Prescription Referral Form

LUMAKRAS® (sotorasib) 120 mg tablets 320 mg tablets

Referring Physician Information

Physician Name: _____

Specialty: _____

Site Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Office Contact: _____

Patient Information

Fill out entirely **OR** ☐ attach Face/Demographic Information Sheet

Patient Name: _____ Date of Birth: _____ Social Security Number: _____ M ❑ F ❑

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____

Additional Contacts: _____

Insurance Information

Fill out entirely **OR** ☐ fax a copy of insurance card front AND back

Primary Insurance: _____	Secondary Insurance: _____
Insured: _____	Insured: _____
Phone: _____	Phone: _____
Policy #: _____	Policy #: _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____
Rx Group: _____ ID#: _____	Rx Group: _____ ID#: _____

Patient Medical Information

❑ Primary ICD-10 Diagnosis Code: _____ ❑ Additional secondary ICD-10 Code, if applicable: _____

Type(s) of labs completed (if any) include Dx test/test result: _____

Date: _____ LUMAKRAS is medically necessary for (Patient's Name) _____

as documented by: _____

_____

_____

Prior Therapy (if any): _____

Reason for discontinuing previous therapy(ies): _____

Contraindications (if any): _____

Patient is currently taking the following supplemental agents: _____

Prescribing Information

Prescription	Strength/Formulation	Directions	Quantity/Refills
LUMAKRAS® (sotorasib)	❑ 120 mg tablet ❑ 320 mg tablet	❑ Take 960 mg (eight 120 mg tablets) orally once daily ❑ Take 960 mg (three 320 mg tablets) orally once daily ❑ Other _____	Quantity _____ Refills _____ ❑ 30-day supply Prescriber DEA#, NPI#, or State License# _____

_____ _____ _____ _____

Date **Dispense as written** **Date** **Substitution allowed**

Stamped signatures are not allowed.

Please contact Amgen Assist 360™ or MyAmgenPortal.com for benefits verification or any questions regarding benefits verification, claims submission, and other payer requirements.

Please see last page for Indication and full Important Safety Information.

Click here for full Prescribing Information.

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Patient Authorization

LUMAKRAS® (sotorasib) 120 mg tablets 320 mg tablets

SIGN HERE

Patient Signature

I authorize Amgen and its contractors and business partners ("Amgen") to use and/or disclose my personal information, *including my personal health information*, only for the following purposes mentioned below in Amgen's Patient Authorization.

First name: _____ **Last name:** _____

Patient Signature: X _____ **Date:** _____

Stamped signatures are not allowed.

Amgen's Patient Authorization

Uses and Disclosure of Personal Information

I authorize Amgen and its contractors and business partners ("Amgen") to use and/or disclose my personal information, *including my personal health information*, only for the following purposes:

- To operate, administer, enroll me in, and/or continue my participation in Amgen's Amgen Assist 360™ program or any other Amgen-affiliated patient support services and activities related to my condition or treatment (for example, co-pay card programs, reimbursement assistance programs, drug coverage verification, nurse educator services, adherence program, and disease management support);
- To contact, with my permission, my doctor and the rest of my health care team and share with them my health information that may be useful for my care;
- **To provide me with informational and promotional materials relating to Amgen products and services, and/or my condition or treatment**; and/or
- To improve, develop, and evaluate products, services, materials and programs related to my condition or treatment.

In order for Amgen to provide me with the services and/or programs described above, Amgen needs to collect and use my personal information, including *my personal health information*. I understand that *my personal health information* may include any information, in electronic or physical form, in the possession of or derived from a Health Care Provider, health care plan, pharmacy, pharmaceutical company, laboratory and/or their contractor ("Health Care Provider"). This may include select information from or about my medical history and general health, my health care plan benefits, payment limits or restrictions covered by my health care plan policy, and/or my adherence to my treatment.

I authorize my Health Care Providers to disclose my *personal health information* to Amgen, and between themselves, as necessary, but only for the purposes stated above in this Authorization. I understand that certain of my Health Care Providers (such as pharmacies and specialty pharmacies) may receive remuneration from Amgen in exchange for disclosing my *personal health information* and/or for using my information to contact me with communications about Amgen products which have been prescribed to me (for example medication reminders programs) and other patient support services.

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Patient Authorization, continued

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Expiration, Right to Obtain a Copy and Right to Cancel

I understand that by signing this form, I authorize my Health Care Providers or others who might hold my health information to only release it to Amgen employees, as well as to its contractors and business partners, who are performing the services set forth in this Authorization. I also understand I am authorizing my personal information, including *my personal health information*, to be used for the purposes described above. I understand and agree that by signing above, I am authorizing those who rely on this Authorization to release my personal health information for the earlier of five (5) years or until my participation in the program ends through my cancellation, unless a shorter time period is required by state law.

I understand that I can obtain a copy of this Authorization or cancel this Authorization at any time by calling Amgen at 1- 888-427-7478 or by writing to PO Box 220354, Charlotte, NC 28222-0354. If I cancel my consent, I will no longer qualify for the services described. I also understand that if a Health Care Provider is disclosing my personal health information to Amgen on an authorized on-going basis, my cancellation with Amgen will be effective with respect to any such Health Care Providers as soon as they receive notice of my cancellation.

No Effect on Treatment

I understand I do not have to sign this Authorization and that my enrollment in any of the services and/or programs described above is entirely voluntary. I understand that Amgen, as well as Health Care Providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment or other care, to sign this Authorization. Federal Law (including HIPAA) requires a signed authorization in order for Amgen to collect this information from my Health Care Providers. I understand I cannot participate in the listed services and/or programs without signing this Authorization or an equivalent authorization with my Health Care Providers.

Information Received From Health Care Providers

I understand that once my personal health information has been disclosed to Amgen, federal privacy laws may no longer apply and protect it from further disclosure. Amgen agrees, however, to protect my personal health information by only using and disclosing it as stated in the Authorization or as otherwise allowed or required by law.

Authorization to Contact

I understand and consent to Amgen contacting me using the contact information provided in this form to enroll me in, operate, and administer Amgen patient support services and/or programs as described above other than promotional communications by telephone or SMS/text. I understand that the operation and administration of certain of these services and/or programs may require that Amgen contact me by telephone or SMS/text.

Please contact Amgen Assist 360™ or MyAmgenPortal.com for benefits verification or any questions regarding benefits verification, claims submission, and other payer requirements.

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INDICATION AND IMPORTANT SAFETY INFORMATION

INDICATION

LUMAKRAS® is indicated for the treatment of adult patients with *KRAS* G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC), as determined by an FDA-approved test, who have received at least one prior systemic therapy.

This indication is approved under accelerated approval based on overall response rate (ORR) and duration of response (DOR). Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

IMPORTANT SAFETY INFORMATION

Hepatotoxicity

- LUMAKRAS can cause hepatotoxicity, which may lead to drug-induced liver injury and hepatitis.
- Among 357 patients who received LUMAKRAS in CodeBreaK 100, hepatotoxicity occurred in 1.7% (all grades) and 1.4% (grade 3). A total of 18% of patients who received LUMAKRAS had increased alanine aminotransferase (ALT)/increased aspartate aminotransferase (AST); 6% were grade 3 and 0.6% were grade 4. In addition to dose interruption or reduction, 5% of patients received corticosteroids for the treatment of hepatotoxicity.
- Monitor liver function tests (ALT, AST, and total bilirubin) prior to the start of LUMAKRAS, every 3 weeks for the first 3 months of treatment, then once a month or as clinically indicated, with more frequent testing in patients who develop transaminase and/or bilirubin elevations.
- Withhold, dose reduce, or permanently discontinue LUMAKRAS based on severity of adverse reaction.

Interstitial Lung Disease (ILD)/Pneumonitis

- LUMAKRAS can cause ILD/pneumonitis that can be fatal. Among 357 patients who received LUMAKRAS in CodeBreaK 100 ILD/pneumonitis occurred in 0.8% of patients, all cases were grade 3 or 4 at onset, and 1 case was fatal. LUMAKRAS was discontinued due to ILD/pneumonitis in 0.6% of patients.
- Monitor patients for new or worsening pulmonary symptoms indicative of ILD/pneumonitis (eg, dyspnea, cough, fever). Immediately withhold LUMAKRAS in patients with suspected ILD/pneumonitis and permanently discontinue LUMAKRAS if no other potential causes of ILD/pneumonitis are identified.

Most Common Adverse Reactions

- The most common adverse reactions ≥ 20% were diarrhea, musculoskeletal pain, nausea, fatigue, hepatotoxicity, and cough.

Drug Interactions

- Advise patients to inform their healthcare provider of all concomitant medications, including prescription medicines, over-the-counter drugs, vitamins, dietary and herbal products.
- Inform patients to avoid proton pump inhibitors and H_2 receptor antagonists while taking LUMAKRAS.
- If coadministration with an acid-reducing agent cannot be avoided, inform patients to take LUMAKRAS 4 hours before or 10 hours after a locally acting antacid.

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