER CONSENT

I certify that I have obtained all necessary consents, authorizations and permissions, including from my patient, required by applicable state and federal laws, including the applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and applicable states laws needed to release the individually identifiable health information included on this form to EMD Serono, Inc. and SpringWorks Therapeutics, Inc. and SpringWorks CareConnections and each of their respective agents and service providers, and for EMD Serono, Inc. and SpringWorks Therapeutics, Inc. and SpringWorks CareConnections to use such information for purposes of verifying my patient's insurance coverage and eligibility; assisting with financial assistance resources and information, such as co-pay support or free drug patient assistance programs for which the patient may be eligible; coordinating the dispensing of my patient's prescription medicine; contacting the patient with educational materials about the patient's prescription medication; and introducing Company support services to my patient (eg, the Patient Support Program), including contacting my patient by telephone or mail for these purposes.

_____ _____ Date _____ /_____ /_____
Provider Signature (Dispense as Written) Provider Signature (Substitutions Allowed) MM DD YYYY

Please see full Prescribing Information at springworkstx.com/gomekli-prescribing-info.

I authorize my treating physician(s), pharmacy(ies), health insurance company(ies), prescription drug plan(s), and other parties providing me health care or paying for my health care (collectively, "My Health Care Providers and Plans") to disclose my personal and protected health information ("Health Information") to EMD Serono, Inc. and SpringWorks Therapeutics, Inc., which are healthcare companies of Merck KGaA Darmstadt, Germany and its agents and representatives (collectively the "Company"). My Health Information may include, but is not limited to, information regarding my treatment with GOMEKLI® (mirdametinib) and my related diagnosis and information included in a Prescription or Patient Support Program Enrollment Form, and any other information deemed relevant by My Health Care Providers and Plans that may be considered sensitive or specially protected by law. The Company may use and further disclose my Health Information to My Health Care Providers and Plans or other third parties in order to: (1) enroll me in and administer the SpringWorks CareConnections Support Program ("CareConnections") and contact me by mail, email, or by live call at the telephone number(s) listed above, or to any future telephone number(s) provided by me; (2) conduct a benefits investigation and coordinate my insurance coverage for any prescribed Company product(s); (3) facilitate the filling of my prescription for and the delivery and administration of that product(s); and (4) contact me regarding CareConnections and conduct quality assurance, surveys, and other internal business activities or analyses in connection with CareConnections.

I understand that once my Health Information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws (e.g., the Health Insurance Portability and Accountability Act [HIPAA]) and may be further disclosed to others.

For more information on your privacy rights and choices, please see EMD Serono's privacy notice at **https://www.emdgroup.com/en/privacy-statement**.

I understand that I may refuse to sign this authorization and such refusal will not affect my eligibility to receive any Company product, my treatment, payment for treatment, or eligibility for or enrollment in health benefits, but it will limit my ability to receive CareConnections services. I understand and agree that this authorization will remain in effect for 10 years from the date of my signature (unless I am a California resident, in which case this authorization will remain in effect for 1 year, or for 10 years if I check the box in Section 3B above) unless I revoke it earlier by contacting the Company at info@springworkstx.com or by phone at 844-CARES-55 (844-227-3755). If I revoke this authorization, My Health Care Providers and Plans will stop disclosing my Health Information to the Company, and the Company will stop using and disclosing this information, as soon as possible, but the revocation will not affect prior use or disclosure of my Health Information in reliance on this authorization.

I understand and agree that the pharmacy that is dispensing my Product may receive remuneration from the Company in exchange for disclosing my Personal Information to the Company for providing me with support services in connection with the Patient Support Program.

OPT-In for Automated Text Messages Communication

I authorize the Company or others on its behalf to contact me by SMS/text message regarding any of the aforementioned services and/or my condition or treatment. I understand that I am not required to provide this consent as a condition of purchasing any goods or services. Message and data rates may apply. Terms & Conditions can be found at **https://springworkstxcares.com/downloads/CareConnections-Mobile-Terms-and-Conditions.pdf**. **To authorize your consent, please check the box listed in Section 3: Patient Authorization on page 1.**

I also understand that I have the right to receive a signed copy of this authorization.

Fair Credit Reporting Act (FCRA) Certification

I understand that I am providing "written instructions" authorizing the Company and its vendors, under the FCRA, to obtain information from my credit profile or other information from the vendor, solely for the purpose of determining financial qualifications for programs administered by EMD Serono, Inc. and SpringWorks Therapeutics, Inc., including the SpringWorks CareConnections Patient Assistance Program. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process.

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US-GOM-01906 11/26
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SpringWorks CareConnections®