

Thank you for downloading this prescription assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER — Send your completed application to the address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the "**Healthcare Savings**" tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.
- **Free, Low-Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low-cost, and sliding scale medical, dental, mental health and substance abuse clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.
- **Coupons, Rebates & More** — You can use the NeedyMeds website to find 2,600+ cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.
- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

NeedyMeds also offers information on diagnosis-based camps and retreats, recreational programs, scholarships, government programs, \$4 generic drug programs, and more.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. Use the card to get discounts on lab tests and also to save 40% on durable medical equipment. To date, our drug discount card has saved patients over \$300,000,000. Check out the following page to learn more.

Feel free to call our toll-free helpline if you have any questions. We can be reached at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thank you for using NeedyMeds. Please let us know if we can do anything else to help you afford the costs of your healthcare.



Rich Sagall, MD
President, NeedyMeds

Clip the card and save



DRUG DISCOUNT CARD

BIN: 020750
RX PCN: NMeds
RX GRP: PDFPDF
ID: NMNA019309901930

Customer Care
1-888-602-2978

This is a drug discount program, not an insurance plan.

NeedyMeds Drug Discount Card
www.needymeds.org

Patient: You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com.

Pharmacist: Administered by Medical Security Company, LLC, Tucson, AZ.

Pharmacy Help Desk: 1-800-404-1031.



- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family

- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

Save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

You can also save an extra 5% on affordable lab tests and online results. No doctor's order or insurance needed. Visit www.needymeds.org/L2L for more information.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
50 Whittemore St.
Gloucester, MA 01930

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.



LIVMARLI™ (MARALIXIBAT) ORAL SOLUTION PATIENT ENROLLMENT FORM

Phone: 1-855-MRM-4YOU | 1-855-676-4968 | Fax: 1-855-282-4884
Monday - Friday: 8:00 am - 8:00 pm ET

Complete this form for all patients. Fields marked with a (*) are required.

Fax completed form and copy of patient's insurance card (front and back) to 1-855-282-4884 and/or include copy of patient demo from electronic medical records. Ensure drug benefit card/information is included.

1. PATIENT INFORMATION (please print)

*First name _____ MI _____ *Last name _____
*Gender M F *Date of birth (MM/DD/YYYY) _____
*Address _____ *City _____ *State _____ *ZIP code _____
Primary guardian full name _____ Relationship _____
*Primary phone _____ Mobile phone _____
Email _____ Primary language _____
Alternate contact full name _____ Relationship _____
Email _____ Mobile phone _____

2. OPT-IN FOR TEXT MESSAGES

By checking this box, I consent to receiving support, reminder, and educational text messages from Mirum to my mobile phone number. Standard text messaging rates will apply.

3. PRESCRIBER INFORMATION (please print)

*First name _____ *Last name _____
Site/Clinic name _____ Office contact name _____
*Address _____ *City _____ *State _____ *ZIP code _____
*Office contact phone _____ *Fax _____ Email _____
*Prescriber NPI# _____ *Specialty _____ State license number _____

4. DIAGNOSIS

*ICD-10-CM code _____ *Sub-category: Alagille syndrome Other _____

5. *PRESCRIPTION (please print)

LIVMARLI™ (maralixibat) 9.5 mg/mL oral solution (NDC 79378-0110-01)

Instructions for use _____

Days 1-7 (190 mcg/kg once daily) Dose _____ mL Beginning Day 8 (380 mcg/kg once daily) Dose _____ mL

OR Please Specify Other Dosing _____ mL

Dosing Weight (kg) _____ Quantity = QS for 30 Days Supply Refills _____ eRx submitted to EVERSANA Life Science Services

6. *PRESCRIBER AUTHORIZATION

I understand and agree that, as the prescriber, I will comply with my state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to me, as the prescriber. I have made the determination, based on my independent clinical judgment, that the medication ordered is medically appropriate for the patient for the intended use. I am personally supervising the care of this patient. I authorize Mirum Pharmaceuticals, Inc., its affiliates, agents, and contractors (collectively, "Mirum") to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy. This authorization includes permitting Mirum to communicate to payers on my behalf to confirm this patient's health plan eligibility and benefits.

X Prescriber Signature _____ Date _____
Written signature only; stamps not acceptable. (Dispense as Written) (Substitution Permitted)



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7. PATIENT AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION AND MIRUM COMMUNICATIONS

Authorization to Share Protected Health Information

By signing this authorization, I (or my representative) authorize my healthcare providers, health plans, and pharmacies (collectively, "Healthcare Organizations") to use and share my personal and health information related to my medical condition, treatment, and insurance coverage (my "health information") with Mirum Pharmaceuticals, Inc., its affiliates, agents, and representatives (collectively, "Mirum") (i) to contact me or my healthcare organizations, or others I have identified, about my disease or treatment, (ii) to work with my insurance carrier and other potential funding sources to try to help me get coverage, reimbursement, or payment for the medication ordered by my prescriber, (iii) for referral to and enrollment in patient support and/or financial assistance programs, (iv) to work with third parties to provide community resources and referrals, (v) for providing me with materials, information, and services related to my drug therapy and ways to help me maintain my prescribed treatment, (vi) for market research purposes, (vii) to improve, develop, and evaluate products, services, programs, or treatments related to my disease, (viii) to use aggregated de-identified data for research or publications, or (ix) as required or permitted by law. I understand that, once disclosed pursuant to this authorization, my health information may no longer be protected under federal or state law and could be disclosed to others, but I understand that Mirum will make reasonable efforts to keep it private and to disclose it only for the purposes set forth in this authorization. I understand that my pharmacy may be paid to share my information with Mirum as allowed under this authorization.

Mirum Communications

I authorize Mirum to contact me by mail, telephone (including voicemail), or email for educational and marketing purposes, including contacting me for market research purposes about Mirum therapies or Mirum. I understand and agree that any information that I provide may be used by Mirum to help develop new products, services, and programs.

I agree that I understand that my authorization is voluntary and that neither Mirum nor any of my healthcare providers, health plans, and pharmacies may condition my treatment, payment for treatment, enrollment or eligibility for benefits, including my eligibility to receive Mirum products, on whether I provide my authorization. However, if I do not provide authorization, I will not be able to receive the Mirum services and support described above. I understand that this authorization will remain valid for 10 years after the date set forth below or such earlier date as required by applicable law, unless I revoke it earlier by cancelling my enrollment in writing, which I may do at any time by contacting Mirum's representative at privacy@mirumpharma.com. I understand that my cancellation will not apply to any use or disclosure of my health information by my healthcare providers, health plans, or pharmacies before they receive notice of my cancellation. I understand I have a right to receive a copy of this authorization.

Print Patient or Authorized Patient Representative Name _____

Signature of Patient or Authorized Patient Representative _____

If Representative, Relationship to Patient:

Parent/Legal Guardian Representative per Power of Attorney Spouse

Date _____





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PATIENT ENROLLMENT FORM

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| Individual Dose Volume by Patient Weight | | |
|--|--|---|
| Patient Weight (kg) | Days 1-7 (190 mcg/kg once daily) Volume QD (mL) | Beginning Day 8 (380 mcg/kg once daily) Volume QD (mL) |
| 5 to 6 | 0.1 | 0.2 |
| 7 to 9 | 0.15 | 0.3 |
| 10 to 12 | 0.2 | 0.45 |
| 13 to 15 | 0.3 | 0.6 |
| 16 to 19 | 0.35 | 0.7 |
| 20 to 24 | 0.45 | 0.9 |
| 25 to 29 | 0.5 | 1 |
| 30 to 34 | 0.6 | 1.25 |
| 35 to 39 | 0.7 | 1.5 |
| 40 to 49 | 0.9 | 1.75 |
| 50 to 59 | 1 | 2.25 |
| 60 to 69 | 1.25 | 2.5 |
| 70 or higher | 1.5 | 3 |

