RYTELO® (imetelstat) for Injection 47 mg 188 mg

Navigating Access for RYTELO Patients

Coverage and reimbursement for RYTELO may vary by payer and site of care. Your office or facility should check directly with your patient's payer(s) to verify specific coding and billing requirements. RYTELO is administered as an IV infusion and is usually managed under the medical benefit. Some payers may have medical policies outlining specific coverage criteria, such appropriate use or patient selection in accordance with the Prescribing Information and/or guidelines.

Each insurance plan's medical policy may vary. Be sure to check each patient's insurance plan for its medical policy coverage for RYTELO.

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Please see Important Safety Information throughout and full Prescribing Information, including Medication Guide.

IV=intravenous.

geron®

Indication

RYTELO® (imetelstat) is indicated for the treatment of adult patients with low- to intermediate-1 risk myelodysplastic syndromes (MDS) with transfusion-dependent anemia requiring 4 or more red blood cell units over 8 weeks who have not responded to or have lost response to or are ineligible for erythropoiesis-stimulating agents (ESA).

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Thrombocytopenia

RYTELO® can cause thrombocytopenia based on laboratory values. In the clinical trial, new or worsening Grade 3 or 4 decreased platelets occurred in 65% of patients with MDS treated with RYTELO.

Please see additional Important Safety Information throughout and full Prescribing Information, including Medication Guide.

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Imetelstat (RYTELO®) Inclusion in the Updated NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Imetelstat (RYTELO®) is an NCCN **Category 1 preferred second-line treatment option** for LR-MDS, symptomatic anemia in eligible RS- and RS+ patients as recommended by the NCCN Guidelines®.[1,a]

NCCN Guidelines recommend imetelstat (RYTELO) as a treatment option **after 6-8 weeks of no response to ESAs.[b]**

Eligible patients are those who are ineligible for or relapsed/refractory to ESAs, requiring ≥4 RBC units over 8 weeks.

[a]For patients with IPSS-R very low-, low-, or intermediate-risk MDS with non-del(5q) ± other cytogenetic abnormalities and with RS <15% (or RS <5% with *SF3B1* mutation) with sEPO ≤500 mU/mL or with non-del(5q) ± other cytogenetic abnormalities with RS ≥15% (or RS ≥5% with an *SF3B1* mutation) with sEPO ≤500 mU/mL.[1]

[b]For patients with IPSS-R very low-, low-, or intermediate-risk MDS with non-del(5q) ± other cytogenetic abnormalities and with RS <15% (or RS <5% with *SF3B1* mutation) with sEPO ≤500 mU/mL.[1]

IPSS-R=Revised International Prognostic Scoring System; NCCN=National Comprehensive Cancer Network; RBC=red blood cell; RS=ring sideroblast; sEPO=serum erythropoietin.

Reference: 1. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Myelodysplastic Syndromes V.2.2025. © National Comprehensive Cancer Network, Inc. 2025. All rights reserved. Accessed June 25, 2025. To view the most recent and complete version of the guideline, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way.

IMPORTANT SAFETY INFORMATION (cont'd)

WARNINGS AND PRECAUTIONS (cont'd)

Thrombocytopenia (cont'd)

Monitor patients with thrombocytopenia for bleeding. Monitor complete blood cell counts prior to initiation of RYTELO, weekly for the first two cycles, prior to each cycle thereafter, and as clinically indicated. Administer platelet transfusions as appropriate. Delay the next cycle and resume at the same or reduced dose, or discontinue as recommended.

Please see additional Important Safety Information throughout and full Prescribing Information, including Medication Guide.

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Prior Authorization for RYTELO

Prior authorizations (PAs) are common for medications such as RYTELO, because they enable insurance plans to ensure medications are being used by appropriate patients only. When requesting a PA, it is important to understand that each payer has different requirements with which your practice or facility must become familiar. With a PA, the payer requires approval of the coverage of a medication or treatment before it is administered.

Step 1: Complete the PA Request

- ☐ Utilize the proper PA form based on your patient's insurance plan.
- ☐ Prepare the supplemental documentation requested by the plan to support the PA, if needed. Each insurance plan may require different information, so it is essential to identify the plan-specific documents required, which may include
  - Medical and medication history, such as lab results, evidence of RBC transfusion dependence, and other prior treatments
  - Pertinent or applicable NCCN Guidelines or CMS-recognized compendia
  - Prescribing Information for RYTELO
  - RYTELO clinical publications

CMS=Centers for Medicare and Medicaid Services.

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IMPORTANT SAFETY INFORMATION (cont'd)

WARNINGS AND PRECAUTIONS (cont'd)

Neutropenia

RYTELO can cause neutropenia based on laboratory values. In the clinical trial, new or worsening Grade 3 or 4 decreased neutrophils occurred in 72% of patients with MDS treated with RYTELO.

Please see additional Important Safety Information throughout and full Prescribing Information, including Medication Guide.

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Sample Prior Authorization Form

The below is provided only as an example. Each provider is responsible for submission of complete and accurate information to plans. Example information provided does not provide a guarantee of reimbursement.

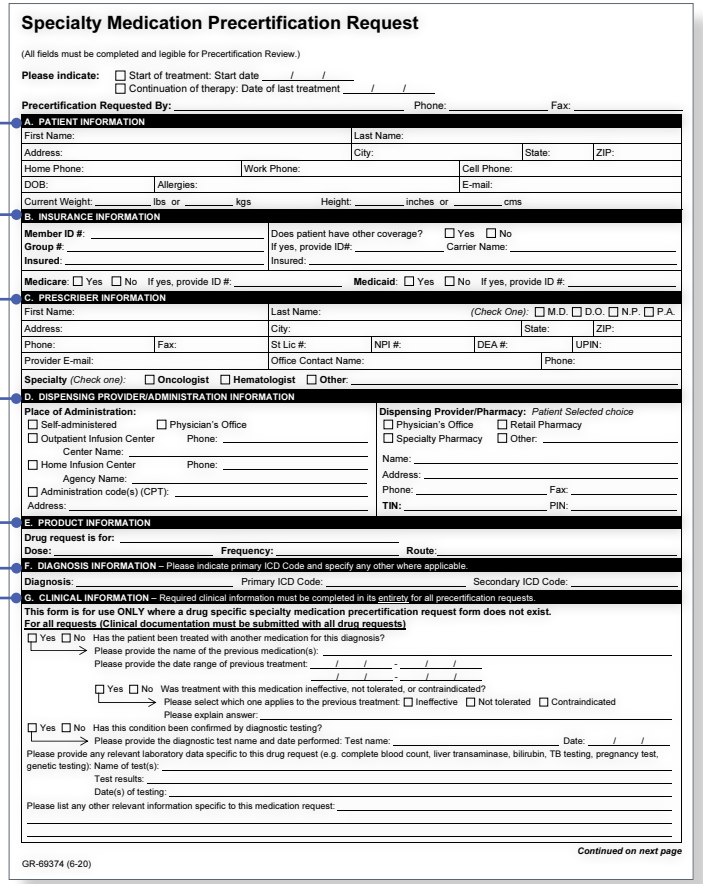
Patient and Insurance Information: List your patient's name exactly as shown on the insurance card and provide relevant information on the insurance plan and primary policyholder.

Prescriber Information: Provide the prescriber's name, office address, credentials, and contact information.

Access and Administration: Include the site of administration and how RYTELO will be obtained (eg, specialty distributor, specialty pharmacy).

Medication and Diagnosis: Enter the medication name and NDC number, dose, frequency, and route of administration. Provide a detailed diagnosis as well as *ICD-10-CM* code(s). Note HCPCS code if required (J0870).[1]

Clinical Information and Treatment History: Include a summary of your patient's medical and medication history, such as lab results, evidence of RBC transfusion dependence, and other prior treatments.



Specialty Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	
Current Weight: ____ lbs or ____ kgs	Height: ____ inches or ____ cms		

B. INSURANCE INFORMATION

Member ID #:	Does patient have other coverage? ☐ Yes ☐ No
Group #:	If yes, provide ID#: Carrier Name:
Insured:	Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:	Last Name:	*(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:	City:	State:	ZIP:		
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:	Office Contact Name:	Phone:			

Specialty *(Check one):* ☐ **Oncologist** ☐ **Hematologist** ☐ **Other:**

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone:
Center Name:
☐ Home Infusion Center Phone:
Agency Name:
☐ Administration code(s) (CPT):
Address:

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other:
Name:
Address:
Phone: Fax:
TIN: PIN:

E. PRODUCT INFORMATION

Drug request is for:
Dose: **Frequency:** **Route:**

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Diagnosis: Primary ICD Code: Secondary ICD Code:

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

This form is for use ONLY where a drug specific specialty medication precertification request form does not exist.
For all requests (Clinical documentation must be submitted with all drug requests)

☐ Yes ☐ No Has the patient been treated with another medication for this diagnosis?
→ Please provide the name of the previous medication(s):
Please provide the date range of previous treatment: ____/____/____ - ____/____/____
____/____/____ - ____/____/____
☐ Yes ☐ No Was treatment with this medication ineffective, not tolerated, or contraindicated?
→ Please select which one applies to the previous treatment: ☐ Ineffective ☐ Not tolerated ☐ Contraindicated
Please explain answer:
☐ Yes ☐ No Has this condition been confirmed by diagnostic testing?
→ Please provide the diagnostic test name and date performed: Test name: Date: ____/____/____
Please provide any relevant laboratory data specific to this drug request (e.g. complete blood count, liver transaminase, bilirubin, TB testing, pregnancy test, genetic testing): Name of test(s):
Test results:
Date(s) of testing:
Please list any other relevant information specific to this medication request:

Continued on next page

GR-69374 (6-20)

ICD-10-CM=International Classification of Diseases, Tenth Revision, Clinical Modification; HCPCS=Healthcare Common Procedure Coding System; NDC=National Drug Code.

Reference: 1. Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) application summaries and coding recommendations. Centers for Medicare & Medicaid Services. Published October 2, 2024. Accessed June 25, 2025. https://www.cms.gov/files/document/2024-hcpcs-application-summary-quarter-3-2024-drugs-and-biologicals-posted-10-02-2024.pdf

IMPORTANT SAFETY INFORMATION (cont'd)

WARNINGS AND PRECAUTIONS (cont'd)

Neutropenia (cont'd)

Monitor patients with Grade 3 or 4 neutropenia for infections, including sepsis. Monitor complete blood cell counts prior to initiation of RYTELO, weekly for the first two cycles, prior to each cycle thereafter, and as clinically indicated. Administer growth factors and anti-infective therapies for treatment or prophylaxis as appropriate. Delay the next cycle and resume at the same or reduced dose, or discontinue as recommended.

Please see additional Important Safety Information throughout and full Prescribing Information, including Medication Guide.

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Prior Authorization for RYTELO (cont'd)

Step 2: Submit the PA Request

- ☐ Determine the appropriate submission method for the PA (eg, fax, email, phone, electronic, portal).
  - You may need to speak to an insurance plan representative on the phone before submitting a PA.
- ☐ Document the date, time, and submission method of the PA and any associated phone or fax numbers.
- ☐ Retain a copy of all attachments submitted with the PA in the medical file.

Step 3: Track the Status and Follow Up Regularly

- ☐ Track regular follow-ups with the plan, noting contact methods, names, conversation summaries, and reference numbers for phone calls.
- ☐ Respond to requests for additional documentation as soon as possible.

PA timelines may vary. For updates, contact your patient's plan directly.

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Medical Exceptions

If a patient does not meet the insurance plan's medical policy criteria for RYTELO, you may consider a medical exception. Consider reviewing the policy to identify which criteria the patient meets and which they do not. Check with the individual plan for more details. It's generally best to tailor your request to the specific patient and point out the criteria that your patient meets and provide clinical rationale on why your patient should be exempt from any criteria they do not meet.

Consider including

- ☐ Background on the patient's diagnosis based on clinical diagnostic tests
- ☐ Medical and medication history, such as lab results, evidence of RBC transfusion dependence, and other prior treatments
- ☐ Clinical justification supporting the choice of RYTELO, and a medical evaluation of potential disease progression if your patient does not receive treatment
- ☐ Any patient-specific reasons for treatment choice
- ☐ Quality of life considerations

Documentation that supports your request, which may include

- ☐ NCCN Guidelines or CMS-recognized compendia
- ☐ Prescribing Information for RYTELO
- ☐ RYTELO clinical publications

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IMPORTANT SAFETY INFORMATION (cont'd)

WARNINGS AND PRECAUTIONS (cont'd)

Infusion-Related Reactions

RYTELO can cause infusion-related reactions. In the clinical trial, infusion-related reactions occurred in 8% of patients with MDS treated with RYTELO; Grade 3 or 4 infusion-related reactions occurred in 1.7%, including hypertensive crisis (0.8%). The most common infusion-related reaction was headache (4.2%). Infusion-related reactions usually occur during or shortly after the end of the infusion.

Please see additional Important Safety Information throughout and full Prescribing Information, including Medication Guide.

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Peer-to-Peer Discussions

If the PA is denied due to clinical reasons, you may be able to request a peer-to-peer discussion between the prescriber and the insurance plan. You may also request that the plan's peer reviewer be of the same specialty (eg, hematology).

Consider gathering relevant information before the discussion

Patient and insurance information

- ☐ Patient name and date of birth
- ☐ Primary insurance policy holder
- ☐ Insurance policy and group number

Drug information

- ☐ Prescribing Information for RYTELO
- ☐ Pertinent or applicable NCCN Guidelines or CMS-recognized compendia

Patient characteristics

- ☐ Quality of life considerations

Clinical documentation

- ☐ Summary of patient's diagnosis
- ☐ Medical justification for prescribing RYTELO
- ☐ Details as to why RYTELO may be medically necessary for the patient
- ☐ Lab test results
- ☐ Medication history, including duration of therapy and side effects, if applicable
- ☐ RBC transfusion history, including frequency

It's ideal to clarify next steps before concluding the discussion—note any required follow-up and confirm approval timing.

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IMPORTANT SAFETY INFORMATION (cont'd)

WARNINGS AND PRECAUTIONS (cont'd)

Infusion-Related Reactions (cont'd)

Premedicate patients at least 30 minutes prior to infusion with diphenhydramine and hydrocortisone as recommended and monitor patients for at least one hour following the infusion as recommended. Manage symptoms of infusion-related reactions with supportive care and infusion interruptions, decrease infusion rate, or permanently discontinue as recommended.

Please see additional Important Safety Information throughout and full Prescribing Information, including Medication Guide.

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Letter of Medical Necessity

Common Scenarios

To demonstrate that your patient is an appropriate candidate for RYTELO, it may be important to submit a letter of medical necessity to the insurance plan. The following are situations in which you may need to demonstrate medical necessity for RYTELO:

- **The required PA is received but denied due to lack of medical necessity.**
- **Your patient does not meet the policy requirements for RYTELO, but the prescriber feels the treatment is medically necessary.**
- **Reauthorization is required for patients who were previously treated with RYTELO but have since been denied.**
- **Change of coverage policy impacts the coverage of RYTELO.**
- **Making a request for RYTELO from a secondary insurance plan after attempts for primary coverage have been exhausted.**

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Tailor the Letter of Medical Necessity

When writing a letter of medical necessity, clearly communicate your patient's individual circumstances.

Consider including

- ☐ Brief description of the diagnosis and clinical status
  - Background on the diagnosis based on clinical diagnostic tests
- ☐ Short summary of your patient's medical history and previous treatment regimens
  - Duration of use and reason for discontinuation of previous treatment regimens
- ☐ Clinical justification supporting the choice of RYTELO, and a medical evaluation of potential disease progression if your patient does not receive treatment
  - State any patient-specific reasons for treatment choice
  - If your patient requires reauthorization or has a change in medical policy, note their progress on RYTELO and state their need for continued treatment
- ☐ Supporting letters from any other specialist(s) currently or previously providing care to your patient, if applicable.
- ☐ Supporting information, including
  - RYTELO indication
  - Pertinent or applicable NCCN Guidelines or CMS-recognized compendia
  - RYTELO clinical publications
  - List of documentation used to write the letter of medical necessity

Refer to the **Sample Letter of Medical Necessity** for additional guidance.

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IMPORTANT SAFETY INFORMATION (cont'd)

WARNINGS AND PRECAUTIONS (cont'd)

Embryo-Fetal Toxicity

Based on animal findings, RYTELO can cause embryo-fetal harm when administered to a pregnant woman. Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with RYTELO and for 1 week after the last dose.

Please see additional Important Safety Information throughout and full Prescribing Information, including Medication Guide.

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Appealing an Insurance Plan's Denial of RYTELO

UNDERSTAND THE REASON FOR THE DENIAL

Read the denial letter carefully to understand why the PA, medical exception, or request for reauthorization was denied.

- Consider calling your patient's plan to clarify the reason for denial and explore a prompt resolution.
- Review each patient's specific coverage details to understand the appropriate steps and timelines for requesting an appeal.

REQUEST AN APPEAL

An organized appeal with supporting clinical documentation may help increase the likelihood of a timely and successful outcome.

- Some insurance plans have their own appeal request forms. Call the plan or check their website, as forms may be available.
- Prepare a letter of appeal.
- Review the request to ensure the information provided is accurate and complete.

Timing is critical. Refer to the denial letter for the appeal submission deadline.

A Letter of Appeal May Play a Critical Role in the Review Process

An effective letter of appeal may include the following elements:

Patient and insurance information

- ☐ Patient name, insurance policy, and group number
- ☐ Case or claim number provided in the denial letter

Denial information

- ☐ Denial reason as listed in the denial letter
- ☐ Reason(s) you disagree with the denial

Patient characteristics

- ☐ Diagnosis based on clinical diagnostic tests
- ☐ Any patient-specific reasons for treatment choice
- ☐ Explanation of medical necessity for RYTELO
- ☐ Medical evaluation of potential disease progression if your patient does not receive treatment

Documentation that may help justify the use of RYTELO

- ☐ Medical and medication history, such as lab results, evidence of RBC transfusion-dependent anemia, and other prior treatments
- ☐ Prescribing Information for RYTELO
- ☐ RYTELO clinical publications
- ☐ Examples of other insurer's policies that your patient would be approved for RYTELO, if applicable

FDA=U.S. Food and Drug Administration.

Review the appeal before submission to avoid processing errors.

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IMPORTANT SAFETY INFORMATION (cont'd)

ADVERSE REACTIONS

Serious adverse reactions occurred in 32% of patients who received RYTELO. Serious adverse reactions in >2% of patients included sepsis (4.2%), fracture (3.4%), cardiac failure (2.5%), and hemorrhage (2.5%). Fatal adverse reactions occurred in 0.8% of patients who received RYTELO, including sepsis (0.8%).

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If the Appeal Is Denied, Your Patient May Consider Exploring Next Steps

EXTERNAL REVIEW

- Following the final appeal decision, your patient must follow the steps and timeline outlined in the denial notice to submit a written request.[1]
- An independent third party will review the written request in collaboration with a physician and must provide written notice of the final decision within 45 calendar days.[1]

URGENT REVIEWS

- In urgent cases, your patient may verbally request an expedited appeal request with the health plan.[1]
  - A decision by the insurance plan is required within 4 business days of receiving the request.[1]
- Urgent or expedited appeal may apply if treatment delays could jeopardize their health.[1]

SECONDARY INSURANCE PLAN SUBMISSION

- If your patient has secondary insurance coverage, submit to the secondary plan after all attempts with the primary plan have been exhausted.

Reference: 1. Patient Advocate Foundation. A patient's guide to navigating the insurance appeals process. Accessed June 25, 2025. https://www.patientadvocate.org/wp-content/uploads/Navigating-the-insurance-appeals-guide-pages.pdf

If the Appeal Is Denied, Your Patient May Request an Independent External Review

Types of Reviews

SPECIALIST REVIEW	Request a hematologist or oncologist to review the claim for medical necessity.
MEDICAL DIRECTOR REVIEW	Direct prescriber-to-medical director communication is recommended.
RESOURCE UTILIZATION	State insurance department resources may be used as a final means of arbitration.

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Reauthorizations

Reauthorizations are typically required for patients continuing RYTELO after the initial authorization period has lapsed, typically around 6 months. Requirements vary by insurance plan but generally include updated documentation from the initial PA and demonstration of efficacy measures, such as proof of clinically meaningful reduction in amount of RBC transfusions needed.

Consider following the steps below, keeping in mind your patient's coverage duration and next scheduled dose.

STEP 1

Contact the plan to find out the specific requirements for reauthorization, such as required forms. Reference the plan's current medical policy for RYTELO.

STEP 2

Determine the supporting documentation that may be required, such as patient history, tolerability, and evidence of RBC transfusion dependence. Please note that RBC transfusion history may be found in your patient's chart.

STEP 3

Submit documentation according to the plan's policy.

Best Practice

Timing is crucial: consider planning ahead before reauthorization is needed and setting a reauthorization target date.

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IMPORTANT SAFETY INFORMATION (cont'd)

ADVERSE REACTIONS (cont'd)

Most common adverse reactions (≥10% with a difference between arms of >5% compared to placebo), including laboratory abnormalities, were decreased platelets, decreased white blood cells, decreased neutrophils, increased AST, increased alkaline phosphatase, increased ALT, fatigue, prolonged partial thromboplastin time, arthralgia/myalgia, COVID-19 infections, and headache.

Please see additional Important Safety Information throughout and full Prescribing Information, including Medication Guide.

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Patient Support Program

REACH4RYTELO helps your patients who have been prescribed RYTELO navigate access and reimbursement.

Benefits Investigation

Prior Authorization

Appeals Support

Copay Program

For eligible, commercially insured patients, the REACH4RYTELO Copay Program offers savings, subject to certain conditions.[a,b] There are no income requirements to participate in the program.

Patient Assistance Program (PAP)

If your patient is uninsured or does not have insurance coverage for RYTELO based on certain eligibility criteria and needs help paying for RYTELO, they may be eligible for the PAP.[b]

[a]The REACH4RYTELO Copay Program is not available to patients with any form of government insurance (such as Medicaid, Medicare, TRICARE, and VA). Patients must meet certain eligibility criteria to qualify for this program, including requirements related to the diagnosis for which the patient is receiving treatment and the patient's insurance status. To enroll in the Copay Program, patients must first enroll in REACH4RYTELO. If eligible for the Copay Program, the patient may pay as little as $0 out-of-pocket for RYTELO with a maximum benefit of $9450 per year for the cost of the drug and a maximum benefit of $1200 per year for the cost of administration (up to $100 per infusion). An itemized explanation of benefits must be provided with a separate line for out-of-pocket cost of administration. Residents of MA, MI, MN, and RI are not eligible to receive copay assistance for product administration and are therefore only eligible for a maximum benefit of $9450 per year for the cost of the drug. For Copay Program eligibility questions, contact a representative from REACH4RYTELO at 1-844-479-8356.

[b]All programs provided through REACH4RYTELO may be subject to additional eligibility requirements. Geron reserves the right to modify or discontinue REACH4RYTELO at any time without notice.

Please see Important Safety Information throughout and full Prescribing Information, including Medication Guide.

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Getting Started With REACH4RYTELO

If you determine RYTELO is right for your patient, download the REACH4RYTELO Patient Enrollment Form.

Download

Download the REACH4RYTELO Enrollment Form here.

Complete

Complete the form with your patient.

Submit

Submit via fax to 1-888-224-2518 or email Support@REACH4RYTELO.com.

Once your patient is enrolled in REACH4RYTELO, a Case Manager will follow up with you.

The accurate completion of reimbursement- or coverage-related documentation is the responsibility of the healthcare provider and patient. REACH4RYTELO and its agents make no guarantee regarding coverage and reimbursement for RYTELO.

Please see Important Safety Information throughout and full Prescribing Information, including Medication Guide.

REACH4RYTELO Enrollment Form Guide

Ensure all sections of the REACH4RYTELO Enrollment Form are accurately completed to avoid processing delays.

Please carefully review the following commonly overlooked information.

Completed by your patient or patient's representative

Page 1


THIS PAGE TO BE COMPLETED BY **PATIENT** OR **PATIENT'S REPRESENTATIVE** 1 of 4

REACH4RYTELO RYTELO (imetelstat) for Injection **Enrollment Form**

Phone: 1-844-4RYTELO
Fax: 1-888-224-2518
Email: support@REACH4RYTELO.com
Monday - Friday, 8 AM to 8 PM ET

After submitting this form, a dedicated REACH4RYTELO Case Manager may reach out to

1. REQUESTED PATIENT SUPPORT *Check all boxes that apply* ☑

All patients enrolled in REACH4RYTELO will receive access and reimbursement support. If you would like to request specific patient support offerings, please check the appropriate box below:

☐ Benefits Investigation, Prior Authorization, Appeals Assistance ☐ Bridge Program Eligibility Screening ☐ Copay Program Eligibility Screening
☐ Patient Assistance Program (PAP) Eligibility Screening ☐ Referral to Geron Field Reimbursement Team

2. PATIENT INFORMATION

First name:	Last name:	MI:	Preferred name:
Address:		Apt/Unit #:	City:
State:	ZIP code:	Phone #: ( ) -	Preferred language:
Email:	Date of birth: / /	Gender: ☐ M ☐ F	SSN (Last 4 digits):
Alternate contact name:	Alternate contact phone #: ( ) -		Relationship to patient:

I authorize REACH4RYTELO to leave a detailed message if I am unavailable when they call, and in the event of contact through email or text, I grant REACH4RYTELO permission to include details such as the name of my prescription. ☐ Yes ☐ No me by phone and/or through my healthcare provider.

3. INSURANCE INFORMATION *Please include a copy of the front and back of insurance card(s).*

☐ Patient is uninsured (ie, no health insurance through any public or private payer)—SEE OPTIONAL "PATIENT FINANCIAL INFORMATION" IN SECTION 5

☐ Patient is insured (Please fill out all of the applicable insurance information below—Include copy [front & back] of all insurance cards, including medical and prescription.)

PRIMARY INSURANCE

Primary insurance:		Plan name:	Insurance phone #: ( ) -
Subscriber name:		Is this a government healthcare program (ie, Medicaid, Medicare, VA, TRICARE)? ☐ Yes ☐ No	
Policyholder name:		Policyholder relationship to patient:	
Member ID #:	Policy/Group #:	Rx Bin #:	Rx PCN #:

☐ **SECONDARY INSURANCE** (Check this box if patient has secondary insurance coverage and include a copy [front and back] of insurance cards, if available.)

Secondary insurance:		Plan name:	Insurance phone #: ( ) -
Subscriber name:		Is this a government healthcare program (ie, Medicaid, Medicare, VA, TRICARE)? ☐ Yes ☐ No	
Policyholder name:		Policyholder relationship to patient:	
Member ID #:	Policy/Group #:	Rx Bin #:	Rx PCN #:

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Requested Patient Support: Indicate the type of support needed:

- Benefits investigation, PA, and appeals assistance
- Referral to Geron Field Reimbursement Team
- Eligibility screening for:
  - Bridge program
  - Copay program
  - PAP

Patient Information: Complete all fields within the patient information section.

Insurance Information: Indicate whether your patient is insured and provide all relevant insurance details if applicable, including primary and secondary insurers.

The accurate completion of reimbursement- or coverage-related documentation is the responsibility of the healthcare provider and patient. REACH4RYTELO and its agents make no guarantee regarding coverage and reimbursement for RYTELO.

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Please see Important Safety Information throughout and full Prescribing Information, including Medication Guide.

RYTELO® (imetelstat) for Injection 47 mg 188 mg

REACH4RYTELO Enrollment Form Guide (cont'd)

Completed by your patient or patient's representative

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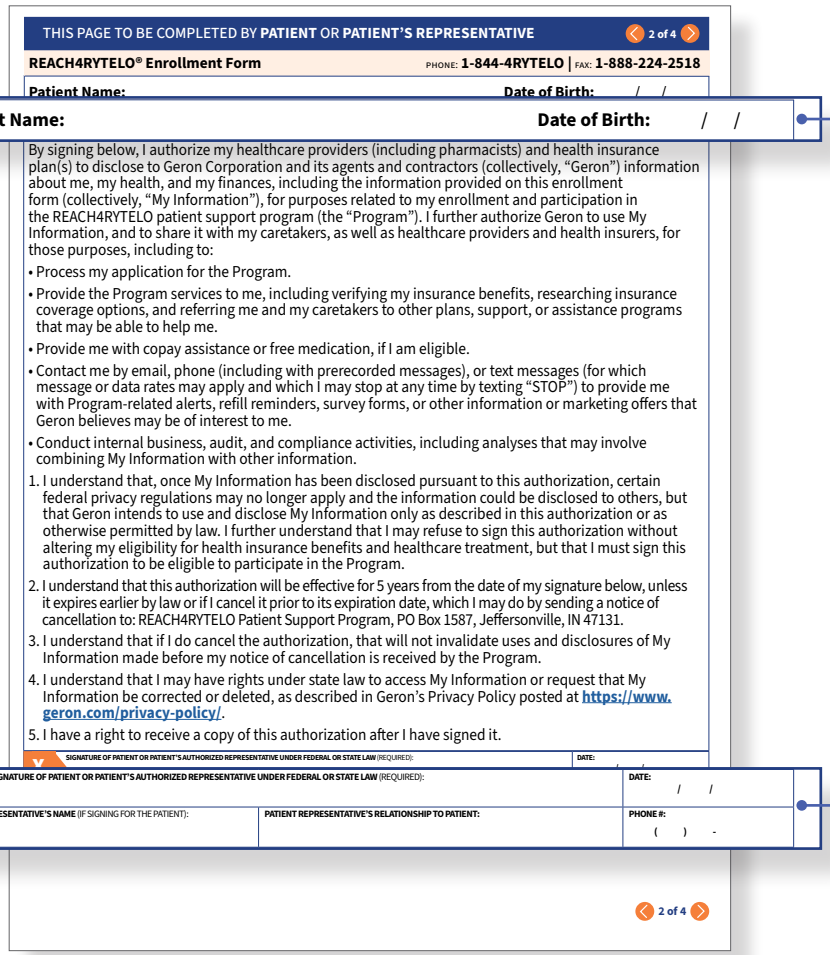

THIS PAGE TO BE COMPLETED BY **PATIENT** OR **PATIENT'S REPRESENTATIVE** 2 of 4

REACH4RYTELO® Enrollment Form PHONE: **1-844-4RYTELO** | FAX: **1-888-224-2518**

Patient Name: **Date of Birth:** / /

By signing below, I authorize my healthcare providers (including pharmacists) and health insurance plan(s) to disclose to Geron Corporation and its agents and contractors (collectively, "Geron") information about me, my health, and my finances, including the information provided on this enrollment form (collectively, "My Information"), for purposes related to my enrollment and participation in the REACH4RYTELO patient support program (the "Program"). I further authorize Geron to use My Information, and to share it with my caretakers, as well as healthcare providers and health insurers, for those purposes, including to:

- Process my application for the Program.
- Provide the Program services to me, including verifying my insurance benefits, researching insurance coverage options, and referring me and my caretakers to other plans, support, or assistance programs that may be able to help me.
- Provide me with copay assistance or free medication, if I am eligible.
- Contact me by email, phone (including with prerecorded messages), or text messages (for which message or data rates may apply and which I may stop at any time by texting "STOP") to provide me with Program-related alerts, refill reminders, survey forms, or other information or marketing offers that Geron believes may be of interest to me.
- Conduct internal business, audit, and compliance activities, including analyses that may involve combining My Information with other information.

1. I understand that, once My Information has been disclosed pursuant to this authorization, certain federal privacy regulations may no longer apply and the information could be disclosed to others, but that Geron intends to use and disclose My Information only as described in this authorization or as otherwise permitted by law. I further understand that I may refuse to sign this authorization without altering my eligibility for health insurance benefits and healthcare treatment, but that I must sign this authorization to be eligible to participate in the Program.
2. I understand that this authorization will be effective for 5 years from the date of my signature below, unless it expires earlier by law or if I cancel it prior to its expiration date, which I may do by sending a notice of cancellation to: REACH4RYTELO Patient Support Program, PO Box 1587, Jeffersonville, IN 47131.
3. I understand that if I do cancel the authorization, that will not invalidate uses and disclosures of My Information made before my notice of cancellation is received by the Program.
4. I understand that I may have rights under state law to access My Information or request that My Information be corrected or deleted, as described in Geron's Privacy Policy posted at https://www.geron.com/privacy-policy/.
5. I have a right to receive a copy of this authorization after I have signed it.

X **SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE UNDER FEDERAL OR STATE LAW** (REQUIRED): **DATE:** / /

PATIENT REPRESENTATIVE'S NAME (IF SIGNING FOR THE PATIENT): **PATIENT REPRESENTATIVE'S RELATIONSHIP TO PATIENT:** **PHONE #:** ( ) -

2 of 4

Provide your patient's name and date of birth.

Patient Certification and Agreement: Ensure your patient reads and signs the patient authorization certification and agreement. Authorized representatives should include their name and relationship to your patient.

The accurate completion of reimbursement- or coverage-related documentation is the responsibility of the healthcare provider and patient. REACH4RYTELO and its agents make no guarantee regarding coverage and reimbursement for RYTELO.

All programs provided through REACH4RYTELO are subject to eligibility requirements. Geron reserves the right to modify or discontinue REACH4RYTELO at any time without notice.

Please see Important Safety Information throughout and full Prescribing Information, including Medication Guide.

RYTELO® (imetelstat) for Injection 47 mg 188 mg

REACH4RYTELO Enrollment Form Guide (cont'd)

Completed by your patient or patient's representative

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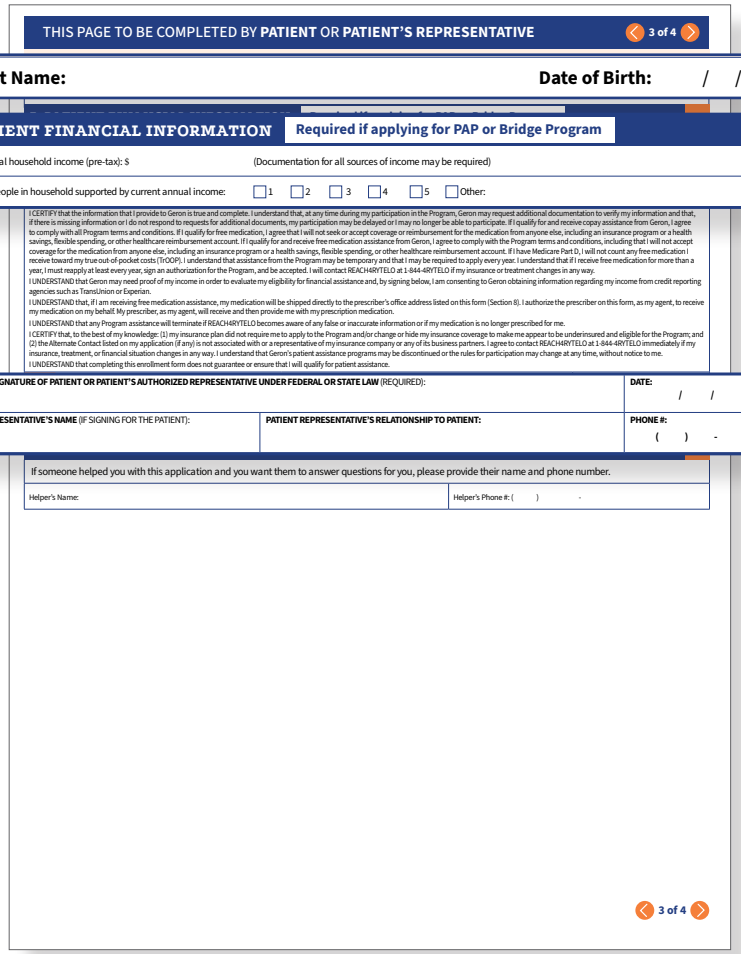

THIS PAGE TO BE COMPLETED BY **PATIENT** OR **PATIENT'S REPRESENTATIVE** 3 of 4

Patient Name: **Date of Birth:** / /

5. PATIENT FINANCIAL INFORMATION **Required if applying for PAP or Bridge Program**

Current annual household income (pre-tax): $ (Documentation for all sources of income may be required)

Number of people in household supported by current annual income: ☐1 ☐2 ☐3 ☐4 ☐5 ☐Other:

I CERTIFY that the information that I provide to Geron is true and complete. I understand that, at any time during my participation in the Program, Geron may request additional documentation to verify my information and that, if there is missing information or I do not respond to requests for additional documents, my participation may be delayed or I may no longer be able to participate. If I qualify for and receive copay assistance from Geron, I agree to comply with all Program terms and conditions. If I qualify for free medication, I agree that I will not seek or accept coverage or reimbursement for the medication from anyone else, including an insurance program or a health savings, flexible spending, or other healthcare reimbursement account. If I qualify for and receive free medication assistance from Geron, I agree to comply with the Program terms and conditions, including that I will not accept coverage for the medication from anyone else, including an insurance program or a health savings, flexible spending, or other healthcare reimbursement account. If I have Medicare Part D, I will not count any free medication I receive toward my true out-of-pocket costs (TrOOP). I understand that assistance from the Program may be temporary and that I may be required to apply every year. I understand that if I receive free medication for more than a year, I must reapply at least every year, sign an authorization for the Program, and be accepted. I will contact REACH4RYTELO at 1-844-4RYTELO if my insurance or treatment changes in any way.

I UNDERSTAND that Geron may need proof of my income in order to evaluate my eligibility for financial assistance and, by signing below, I am consenting to Geron obtaining information regarding my income from credit reporting agencies such as TransUnion or Experian.

I UNDERSTAND that, if I am receiving free medication assistance, my medication will be shipped directly to the prescriber's office address listed on this form (Section 8). I authorize the prescriber on this form, as my agent, to receive my medication on my behalf. My prescriber, as my agent, will receive and then provide me with my prescription medication.

I UNDERSTAND that any Program assistance will terminate if REACH4RYTELO becomes aware of any false or inaccurate information or if my medication is no longer prescribed for me.

I CERTIFY that, to the best of my knowledge: (1) my insurance plan did not require me to apply to the Program and/or change or hide my insurance coverage to make me appear to be underinsured and eligible for the Program; and (2) the Alternate Contact listed on my application (if any) is not associated with or a representative of my insurance company or any of its business partners. I agree to contact REACH4RYTELO at 1-844-4RYTELO immediately if my insurance, treatment, or financial situation changes in any way. I understand that Geron's patient assistance programs may be discontinued or the rules for participation may change at any time, without notice to me.

I UNDERSTAND that completing this enrollment form does not guarantee or ensure that I will qualify for patient assistance.

X **SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE UNDER FEDERAL OR STATE LAW** (REQUIRED): **DATE:** / /

PATIENT REPRESENTATIVE'S NAME (IF SIGNING FOR THE PATIENT): **PATIENT REPRESENTATIVE'S RELATIONSHIP TO PATIENT:** **PHONE #:** ( ) -

If someone helped you with this application and you want them to answer questions for you, please provide their name and phone number.

Helper's Name: Helper's Phone #: ( ) -

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Provide your patient's name and date of birth.

Patient Financial Information: For PAP and Bridge Program applicants, your patient should provide their annual pretax household income and number of dependents. Documentation for all income sources may be required.

Patient Certification and Agreement: Ensure your patient reads and signs the patient authorization certification and agreement. Authorized representatives should include their name and relationship to your patient.

The accurate completion of reimbursement- or coverage-related documentation is the responsibility of the healthcare provider and patient. REACH4RYTELO and its agents make no guarantee regarding coverage and reimbursement for RYTELO.

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Please see Important Safety Information throughout and full Prescribing Information, including Medication Guide.

RYTELO® (imetelstat) for Injection 47 mg 188 mg

REACH4RYTELO Enrollment Form Guide (cont'd)

Completed by the prescriber

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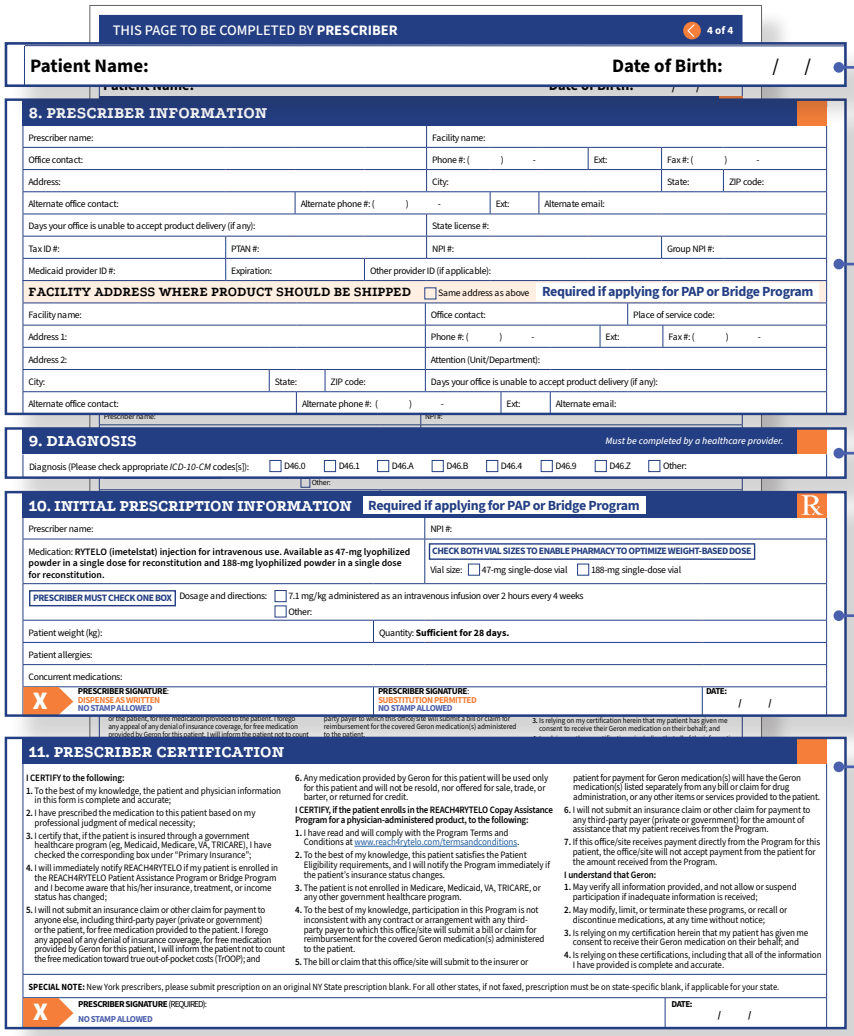

THIS PAGE TO BE COMPLETED BY **PRESCRIBER** 4 of 4

Patient Name: **Date of Birth:** / /

8. PRESCRIBER INFORMATION

Prescriber name:		Facility name:	
Office contact:	Phone #: ( ) -	Ext:	Fax #: ( ) -
Address:	City:		State: ZIP code:
Alternate office contact:	Alternate phone #: ( ) -	Ext:	Alternate email:
Days your office is unable to accept product delivery (if any):		State license #:	
Tax ID #:	PTAN #:	NPI #:	Group NPI #:
Medicaid provider ID #:	Expiration:	Other provider ID (if applicable):	

FACILITY ADDRESS WHERE PRODUCT SHOULD BE SHIPPED ☐ Same address as above **Required if applying for PAP or Bridge Program**

Facility name:	Office contact:		Place of service code:
Address 1:	Phone #: ( ) -	Ext:	Fax #: ( ) -
Address 2:	Attention (Unit/Department):		
City: State: ZIP code:	Days your office is unable to accept product delivery (if any):		
Alternate office contact:	Alternate phone #: ( ) -	Ext:	Alternate email:

9. DIAGNOSIS *Must be completed by a healthcare provider.*

Diagnosis (Please check appropriate *ICD-10-CM* codes[s]): ☐ D46.0 ☐ D46.1 ☐ D46.A ☐ D46.B ☐ D46.4 ☐ D46.9 ☐ D46.Z ☐ Other:

10. INITIAL PRESCRIPTION INFORMATION **Required if applying for PAP or Bridge Program**

Prescriber name:	NPI #:
Medication: **RYTELO (imetelstat) injection for intravenous use. Available as 47-mg lyophilized powder in a single dose for reconstitution and 188-mg lyophilized powder in a single dose for reconstitution.**	CHECK BOTH VIAL SIZES TO ENABLE PHARMACY TO OPTIMIZE WEIGHT-BASED DOSE Vial size: ☐ 47-mg single-dose vial ☐ 188-mg single-dose vial
PRESCRIBER MUST CHECK ONE BOX Dosage and directions: ☐ 7.1 mg/kg administered as an intravenous infusion over 2 hours every 4 weeks ☐ Other:	
Patient weight (kg):	Quantity: **Sufficient for 28 days.**
Patient allergies:	
Concurrent medications:	
X **PRESCRIBER SIGNATURE:** DISPENSE AS WRITTEN NO STAMP ALLOWED	**PRESCRIBER SIGNATURE:** SUBSTITUTION PERMITTED NO STAMP ALLOWED — **DATE:** / /

11. PRESCRIBER CERTIFICATION

I CERTIFY to the following:

1. To the best of my knowledge, the patient and physician information in this form is complete and accurate;
2. I have prescribed the medication to this patient based on my professional judgment of medical necessity;
3. I certify that, if the patient is insured through a government healthcare program (eg, Medicaid, Medicare, VA, TRICARE), I have checked the corresponding box under "Primary Insurance";
4. I will immediately notify REACH4RYTELO if my patient is enrolled in the REACH4RYTELO Patient Assistance Program or Bridge Program and I become aware that his/her insurance, treatment, or income status has changed;
5. I will not submit an insurance claim or other claim for payment to anyone else, including third-party payer (private or government) or the patient, for free medication provided to the patient. I forego any appeal of any denial of insurance coverage, for free medication provided by Geron for this patient, I will inform the patient not to count the free medication toward true out-of-pocket costs (TrOOP); and
6. Any medication provided by Geron for this patient will be used only for this patient and will not be resold, nor offered for sale, trade, or barter, or returned for credit.

I CERTIFY, if the patient enrolls in the REACH4RYTELO Copay Assistance Program for a physician-administered product, to the following:

1. I have read and will comply with the Program Terms and Conditions at www.reach4rytelo.com/termsandconditions.
2. To the best of my knowledge, this patient satisfies the Patient Eligibility requirements, and I will notify the Program immediately if the patient's insurance status changes.
3. The patient is not enrolled in Medicare, Medicaid, VA, TRICARE, or any other government healthcare program.
4. To the best of my knowledge, participation in this Program is not inconsistent with any contract or arrangement with any third-party payer to which this office/site will submit a bill or claim for reimbursement for the covered Geron medication(s) administered to the patient.
5. The bill or claim that this office/site will submit to the insurer or patient for payment for Geron medication(s) will have the Geron medication(s) listed separately from any bill or claim for drug administration, or any other items or services provided to the patient.
6. I will not submit an insurance claim or other claim for payment to any third-party payer (private or government) for the amount of assistance that my patient receives from the Program.
7. If this office/site receives payment directly from the Program for this patient, the office/site will not accept payment from the patient for the amount received from the Program.

I understand that Geron:

1. May verify all information provided, and not allow or suspend participation if inadequate information is received;
2. May modify, limit, or terminate these programs, or recall or discontinue medications, at any time without notice;
3. Is relying on my certification herein that my patient has given me consent to receive their Geron medication on their behalf; and
4. Is relying on these certifications, including that all of the information I have provided is complete and accurate.

SPECIAL NOTE: New York prescribers, please submit prescription on an original NY State prescription blank. For all other states, if not faxed, prescription must be on state-specific blank, if applicable for your state.

X **PRESCRIBER SIGNATURE** (REQUIRED): NO STAMP ALLOWED — **DATE:** / /

Provide your patient's name and date of birth.

Prescriber Information: Include the prescriber's name, credentials, and office contact information. For PAP and Bridge Program applicants, provide the contact information of the facility where RYTELO should be shipped if it differs from your office.

Diagnosis: Include the *ICD-10-CM* code(s) associated with your patient's diagnosis.

Initial Prescription Information: For PAP and Bridge Program applicants, the initial prescription is issued without refills. Since RYTELO has weight-based dosage, a new prescription is required each month if your patient is accepted. REACH4RYTELO will contact the prescriber for a new prescription each month.

- Check both vial size boxes, as appropriate, to enable the pharmacy to optimize weight-based dosing.

The prescriber's signature must be handwritten, no stamped signatures.

Prescriber Certification: Read and sign the prescriber certification.

Print, sign, and fax the completed REACH4RYTELO Enrollment Form to 1-888-224-2518 or email Support@REACH4RYTELO.com.

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