SpringWorks CareConnections™

GOMEKLI™ (mirdametinib)
TREATMENT-RELATED COST REIMBURSEMENT FORM

This form is intended for patients enrolled in SpringWorks CareConnections who have been prescribed GOMEKLI™ (mirdametinib). It is used to request reimbursement for eligible treatment-related costs under the SpringWorks CareConnections program.

1. *Send this completed form to the email address, fax number, or mailing address below. Include the detailed Explanation of Benefits (EOB) or an invoice from the healthcare provider who has provided the treatment-related services. If upfront payment was made, also include copies of receipts.*
2. *Once this form is received and eligibility is verified, a check will be mailed to the individual listed below. Payment typically arrives 6-8 weeks after program approval.**

Patient Information — SECTION 1

Patient First and Last Name: ______________________ Date of Birth: ____/____/____ (MM DD YYYY)

Street Address: ______________________ Apt: __________ City: __________

State: __________ ZIP: ______ Mobile Phone: (____) __________ ◯ Preferred # Alternate Phone: (____) __________ ◯ Preferred #

Email: ______________________ Primary Language: ______________________

Legal Representative Name: ______________________ Relationship to Patient: __________ Phone Number: (____) __________

Treatment-Related Cost Details — SECTION 2

Date	Description of Treatment-Related Service (exam, visit, etc)	Amount Charged (USD)	Receipt Attached (Yes/No)

Total Amount Requested for Reimbursement: $ ______________________

Payee Information (if different than the patient listed above): — SECTION 3

Indicate who will receive reimbursement: ◯ Patient ◯ Legal Representative ◯ Treatment-Related Cost Healthcare Provider

Make Check Payable to: First Name: ______________________ Last Name: ______________________

Name of Institution (if Applicable): ______________________ Address: ______________________ City: __________

State: __________ ZIP: ______ Phone: (______) __________ Email: ______________________

*Payment of the reimbursement is subject to expense verification and pursuant to the terms and conditions and eligibility criteria of the SpringWorks CareConnections Treatment-Related Cost Reimbursement program.

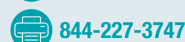
Patient Certification Statement — SECTION 4

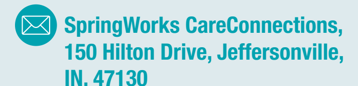
I certify that the information I have given for this reimbursement request is accurate, and that the expenses requested for reimbursement were actually incurred by me or otherwise invoiced to me for eligible treatment-related services rendered. I also certify that I am not enrolled in any of the following government-funded healthcare programs: Medicare (Part A, Part B, Part D, Medicare Advantage Plan or Medicare Prescription Drug Benefit Plan), Medigap, VA, DoD, TRICARE, CHAMPVA, or Puerto Rico Government Health Insurance Plan, nor am I a Medicare-eligible patient enrolled in an employer-sponsored health plan or prescription drug benefit program for retirees. I will not seek reimbursement for the value received from this program from other parties, including any health insurance program or plan, flexible spending account, or healthcare savings account. I will comply with any applicable limitations and requirements of my health plan related to the use of the program.

Patient Signature/Legal Representative Signature: ______________________ Date __________

Legal representative must be 18 years of age or older and have legal authority to act on the patient's behalf.

PLEASE COMPLETE ENTIRE FORM, SIGN AND SUBMIT ALONG WITH THE SUPPORTING DOCUMENTATION VIA EMAIL, FAX, OR MAIL TO ONE OF THE FOLLOWING:





If you have any questions, please call 844-CARES-55 (844-227-3755) Monday – Friday, 8 AM – 10 PM ET.

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