PROGRAM OVERVIEW

Goal
Cancer patients have little opportunity to save for the high costs of cancer treatment, let alone budget for procedures or treatments intended to preserve the possibility of conceiving with their own eggs. Yet there is only a small window of opportunity between diagnosis and treatment during which cancer patients may pursue these options, and the upfront costs are often prohibitive. The goal of Fertile Hope for Women is to increase access to such procedures and treatments for qualified women who are diagnosed with cancer in their reproductive years.

We are proud to offer assistance to qualified female applicants by providing access to fertility medications donated by EMD Serono, Inc., and discounted services from reproductive endocrinologists across the country.

Overview
Fertile Hope does not grant direct financial contributions to individuals, but instead has partnered with key organizations to increase access to procedures and treatments intended to preserve the possibility of fertility for certain qualified cancer patients whose medical treatments present the risk of infertility and who meet the criteria set forth below.

For a list of participating facilities, please call 1-855-220-7777.

What is covered?
This program helps reduce the cost of embryo freezing and egg freezing procedures.

Embryo freezing is a medically accepted way to preserve the possibility of fertility. First, the ovaries are stimulated to mature multiple eggs. Doctors remove the mature eggs and fertilize them in the lab with sperm from a partner or donor to create embryos. The fertilization process is called in vitro fertilization (IVF). Embryos are then frozen for future use. The steps involved in embryo freezing require between two and six weeks.

Egg freezing may be an option for women who do not have a male partner and do not want to use donor sperm. First, the ovaries are stimulated to mature multiple eggs. Doctors then remove the mature eggs and freeze them for future use. This procedure is considered experimental, which means it should only be offered in accordance with good clinical practice, including, but not limited to, any applicable guidelines issued by the American Society for Reproductive Medicine (ASRM) or similar professional organizations. The steps involved in egg freezing require between two and six weeks.

Certain medications prescribed by a reproductive endocrinologist to assist in the development of multiple follicles through ovarian stimulation will be provided through a donation from EMD Serono, Inc. to qualifying applicants (see eligibility criteria). Additionally, partnering local reproductive endocrinologists will offer embryo and egg freezing services at a significantly discounted rate. The program includes one embryo freezing or egg freezing procedure and certain medications prescribed by physicians for ovarian stimulation.
What is not covered?
While we understand the importance of other fertility preservation and parenthood options, this program only covers egg and/or embryo freezing. The reduced cost offered by the reproductive center does not include many of the ancillary costs of preparing for or going through treatment.

These additional costs could include, but are not limited to:
- Laboratory work performed on your behalf
- Anesthesia costs
- Doctor’s fees
- Short-term or long-term storage of frozen eggs or embryos
- Implantation procedures
- Prenatal care

Discounts on long-term storage may be available.

The program participant or her insurance company will have to bear the costs of services provided by entities or individuals not affiliated with Fertile Hope, including, but not limited to, the costs associated with the ancillary services noted above. It is important to know what those costs are and to plan accordingly.

If a physician determines that treatments or medications other than the services provided by the fertility center are necessary, the participant will be responsible for the cost of such treatments and medications.

Some of the fertility preservation technologies discounted in this program are only available in major metropolitan areas. We will make our best effort to refer patients to the nearest participating facility, but the program does not cover the cost of travel.

This program does not cover the cost of oncology services or any associated expenses incurred during cancer treatments. Keep in mind that neither the Foundation nor EMD Serono are medical providers; all program participants acknowledge and agree that neither the Foundation nor EMD Serono shall be liable for any aspect of their current and future treatment. All cancer patients should discuss the risks, side effects, time requirements and other aspects of all treatment options with their physicians before selecting the most appropriate course of care.

For more information about this program or cancer navigation services at the Foundation which can help anyone affected by cancer, contact us at 855-220-7777.
HOW TO APPLY

Eligibility Criteria
Applications for this program are reviewed based on the following criteria. Only patients who meet all of the following criteria will be accepted.

- U.S. citizen or permanent resident
- Annual household income is less than or equal to $100,000 (if single) or $135,000 (if married)
- Diagnosis of cancer
- Oncologist has determined that the recommended cancer treatments present the risk of infertility
- Individual has not yet started fertility-damaging cancer treatments
- Oncologist and reproductive endocrinologist have both determined that the treatments and associated medications are medically appropriate
- No contraindication to fertility preservation and/or fertility treatments as determined by an oncologist
- Uninsured or denied insurance coverage for the treatments and procedures required for embryo freezing or egg freezing
- Individual has not previously been approved for the program

Please contact us directly for further clarification regarding any of the eligibility requirements listed above.

Application Requirements
Please complete the following forms with the help of your medical team and make a copy for your records. Please print clearly and submit your completed application to the Foundation via mail, fax or email to:

The Lance Armstrong Foundation
Attn: Fertile Hope
2201 East Sixth Street Austin, TX 78702
Fax: 512-857-0164
Email: cancer.novation@LIVESTRONG.org

Please note your application will not be fully processed if any of the following information has not been received:

- Completed Patient Authorization and Consent Form
- Completed Oncologist Referral and Certification Form
- Completed Reproductive Endocrinologist Certification Form
- Copy of your 1040 Federal Tax Return Form from the most recent year
  If you did not file taxes, contact us at 855-220-7777 for more information.

Next Steps
The Foundation will notify applicants of approval or denial by phone, mail and/or email within 1–2 business days of receipt of all required forms. If we have not contacted you within that time frame, please contact us to verify receipt. All approved applicants will receive an approval letter outlining next steps.
**PATIENT AUTHORIZATION AND CONSENT FORM**

Complete all the fields in the following form and keep a copy for your records. Incomplete applications will not be processed.

Note: You should discuss the risks, side effects and other aspects of all treatment options with your physicians before selecting the best course of treatment for you. If at any time your physicians have advised you or do advise you to seek treatment for cancer immediately, it is the position of the Lance Armstrong Foundation that you should not delay your treatments in order to participate in this program.

### PERSONAL INFORMATION

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☐ I give the Lance Armstrong Foundation permission to speak with another party regarding my Fertile Hope application (e.g., parent/guardian, significant other, friend).

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### INSURANCE INFORMATION

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### FINANCIAL INFORMATION

**Average Three-Year Annual Household Income**

I certify that my yearly income or three-year income average is

☐ equal to or less than $100,000 (for single applicants)

☐ equal to or less than $135,000 (for married applicants)

Confirm

☐ I have sent in my 1040 Federal Tax Return form from the most recent year.

When speaking to the IRS, all references to fertile hope should be made by stating that it is a program administered by the Lance Armstrong Foundation.

☐ I am currently unemployed and have been unemployed for a consecutive period of six (6) months prior to the date of this application. If I cannot provide sufficient proof of unemployment by copy of my most recent unemployment benefit claims statement or payment, I authorize the Lance Armstrong Foundation to reasonably verify my unemployment status as part of the income verification process for the purposes of this application only.
Applicant Certification and Authorization to Release Medical Information

I certify that all of the information provided in this application is complete and accurate. I authorize the release of the information contained in this application. I understand it is for the sole use of the Lance Armstrong Foundation, its program participants, its representatives and/or agents (collectively, “the Foundation”) in order to assess my eligibility for participation in the Fertile Hope Program (the “Program”). I authorize the Foundation to request and obtain from my physicians and any insurer any medical or other patient information related to my treatment for cancer and infertility. I authorize the Foundation to share the information contained herein with EMD Serono, Inc. and participating fertility centers in connection with the Program. I agree to immediately inform the Foundation if my income or insurance status changes and to provide any documentation that the Foundation requests to verify the same. I authorize the Foundation to contact me directly to process this application. I understand that my application for assistance does not guarantee that assistance will be provided. I understand that eligibility for the Program is subject to approval under the criteria and requirements set forth herein and that the Foundation reserves the right to change or terminate the Program without prior notice. I agree to abide by this certification and authorization during my participation in the Program and to notify the Foundation if aspects of my application, certification or authorization are no longer applicable.

I understand that neither the Foundation nor EMD Serono, Inc. are medical providers, and by submitting this application with my signature below, I acknowledge and agree that neither the Foundation nor EMD Serono, Inc. shall be liable for any aspect of my current and future treatment. I understand that there are no guarantees that the procedures intended to assist in preserving fertility or the associated medications that may be provided to me under the Program will be successful in preserving my fertility. I understand the experimental nature and success rates of the procedures, and I agree that neither the Foundation nor EMD Serono, Inc. shall be liable for any treatment failure.

I assume all risk of and financial responsibility for any loss or injury related directly or indirectly to my participation in the Program and agree to indemnify and hold the Foundation and EMD Serono, Inc. harmless from and against any and all costs, claims, demands, charges, liabilities, obligations or fees incurred or suffered by me as a result of, or arising out of, my participation in the Program except for claims resulting wholly from the gross negligence of the Foundation or EMD Serono, Inc.

I understand that if I qualify for the Program, I may receive certain medications from EMD Serono, Inc. that my physician may prescribe in connection with one embryo freezing procedure or one egg freezing procedure. I understand that if I receive such medications, EMD Serono, Inc. is under no obligation to provide me with additional medications.

I have discussed with my physicians the risks, side effects and other aspects of all treatment options before selecting a course of treatment for me.

I understand that the Foundation is authorized as a “business associate” under 45 CFR 160.103 (in the act commonly known as “HIPPA”) and that as a business associate, health providers are allowed to disclose my protected health information to the Foundation based on the written assurances made by the Foundation to the health provider that the information will only be used for the purposes of this program, that the information will be safeguarded from misuse, and that the Foundation will help the health provider comply with their HIPPA duties.

By signing below, I certify that I have completely and accurately disclosed, and at all times will completely and accurately disclose, my medical history to all of my health care providers, including but not limited to, any oncologist or reproductive endocrinologist. I understand that the agreements under Fertile Hope shall be construed and interpreted in accordance with the laws of the State of Texas without regard to its conflicts of law provisions.

PATIENT SIGNATURE  DATE
PARENT/GUARDIAN SIGNATURE  DATE
(IF PATIENT UNDER AGE 18)
ONCOLOGIST REFERAL & CERTIFICATION FORM

COMPLETE ALL THE FIELDS IN THE FOLLOWING FORM AND KEEP A COPY FOR YOUR RECORDS. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.

NOTE: YOU SHOULD DISCUSS THE RISKS, SIDE EFFECTS AND OTHER ASPECTS OF ALL TREATMENT OPTIONS WITH YOUR PATIENT BEFORE RECOMMENDING THE BEST COURSE OF TREATMENT. IF AT ANY TIME YOU HAVE ADVISED OR DO ADVISE YOUR PATIENT TO SEEK TREATMENT FOR CANCER IMMEDIATELY, IT IS THE POSITION OF THE LANCE ARMSTRONG FOUNDATION THAT THE PATIENT SHOULD NOT DELAY TREATMENTS IN ORDER TO PARTICIPATE IN THIS PROGRAM.

PATIENT INFORMATION

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PHYSICIAN INFORMATION

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TREATMENT INFORMATION

CANCER TYPE:

TREATMENT PLAN (CHECK ALL THAT APPLY)

- ☐ SURGERY TO THE REPRODUCTIVE AREA, EXPLAIN
- ☐ RADIATION TO THE BRAIN OR REPRODUCTIVE AREA, EXPLAIN
- ☐ CHEMOTHERAPY, EXPLAIN
- ☐ OTHER, EXPLAIN

TREATMENT TIMELINE (SHOULD FALL AFTER COMPLETION OF FERTILITY TREATMENT)

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<th>ESTIMATED START DATE</th>
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For the following two questions, check yes or no. ANSWERS ARE REQUIRED FOR BOTH QUESTIONS; INCOMPLETE ANSWERS WILL DELAY PROCESSING.

1. MY INTENDED TREATMENT PLAN PRESENTS A RISK THAT THE PATIENT MAY BECOME INFERTILE.
   - YES
   - NO

2. ARE THERE ANY KNOWN MEDICAL CONTRAINDICATIONS TO THE ABOVE-NAMED PATIENT UNDERGOING FERTILITY PRESERVATION TREATMENTS AND THE ASSOCIATED RISKS AND SIDE EFFECTS?
   - YES
   - NO

I have discussed with the patient the risks, side effects and other aspects of all her treatment options.

I certify that I have read the full physician prescribing information for each of the EMD Serono, Inc. products that may be prescribed by a reproductive endocrinologist under this program (Gonal-f®, Ovidrel® PreFilled Syringe, Cetrotide® 0.25mg) and that: the use of such medications for the above-named patient is consistent with each product’s labeling, and in my medical judgment there is no reason that the above-named patient should not be treated with any one or more of these medications.

Neither the Lance Armstrong Foundation nor EMD Serono, Inc. is a medical provider, and I acknowledge and agree that neither the Foundation nor EMD Serono, Inc. shall be liable for any aspect of the treatment of the patient I have referred to the Foundation for participation in the the Foundation’s Fertile Hope Program.

ONCOLOGIST SIGNATURE ___________________________ DATE ___________________________
REPRODUCTIVE ENDOCRINOLOGIST CERTIFICATION FORM

COMPLETE ALL THE FIELDS IN THE FOLLOWING FORM AND KEEP A COPY FOR YOUR RECORDS. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.

NOTE: YOU SHOULD DISCUSS THE RISKS, SIDE EFFECTS AND OTHER ASPECTS OF ALL TREATMENT OPTIONS WITH YOUR PHYSICIANS BEFORE SELECTING THE BEST COURSE OF TREATMENT FOR YOU. IF AT ANY TIME YOUR PHYSICIANS HAVE ADVISED YOU OR DO ADVISE YOU TO SEEK TREATMENT FOR CANCER IMMEDIATELY, IT IS THE POSITION OF THE LANCE ARMSTRONG FOUNDATION THAT YOU SHOULD NOT DELAY YOUR TREATMENTS IN ORDER TO PARTICIPATE IN THIS PROGRAM.

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TREATMENT PLAN

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<td>THE PATIENT LISTED ABOVE HAS BEEN DENIED INSURANCE COVERAGE FOR THE TREATMENTS AND PROCEDURES REQUIRED FOR THE ABOVE-NOTED TREATMENT PLAN.</td>
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SPECIFIC DRUG REQUESTED

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<td>(MAY CHOOSE ONLY PEN OR MULTI-DOSE, NOT BOTH)</td>
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<td>GONAL-F® 450 IU RFF PEN (FOLLITROPIN ALFA INJECTION)</td>
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<td>GONAL-F® 450 IU MULTI-DOSE (FOLLITROPIN ALFA FOR INJECTION)</td>
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<td>CETROTIDE® 0.25 MG (CETREORELIX ACETATE FOR INJECTION)</td>
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Contact: The Lance Armstrong Foundation; attn: Fertile Hope; 2201 East Sixth Street; Austin, TX 78702; fax: 512-857-0164; cancer.nabigation@livestrong.org

Last Update 8/12
Package inserts for EMD Serono Inc.’s US marketed products are available at emdserono.com or by calling 888.275.7376.

Neither the Lance Armstrong Foundation nor EMD Serono, Inc. is a medical provider, and I acknowledge and agree that neither the Foundation nor EMD Serono, Inc. shall be liable for any aspect of the treatment of the patient I have referred to the Foundation for participation in the Foundation’s Fertile Hope Program. I certify that I have read the full physician prescribing information for each of the EMD Serono, Inc. products that may be prescribed by a reproductive endocrinologist under this program (Gonal-f®, Ovidrel® PreFilled Syringe and Cetrotide® 0.25mg) and that: such medications are not contraindicated for the above-named patient, and in my medical judgment there is no reason that the above-named patient should not be treated with any one or more of these medications. I have discussed with the patient the risks, side effects and other aspects of all her treatment options. I have provided the patient with the patient information leaflet for each of the EMD Serono, Inc. medications available under Fertile Hope and discussed with her the potential risks and side effects of taking such medications.

I have also explained to her that there are no guarantees that the procedure or associated medications provided to her under Fertile Hope will be successful in her effort to conceive using her own eggs. I have discussed both the experimental nature and success rates of the procedures with the above-referenced patient and agree to undertake the procedure in accordance with good clinical practice, including but not limited to any applicable guidelines issued by the American Society for Reproductive Medicine or other similar professional organizations. I understand that any medications provided to me through Fertile Hope must be provided only to the above-named patient and are not for trade, sale or purchase. I agree that I will not seek reimbursement by any federal, state or private program for any of the medications provided to the above-named patient under Fertile Hope.