gamifant cares™
Support for the journey ahead

PRESCRIPTION AND ENROLLMENT FORM

- Call Gamifant Cares at **1-833-597-6530** Monday through Friday 8 AM to 8 PM ET, or visit **Gamifant.com**

- **Healthcare providers** please complete this form, have the patient sign the indicated area on **page 2**, and fax it to Gamifant Cares at **1-866-895-7204**, or email to **GamifantCares@rxallcare.com**. Remember to complete the Prescription Information section

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____ Date of Birth: ____/____/____

Street: _____ Unit: _____ City: _____ State: _____ ZIP Code: _____

Home Phone #: _____ Mobile Phone #: _____ Email: _____

Preferred Contact Method: ☐ Phone ☐ Text ☐ Email Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____ Sex: ☐ Male ☐ Female US Resident: ☐ Yes ☐ No

State Where Patient Is Receiving Treatment: _____

CAREGIVER/AUTHORIZED REPRESENTATIVE INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Home Phone #: _____ Mobile Phone #: _____ Email: _____

Preferred Contact Method: ☐ Phone ☐ Text ☐ Email Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

Relationship to Patient: I am a *(select one)* ☐ Parent ☐ Caregiver ☐ Advocate

☐ **As a patient, parent, caregiver, or advocate, I am interested in being considered for the Nursing Support Program.**
The Nursing Support Program is a voluntary program for eligible patients and their caregivers to be supported by a team of registered nurses. The mission of the program is to educate and empower patients and their families.

INSURANCE INFORMATION

Please fax a copy of all insurance cards (front and back) with this form to Gamifant Cares ☐ **No insurance**

Primary Medical Insurance: _____ Insurance Phone #: _____

Policyholder Full Name: _____ Policyholder Date of Birth: ____/____/____

Relationship to Patient: _____ Group #: _____ Member ID #: _____

Prescription Insurance: _____ RxGroup: _____ RxBin: _____ RxPCN: _____

Secondary Medical Insurance: _____ Insurance Phone #: _____

Policyholder Full Name: _____ Policyholder Date of Birth: ____/____/____

Relationship to Patient: _____ Group #: _____ Member ID #: _____

Prescription Insurance: _____ RxGroup: _____ RxBin: _____ RxPCN: _____

PRESCRIBER INFORMATION

Last Name: _____ First Name: _____ Specialty: _____

NPI #: _____ DEA #: _____ Tax ID #: _____ Medicaid Provider ID #: _____

Email: _____

INSTITUTION INFORMATION

Institution Name: _____ NPI #: _____ Tax ID #: _____

Street: _____ Unit: _____ City: _____ State: _____ ZIP Code: _____

Phone #: _____ Fax #: _____ Email: _____

SERVICING SITE OF CARE INFORMATION

Current Site of Care Name: _____ ☐ Inpatient ☐ Outpatient ☐ Other: _____

Future Site of Care Name: _____ ☐ Inpatient ☐ Outpatient ☐ Other: _____

Servicing Site of Care Name (if location is different than above): _____ Servicing Site of Care NPI #: _____

Street: _____ City: _____ State: _____ ZIP Code: _____

Hospital Admission Date: ____/____/____ ☐ Emergent ☐ Planned

Has inpatient authorization been submitted? ☐ Yes ☐ No Authorization #: _____

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Last Name: _____ First Name: _____ Date of Birth: _____/_____/_____

ADDITIONAL CARE TEAM INFORMATION

CARE TEAM ROLE	NAME	EMAIL	PHONE
Pharmacy			
Billing/Payer Relations			
Prior Authorization			
Office			
Institution			

☐ **I would like my patient to be enrolled into the Nursing Support Program.**
The Nursing Support Program is a voluntary program for eligible patients and their caregivers to be supported by a team of registered nurses. The mission of the program is to educate and empower patients and their families.

PREFERRED DELIVERY METHOD

☐ McKesson Biologics Specialty Distributor (Buy & Bill–Inpatient) ☐ McKesson Specialty Distributor (Outpatient)
☐ Biologics Specialty Pharmacy (Outpatient/Inpatient)

PRESCRIPTION INFORMATION

Recommended starting dose is 1 mg/kg. See Prescribing Information for dosing titration details.

Patient Weight: _____kg Anticipated Start Date: _____/_____/_____ Anticipated Starting Dose: _____mg

Note: Dosing and administration information can be found in the Prescribing Information for Gamifant® (emapalumab-lzsg) and at www.Gamifant.com.

MEDICATION	STRENGTH	QUANTITY	REFILLS
☐ Gamifant® (emapalumab-lzsg)	10 mg/2 mL (5 mg/mL) single-dose vial		
☐ Gamifant® (emapalumab-lzsg)	50 mg/10 mL (5 mg/mL) single-dose vial		
☐ Gamifant® (emapalumab-lzsg)	100 mg/20 mL (5 mg/mL) single-dose vial		

SIGN HERE **Prescriber Signature:** _____ **Date:** _____/_____/_____
Stamp Signature Not Allowed
☐ **Dispense as Written** ☐ **Substitution Permitted**

PRESCRIBER CERTIFICATION

My signature below certifies that I have read, understand, and agree to the Prescriber Certification Statement on page 3.

SIGN HERE **Prescriber Signature:** _____ **Date:** _____/_____/_____
Stamp signature not accepted. *This form cannot be processed without an original signature.*

GAMIFANT CARES PATIENT AUTHORIZATION

My signature below certifies that I have read, understand, and agree to the Patient Authorization Statement on page 3.

SIGN HERE **Patient Signature:** _____ **Date:** _____/_____/_____
OR
SIGN HERE **Caregiver/Authorized Representative Signature:** _____ **Date:** _____/_____/_____
I am signing on behalf of the patient, and I affirm that I have the legal right to do so, that I am the parent or legal guardian of the patient, or that I otherwise have a valid power of attorney to act on behalf of the patient.

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PATIENT AUTHORIZATION STATEMENT

My signature on this enrollment form authorizes my doctor(s), healthcare providers, health plan or payer, and my pharmacy to disclose to Sobi, Inc. ("Company") and its third party suppliers, vendors, and other service providers supporting Gamifant Cares (collectively, the "Service Providers") information about me (for example, my name, Social Security number, address, insurance policy number, and income) and my medical condition (for example, my diagnosis or medications) (together, "Personally Identifiable Information"). This information can include spoken or written facts about my health and insurance benefits. It can include copies of records from my healthcare providers or health plans about my health or healthcare. I understand that my healthcare providers and my pharmacy may receive remuneration, or payment, for disclosing my information pursuant to this authorization. I understand that Gamifant Cares and other Service Providers may be compensated by Sobi.

The Service Providers will use and give out my information to (i) assist in my enrollment in Gamifant Cares and to contact me and/or the person legally authorized to sign on my behalf; (ii) provide me and/or the person legally authorized to sign on my behalf with educational material and other information materials related to the Gamifant Cares offerings; (iii) verify, investigate, assist with, and coordinate my coverage for Gamifant® (emapalumab-lzsg) with my payer; (iv) coordinate prescription fulfillment; (v) assess my eligibility for the Gamifant patient assistance program (PAP), if necessary and applicable; (vi) assess my eligibility for the Nursing Support Program; and (vii) assist with analyses of the efficiencies and performance of Services provided by Service Providers.

If I am considered for the Nursing Support Program, I understand I will be contacted by a registered nurse to evaluate my eligibility. In some instances, the Service Providers may de-identify my information and use or disclose the de-identified information (in individual or aggregated form) for any legitimate business purposes. I understand that the Service Providers will make reasonable efforts to keep my information private; however, I understand that once my information has been disclosed to the Service Providers, how the Service Providers further disclose my information may no longer be protected under federal and state privacy laws.

This authorization will last for three (3) years from the date of my signature or until I am no longer receiving Gamifant or enrolled in Gamifant Cares, whichever is later. I understand that I do not have to sign this authorization, but if I do not, I will not be able to have my insurance coverage verified, have alternate sources of assistance researched, or access other support provided by or on behalf of Gamifant Cares. My choice as to whether to sign this form will not change the way my doctors, healthcare providers, or payers treat me.

If I no longer wish to participate in Gamifant Cares, I shall inform my healthcare providers and/or the administrators of Gamifant Cares in writing that I do not want them to share any more information with the Service Providers, but it will not change any actions that took place before I told them. I have the right to revoke or cancel this authorization, in writing, at any time by providing written notice to my healthcare providers and/or the administrators of Gamifant Cares. Cancellation of this authorization will be valid when received by the administrators of Gamifant Cares. I understand that a cancellation is not effective to the extent that any person or entity has already acted in reliance on my authorization. I know I have a right to see or copy the information my healthcare providers or payers have given to the Service Providers.

If I am eligible for assistance through the Gamifant PAP, I agree to allow Company and Service Providers to use my demographic information, including, but not limited to, Social Security number, date of birth, name, and/or address as needed to access my credit information and information derived from public and other sources, including information from a consumer reporting agency (credit bureau), to estimate my income in conjunction with the eligibility determination process performed in reviewing eligibility under the PAP. Company and Service Providers reserve the right to ask for additional documents and information at any time. I agree to notify my healthcare providers if I become aware in the future of changes that would affect my eligibility, including, but not limited to, changes in health insurance status or coverage, financial status, and United States residing status.

If I receive services offered through Gamifant Cares, I agree to allow Company and Service Providers to contact me via email or cell phone using the contact information provided in this enrollment form. Text messages are optional, and I can participate in the programs without signing up for text messages. When I sign up for the text messages (by providing my cell phone number), I understand that I am agreeing to the following conditions:

- Company and Service Providers are not responsible if a communication is not delivered due to technical difficulties like server issues, phone carrier outages, or discontinued service
- I can opt out at any time by replying "STOP" to the text messages
- I am aware that anyone who can open or have access to my phone might see the text messages
- If my mobile operator is not participating in text messaging services, I will not receive text messages
- I CANNOT report product complaints or adverse events (like side effects) by text message. To report these, please call Gamifant Cares at 1-833-597-6530

This Authorization Statement is governed by and interpreted in accordance with the laws of the state of Massachusetts, excluding Massachusetts conflict of law rules, and applicable federal law.

PRESCRIBER CERTIFICATION STATEMENT

I hereby attest that I am the prescribing healthcare provider and I agree to submit requests to Gamifant Cares because I have determined that Gamifant is medically appropriate, and I have explained such to my patient. I certify that I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act [HIPAA] of 1996) to Service Providers for the purpose of providing access, reimbursement and nursing support, assisting in initiating or continuing therapy, and/or the evaluation of the patient's eligibility for support. I authorize the Service Providers, as my designated agent and on behalf of my patients, to forward a prescription for Gamifant, by fax or other mode of delivery, to an appropriate pharmacy that dispenses Gamifant.

I also certify that this prescription complies with all appliable state and local laws. I agree to notify the Service Providers if I become aware at any time in the future of changes in my patient's circumstance that would affect their eligibility, including, but not limited to, changes in health insurance status or coverage, financial or United States residency status. I understand that I am under no obligation to prescribe any Sobi products and that I have not received, nor will I receive any benefit from Sobi for doing so. Furthermore, I will not seek reimbursement from any third-party payer or government entity for any product that may be provided free of charge through a support program offered by Gamifant Cares.

I acknowledge I may be contacted by email, postal mail, or fax using the information I've provided, and I understand my personal information will be used and disclosed by Gamifant Cares in accordance with Sobi's privacy policy, available at https://sobi-northamerica.com/privacy-policy.

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