MyRightDose
Dose Exchange Program

Retevmo®
selpercatinib capsules
40 mg • 80 mg

**Enrollment Form**

- **With MyRightDose, your patients can continue their Retevmo therapy at the appropriate dose for them, without the hassle of delays or additional co-pays**

For more information, call 1-833-920-2175 Monday-Friday, 9 AM-6 PM ET, or visit Retevmo.com. For more information about Lilly's privacy practices, please view the Privacy Statement.

| Instructions for Physician | ✓ Complete | ✓ Sign | ✓ Fax |
|---|---|---|---|
| | Review and complete this entire form | Prescriber must sign and date the bottom of section 4 | Fax this entire form to 1-844-372-9043 |

## Eligibility Requirements

To be eligible for the MyRightDose program, a patient must:

- Return unused pills in the provided pre-addressed envelope and according to the instructions provided by MyRightDose
- Be a resident of the United States or Puerto Rico
- Be prescribed Retevmo for an FDA-approved indication

**Please note:** To provide their dose at no charge, this program is dispensed by Sonexus rather than your in-office dispensary or the specialty pharmacy that is currently dispensing your patient's prescription. Retevmo can be shipped to the patient as early as 48 hours after the receipt of this form. We will contact your office as soon as the patient has received their new dose so you can begin the process of starting the next month's script.

## SECTION 1. PATIENT INFORMATION

| | | |
|---|---|---|
| Name | DOB (mm/dd/yyyy) | Phone |
| Address | | |
| Email | Best time to contact | |
| Caregiver or authorized representative: Name | | Phone |

## SECTION 2. PRESCRIBER INFORMATION

| | | | |
|---|---|---|---|
| Name | | Practice | |
| Address | | | |
| Office contact | | Preferred method of contact: ☐ Phone ☐ Fax ☐ Email | |
| Phone | Fax | Email | |
| NPI # | State license # | Tax ID # | DEA # |

## SECTION 3. PRESCRIPTION — Choose one in each column

Existing dose:
- ☐ Retevmo® (selpercatinib) 160 mg BID
- ☐ Retevmo® (selpercatinib) 120 mg BID
- ☐ Retevmo® (selpercatinib) 80 mg BID
- ☐ Retevmo® (selpercatinib) 40 mg BID
- ☐ Retevmo® (selpercatinib) 40 mg QD

New dose:
- ☐ Retevmo® (selpercatinib) 160 mg BID
- ☐ Retevmo® (selpercatinib) 120 mg BID
- ☐ Retevmo® (selpercatinib) 80 mg BID
- ☐ Retevmo® (selpercatinib) 40 mg BID
- ☐ Retevmo® (selpercatinib) 40 mg QD

Directions
Taken as prescribed

Quantity
___ days to be exchanged

Diagnosis code

## SECTION 4. TERMS AND CONDITIONS

- The MyRightDose program is available at no charge to a patient prescribed Retevmo for an FDA-approved indication for up to three separate dose exchanges in a 12-month period. The quantity to be exchanged should be between 5 and 30 days per exchange
- Neither the prescriber, prescriber's institution, pharmacy, pharmacist, or any other person, including the patient, may seek payment or accept reimbursement from any patient, any third-party payer, including any state or federal entity or any private or other insurance plan, or from any other person or entity, for Retevmo supplied under this program, regardless of whether the payer subsequently determines it will cover the product
- Product provided pursuant to this program may not be sold, traded, or distributed for sale
- If a patient is enrolled in a Medicare Part D plan, the prescriber must notify the patient that they must not attempt to have this prescription or any costs associated with it counted as any portion of true out-of-pocket ("TrOOP") cost for prescription drug calculations
- No purchase contingency or other obligation accompanies program participation
- Lilly reserves the right to change or end the program at any time without notice. Benefits provided under the program are not transferable

**Prescriber:** I certify that I understand and agree: 1) That I have explained to my patient that he/she must return the unused drug according to the instructions provided by the MyRightDose program; 2) To the Terms and Conditions of the MyRightDose program; 3) My patient meets the patient Eligibility Requirements of MyRightDose; 4) I am licensed to prescribe the prescription medication identified in this form, the prescription complies with my state-specific prescribing requirements; 5) In my medical judgment, the new strength of Retevmo is clinically appropriate for the patient named above and its use is consistent with the FDA-approved indication; and 6) This supply of Retevmo is specifically for the patient named above.

Prescriber's signature _____ Date _____

**For assistance and/or additional information, call 1-833-920-2175 Monday-Friday, 9 AM-6 PM ET.**
**Please click to access full Prescribing Information for Retevmo.**



Lilly