Patient consent form

KIMMTRAK CONNECT®

KIMMTRAK CONNECT® is a support program (the "program") available at no cost for adult patients prescribed KIMMTRAK® (tebentafusp-tebn). Sponsored by Immunocore, the maker of KIMMTRAK, the program* matches each patient and caregiver with a dedicated nurse case manager, who offers support and one-on-one guidance tailored to their individual needs.

Customized support

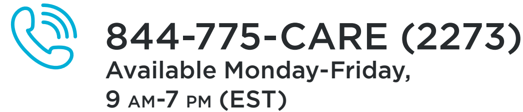
Care coordination

Financial assistance

* Terms and conditions apply. Immunocore reserves the right to rescind, revoke, or amend the program at any time without notice.

Instructions for patients

Request KIMMTRAK CONNECT support by completing this form, which you or your doctor's office can submit in one of the following ways:



844-775-CARE (2273)
Available Monday-Friday,
9 AM-7 PM (EST)

KIMMTRAKCONNECT.com/enroll

866-981-3072

PatientSupport@
kimmtrakconnect.com

STEP 1 - Patient information (*Required)

Patient first name* | **Patient last name*** | Primary language | Email address

Sex: ○ Male ○ Female

Date of birth* ____/____/______ (MM/DD/YYYY)

Address*

City* | **State*** | **ZIP code***

Primary telephone* ○Home ○Mobile

Consent to leave voice message at patient telephone? ○Yes ○No

Consent to be contacted via SMS texting (texting and data rates may apply)? ○Yes ○No

STEP 2 - Authorization to use and disclose personal information

I authorize my healthcare providers, my health insurance plan, and my pharmacies (collectively, the "Disclosing Parties") to use and disclose my personal information, including my medical records, insurance coverage information, name, address, and telephone number, to Immunocore Ltd., its affiliates, agents, and service providers (together, "Immunocore"). I authorize Immunocore to receive, use, and share my personal information in order to provide me with access to the products, services, and programs described on this form, which may include the following:

- Establishing eligibility for benefits and coverage information;
- Communicate with my healthcare providers and me about my treatment or condition and related products relevant to receiving treatment for my condition;
- Coordinating my prescription through a hospital, pharmacy, infusion site and/or other site of service;
- Determining my eligibility for and facilitating enrollment into the program.
- Ensuring quality and safety and improving our products and services;
- Contacting me by mail, email, calls, and text messages at the number(s) and address(es) provided for Program purposes.

I understand that this will include the sharing and use of information that could be considered sensitive personal information, such as health conditions, but that the use of this information by Immunocore is necessary to determine if I qualify for and the administration of the Program. I understand that Immunocore may also share my personal information for the purposes described in this authorization with my healthcare providers, service providers, and any individual I designate as a personal representative.

I understand that I can choose not to sign this authorization, but Immunocore will not be able to provide the services without it. However, my healthcare providers may not make my treatment, payment, enrollment, or benefits depend on whether I sign this authorization.

I understand and agree that:

- This authorization is valid for 5 years from the date I sign or the date I last enrolled, whichever comes first, unless a shorter period is required by law, or I revoke it earlier;
- My personal information released under this authorization may no longer be protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA). However, Immunocore will only use and share my personal information for the purposes stated on this authorization or as otherwise permitted by law;
- I have the right to revoke this authorization at any time by submitting written notice to: (Immunocore c/o: Optime Care 4060 Wedgeway Ct, Earth City, MO 63045). If I revoke this authorization, I will no longer be eligible for the services described. If a healthcare provider is disclosing my personal information to Immunocore on an authorized, ongoing basis, my revocation will be effective with respect to such healthcare provider when they receive notice of my revocation. My revocation will not impact uses and disclosures of my personal information that have already occurred in reliance on this authorization;
- More information on my privacy rights can be found in Immunocore's privacy policy, as updated from time to time (https://www.immunocore.com/privacy-and-social-media -guidelines); and
- I have a right to receive a copy of this authorization.

STEP 2 - Authorization to use and disclose personal information (continued)

By signing this form, I acknowledge that I have provided accurate and complete information and understand and agree to the terms of this form. My signature certifies that I wish to enroll in the Program and that I have read, understood, and agree to the release and use of my personal information, including sensitive personal information, pursuant to the authorization to use and disclose personal information and as otherwise stated on this form.

○ I do not consent to this authorization.

Patient authorization

> ______________________________

Signature of patient or patient's personal representative

Date of birth: ____/____/______ (MM/DD/YYYY)

____

Printed full name

Date: ____/____/______ (MM/DD/YYYY)

STEP 3 - Infusion facility

Please fill out the following for your preferred infusion facility. If you are unsure what facility to list, please speak with your physician.

Facility name

Facility address

Telephone

Fax

City

State

ZIP code

Insurance information

Primary insurance

Policy #

Policyholder's first and last name

Insurance company telephone

Group #

Policyholder's date of birth: ____/____/______ (MM/DD/YYYY)

Secondary insurance (if applicable)

Policy #

Policyholder's first and last name

Insurance company telephone

Group #

Policyholder's date of birth: ____/____/______ (MM/DD/YYYY)

Check here if you do not have medical insurance.

☐ No medical insurance coverage

Please include *front and back* copy of insurance card(s) along with this form.

Prescriber certification for enrollment

Steps 4–6 to be completed by prescriber

STEP 4 - Prescriber information

Prescriber first name | Prescriber last name | Group name | Group tax ID #

Office address | Clinic/hospital affiliation | NPI #

City | State | ZIP code

Office contact name | Email address

Office contact telephone | Fax | Prescriber specialty

Co-managing prescriber name (leave field blank if not applicable)

- ○ Medical oncologist: ______ NPI #
- ○ Oncologist/hematologist: ______ NPI #
- ○ Other specialty (please specify): ______ NPI #

STEP 5 - Diagnosis (Required for benefits investigation)

Primary diagnosis code (Please select one)

- ○ C69 – Neoplasms of the eye
- ○ Other ICD-10 code: ______

- ○ C69.9X (C69.90, C69.91, C69.92) – Malignant neoplasm of unspecified site of eye
- ○ C69.3X (C69.30, C69.31, C69.32) – Malignant neoplasm of choroid
- ○ C69.4X (C69.40, C69.41, C69.42) – Malignant neoplasm of ciliary body

Does patient have documented metastatic uveal melanoma (mUM)? ○ Yes ○ No

Additional disease manifestation codes: ______

Steps 4–6 to be completed by prescriber

STEP 6 - Prescriber certification

By signing below, I certify: (1) this prescription is medically appropriate for this patient and I will supervise this patient's treatment; (2) I have received the necessary authorizations, including those required by HIPAA, to release this patient's personal information submitted with this authorization form to Immunocore to enable enrollment in the Program; (3) I appoint Immunocore, on my behalf, to proceed with services and convey this prescription to the dispensing pharmacy, to the extent permitted under state law; (4) I am under no obligation to prescribe any Immunocore product and have not, nor will I receive, any benefit from Immunocore for prescribing any Immunocore product; and (5) I understand that Immunocore may revise, change, or terminate the Program at any time without notice.

Prescriber certification

> PRESCRIBER SIGNATURE (REQUIRED)

Dispense as written

Date: ____ /____ /______
(MM/DD/YYYY)

Written or e-signature only; stamps not acceptable. The above signature grants permission to share records with the co-management team.

KIMMTRAK CONNECT®

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