KIMMTRAK CONNECT®

Sign up for support with KIMMTRAK CONNECT®

KIMMTRAK CONNECT is a support program available at no cost for eligible adult patients prescribed KIMMTRAK® (tebentafusp-tebn). Sponsored by Immunocore, the maker of KIMMTRAK, the program matches patients and caregivers with a dedicated nurse case manager who is US-based and provides customized support—from financial assistance to scheduling appointments to educational support.

Once complete, fax to 866-981-3072 or e-mail PatientSupport@kimmtrakconnect.com.

Complete the information below to initiate patient enrollment process.

If you are a California resident, please visit www.immunocore.com/site/privacy to learn more about our data collection practices and your rights under the California Consumer Privacy Act.

For support, call KIMMTRAK CONNECT at 844-775-CARE (844-775-2273).

Steps 1–3 to be completed by patient

Step 1

Patient information (* Required)

Patient first name* _____ **Patient last name*** _____ Primary language _____ E-mail 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? ○ Yes ○ No
(texting and data rates may apply)

Preferred means of contact*:
○ E-mail ○ Mail
○ Telephone ○ Text message

Preferred time of contact:
☐ Morning (8 AM-11 AM)
☐ Afternoon (11 AM-3 PM)
☐ Evening (3 PM-6 PM)

By providing my phone number and signing on the top of the next page, I consent to receive recurring KIMMTRAK CONNECT calls and texts, including to my mobile phone, from and on behalf of Immunocore Ltd. I understand calls and texts may be made using automated technology and/or a prerecorded message. I understand consent is not a condition of purchasing any goods or service. I consent to receive calls and texts even if my phone number is on the national or state(s) do not call registry. Standard message and data rates may apply.

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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.

I understand that I am enrolling in KIMMTRAK CONNECT to help facilitate access to my prescribed medication and other potential patient support benefits that may be offered pending my eligibility. I can cancel my enrollment in KIMMTRAK CONNECT by contacting KIMMTRAK CONNECT at 844-775-2273.

> _____

Signature of patient or patient's personal representative

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

_____

Printed full name

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

Signature is also needed on page 3.

Step 2

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

Step 3

Patient HIPAA authorization

Please read the patient HIPAA authorization section below

I hereby authorize my healthcare providers, my health insurance carriers, and my pharmacies (collectively, the "Disclosing Parties") to use and disclose my individually identifiable health information, including my medical records,

Step 3 (continued)

insurance coverage information, name, address, and telephone number, to Immunocore Ltd., its affiliates, agents, representatives, and service providers, including those authorized by Immunocore (together, "Immunocore") to provide drug support and to distribute indigent care drugs for the following purposes: (1) to establish eligibility for benefits and coverage benefits information; (2) to communicate with my healthcare providers and me about my treatment or condition and related products relevant to receiving treatment for my condition; (3) to facilitate the provision of products, supplies, or services by a third party including, but not limited to, infusion centers; (4) to register me in any applicable product registration program required for my treatment; and (5) to enroll me in eligible patient support programs offered by KIMMTRAK CONNECT and/or Immunocore, including nursing or patient access support services.

I understand that Immunocore, as well as the Disclosing Parties, cannot require me, as a condition of having access to prescription medications, treatment, or other care, to sign this Authorization, but the services offered by KIMMTRAK CONNECT may be limited or unavailable without it. I understand that I am entitled to a copy of this Authorization.

I understand that information disclosed pursuant to this Authorization in some cases may be redisclosed by the recipient and no longer protected by HIPAA or other privacy laws. However, Immunocore has agreed to use and disclose my information only for purposes of operating the KIMMTRAK CONNECT program. I understand that I may revoke this Authorization at any time by mailing a signed letter requesting such cancellation to KIMMTRAK CONNECT (include address for service provider), but that this revocation will not apply to any information used or disclosed by the Disclosing Parties based on this Authorization before they are notified that I have cancelled it. Unless required by state law, this Authorization is valid for whichever is greater: (a) the duration of my treatment for mUM or (b) 10 years from the date signed below. A photocopy of this Authorization will be treated in the same manner as the original.

Patient authorization

> _____ Date of birth: ____ / ____ / _____ (MM/DD/YYYY)

Signature of patient or patient's personal representative

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

Printed full name

For coordination support or assistance obtaining patient signature, speak with KIMMTRAK CONNECT at 844-775-2273.

Physician certification for enrollment in KIMMTRAK CONNECT®

KIMMTRAK CONNECT®

Steps 4–6 to be completed by physician

Step 4

Physician information

Physician first name _____ Physician last name _____ Group name _____ Group tax ID # _____

Office address _____ Clinic/hospital affiliation _____ NPI # _____

City _____ State _____ ZIP code _____

Office contact name _____ E-mail address _____

Office contact telephone _____ Fax _____ Physician specialty _____

Co-managing physician 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: _____

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Step 6

Physician certification

By signing below, I certify: (1) the therapy is medically necessary based on my independent, professional judgment and that the information provided is accurate to the best of my knowledge; (2) I am disclosing this information to help enable treatment for this Patient, and I understand that Immunocore Ltd., its affiliates, agents, representatives, and service providers and their respective employees or agents (together, "Immunocore") will use this information to help enable treatment for this Patient through KIMMTRAK CONNECT ("Program"); (3) my Patient or my Patient's authorized representative has provided a signed HIPAA authorization, and I have provided a copy of Notice of Privacy Practices that allows me to share protected health information with Immunocore for purposes of the Program; (4) 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; (5) I understand and agree that any medication or service provided through the Program as a result of this form is for the named Patient only and is not being made in exchange for any express or implied agreement or understanding that I would recommend or prescribe any Immunocore product or service, for any other person; (6) I will not seek reimbursement from any third party for any service provided by Immunocore or through the Program or for any part of the financial benefit received by the Patient from Immunocore; (7) I am licensed to prescribe the medication indicated in this form and that the prescription complies with my state-specific prescribing requirements; and (8) I understand that Immunocore may modify or terminate the Program at any time without notice, and that Patient and healthcare provider are responsible for completing and submitting coverage- or reimbursement-related documentation. Immunocore makes no representation or guarantee concerning coverage or reimbursement for any item or service. By filling out this form, upon receipt, my Patient will be contacted by Immunocore to confirm understanding of the services offered via the Program and to provide services for which Patient is eligible. I am requesting Immunocore support the Patient listed in this form for the prescribed medication pursuant to an FDA-approved indication.

Physician certification

> PHYSICIAN SIGNATURE (REQUIRED)

Dispense as written

PHYSICIAN SIGNATURE

Substitutions allowed

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.

Additional support information

Additional support options provided by KIMMTRAK CONNECT are services that may provide additional support after you've received your medication, like check-in calls to answer any questions you might have about KIMMTRAK. By being enrolled in KIMMTRAK CONNECT, Immunocore Ltd., its affiliates, agents, representatives, and service providers and their respective employees or agents (together, "Immunocore") may use, disclose, and/or transfer the personal information you supply to provide services related to your condition and prescribed treatment and to administer the program.

I understand that KIMMTRAK CONNECT may contact me by phone, text, or e-mail to provide personalized services, which may be informational and marketing related and include details about Immunocore products, my treatment, my insurance coverage, and my doctor's name. I understand that Immunocore may use, disclose, and/or transfer the personal information I supply to send me relevant information or offer me services related to my treatment or condition and to contact me occasionally to obtain my feedback (for market research purposes only) about my treatment, my condition, or my experience with Immunocore and/or KIMMTRAK CONNECT otherwise, as required or permitted by law.

Privacy notice

We may use and save your personal information to meet legal or regulatory obligations that are in the legitimate interest of Immunocore and/or to fulfill legal requirements and other permitted business purposes in accordance with Immunocore's record-retention policies and applicable laws and regulations. We may also use your information to respond to lawful requests by public authorities, including to comply with national security or law enforcement requests. Your information may be combined with other information that you may have previously provided or that Immunocore has received. We do not sell personal information.

We may transmit personal information about you to other Immunocore affiliates worldwide. These affiliates may in turn transmit personal information about you to other Immunocore affiliates. Some of Immunocore's affiliates may be located in countries that do not ensure the same level of data protection. Nevertheless, all of Immunocore's affiliates are required to treat personal information in a manner consistent with this notice. To obtain additional information about Immunocore's privacy practices, you may visit www.immunocore.com.

We do provide reasonable physical, electronic, and procedural safeguards to protect information we work with and maintain. We limit access to your information to authorized employees, agents, contractors, vendors, subsidiaries, and business

Privacy notice (continued)

partners, or others who need such access to information to carry out their assigned roles and responsibilities on behalf of Immunocore. Although we try to protect the information we work with and maintain, no security system can prevent all potential security breaches.

Upon verification, you have the right to request information from us regarding how your personal information is being used and how it is being shared. You also have the right to request a copy of the personal information that we have about you, request its correction, or request its erasure/deletion. There may be exceptions that apply to your request. In limited circumstances, you may have the right to have your information transmitted to another entity or person in a machine-readable format. You will not be discriminated against for exercising any of your rights.

To exercise your rights, you or your authorized representative may submit a request by contacting us using one of the methods listed below. You may make any of the above requests by contacting us at: lily.hepworth@immunocore.com. If you wish to raise a complaint about how we have handled your personal information, you may contact the Compliance Officer at lily.hepworth@immunocore.com, who will investigate the matter. If you are not satisfied with our response or have any concerns about how your data is being processed, you may register a complaint with a relevant regulatory authority (e.g., a Data Protection Authority [DPA] or Attorney General).

Please see the KIMMTRAK Patient Information and Important Safety Information including **BOXED WARNING for Cytokine Release Syndrome (CRS)** on KIMMTRAKCONNECT.com.

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