gamifant cares™
Support for the journey ahead

# PATIENT 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 and fax it to Gamifant Cares at **1-866-895-7204**, or email to **GamifantCares@pharmacord.com**

## 1 PATIENT AND CAREGIVER INFORMATION

### 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

### 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* **Parent/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.

## 2 INSURANCE INFORMATION

***Please fax a copy of medical and prescription 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: _____

## 3 CARE TEAM INFORMATION

### ORDERING PHYSICIAN

Last Name: _____ First Name: _____ Specialty: _____
NPI #: _____ Tax ID #: _____ Medicaid Provider ID #: _____ Phone: _____
Email: _____ State License #: _____

### CLINIC/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
Have you notified the payer of the inpatient stay? ☐ Yes ☐ No Authorization: _____

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## 4 ADDITIONAL CARE TEAM INFORMATION

| CARE TEAM ROLE | NAME | EMAIL | PHONE |
|---|---|---|---|
| Pharmacy | | | |
| Billing/Payer Relations | | | |
| Prior Authorization | | | |
| Office | | | |
| Social Worker/Case Manager | | | |

## 5 PREFERRED DELIVERY METHOD

☐ McKesson Specialty Distributor (Buy & Bill) ☐ Biologics Specialty Pharmacy

## 6 PRESCRIPTION INFORMATION (Required when preferred delivery method is Biologics Specialty Pharmacy.)

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.*** *This form cannot be processed without an original signature.*

☐ **Dispense as written** ☐ **Substitution permitted**

## 7 PRESCRIBER CERTIFICATION

I hereby attest that I am the prescribing healthcare provider or an authorized agent in the healthcare provider's practice acting on behalf of the healthcare provider, and I agree to submit requests to Gamifant Cares because our medical team has determined that Gamifant is medically appropriate for our patient, and we have explained such to our patient. I also certify that this prescription complies with all applicable state and local laws. 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 my patient with access and reimbursement assistance for Gamifant, assisting in initiating or continuing therapy, and/or the evaluation of the patient's eligibility for patient support offerings, if any.

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. Furthermore, if my patient obtains Gamifant via the PAP, I understand that (a) no third-party, or patient can be charged for Gamifant provided under PAP and (b) that drug as a part of the PAP is not contingent upon future purchases or prescribing of Gamifant.

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 www.sobi.com/usa/en/privacy-policy-us.

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

SIGN HERE **Prescriber Signature:** _____ **Date:** _____/_____/_____

***Stamp signature not allowed.*** *This form cannot be processed without an original signature.*

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

## 8 PATIENT AUTHORIZATION STATEMENT

My signature on this application for the Gamifant Patient Assistance Program ("PAP" or "Program"), 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. This information may include, but is not limited to, my 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) as well as my medical condition (for example, my diagnosis or medications) (together, "Protected Health Information and/or Personally Identifiable Information"). The Personally Identifiable Information may be used to estimate my income in conjunction with evaluating my financial eligibility, as well as my overall eligibility, under the Gamifant PAP, and to enroll me in Gamifant Cares. The Personally Identifiable Information used by Service Providers 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. I understand that 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 residency.

The Service Providers will use and give out my information to (i) assess my eligibility under the Gamifant PAP; (ii) enroll me in the Gamifant PAP if I am determined eligible; (iii) provide me and/or the person legally authorized to sign on my behalf with information and educational material; (iv) verify my eligibility for re-enrollment in the Gamifant PAP, if applicable; and (v) assist with analyses of the efficiencies and performance of Services provided by Service Providers. If I am eligible for the Gamifant PAP, I understand that continued enrollment in the Program is not guaranteed, and re-enrollment is not automatic. 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 enrolled in the Gamifant PAP, whichever is later, unless a shorter period is mandated by state law. I understand that I do not have to sign this Authorization, but if I choose not to sign this Authorization, Gamifant Cares will not be able to evaluate my eligibility for participation under the Gamifant PAP.

I understand that I cannot submit a claim or seek reimbursement or credit for PAP product I receive under the Gamifant PAP from my insurance provider or payer. No payer, third party, or patient may be charged for PAP product provided under this PAP Program.

If I receive services offered from Gamifant Cares I agree to allow Service Providers to contact me via email or cell phone using the contact information provided in this enrollment form. Receiving text messages is optional and I can participate in Gamifant Cares without agreeing to receive text messages. I understand that by providing my cell phone number on this application I agree to receive text messages with the following conditions:

- Service Providers may send an autodialed pre-recorded text message (standard text message and data rates apply).
- I can opt out at any time by calling 1-833-597-6530 or replying "STOP" to the text messages.
- 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 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.