gamifant cares™
Support for the journey ahead

PATIENT ENROLLMENT FORM

- Call Gamifant Cares at **1-833-597-6530** Monday through Friday 8:30 AM to 7 PM ET, or visit **Gamifant.com**

- **Healthcare providers**, please complete and sign the appropriate sections of this form, have the patient sign section 2, and fax it to Gamifant Cares at **1-866-895-7204**, or email to **GamifantCares@AssistRx.com**
- **To enroll online**, please visit **SobiPatientSupport.iassist.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: _____ Gender: ☐ 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

2 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.

3 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: _____

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

5 ADDITIONAL CARE TEAM INFORMATION

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

6 PREFERRED DELIVERY METHOD

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

7 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**

8 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 for my patient and 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 Gamifant Cares for the purpose of providing my patient with assistance in accessing, initiating or continuing Gamifant therapy, and/or evaluating my patient's eligibility for patient support programs that may be available, if any.

I certify that the prescription on this form complies with all applicable state and local laws. On behalf of my patient, I authorize Gamifant Cares, as my designated agent to forward a prescription for Gamifant, by fax or other means under applicable law, to an appropriate specialty pharmacy if necessary.

I agree to notify Gamifant Cares 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 status or United States residency. 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 to my patient through the Gamifant Patient Assistance Program. I acknowledge I may be contacted by email, postal mail, or fax using the information provided on this form, and I understand my 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.*

PATIENT ENROLLMENT FORM

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

9 PATIENT AUTHORIZATION STATEMENT

My signature on this 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, address, insurance policy number, and income) and my medical condition (for example, my diagnosis or medications) (together, "Protected Health Information" and/or Personally Identifiable Information"). This Personally Identifiable 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 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) with my payer; (iv) coordinate prescription fulfillment; (v) assess my eligibility, for patient assistance and/or benefits, if necessary and applicable; and (vi) assist with analyses of the efficiencies and performance of services provided by Service Providers.

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, unless a shorter period is mandated by state law. I understand that I do not have to sign this Authorization, but if I do not, I may 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 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 Gamifant Cares at 495 N Keller Rd, Suite 100, Maitland, FL 32751. 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 request a copy of the information my healthcare providers or payers have given to the Service Providers.

If I am being evaluated for assistance under the Gamifant Patient Assistance Program (PAP), I agree to allow Service Providers to use my demographic information, including, but 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), to estimate my income in conjunction with the eligibility determination process performed to evaluate my eligibility under the PAP. Service Providers reserve the right to ask for additional documents and information at any time. If I am eligible to participate in the Gamifant PAP I understand that: (i) continued enrollment in the PAP is not guaranteed, (ii) re-enrollment is not automatic, (iii) I cannot submit a claim or seek reimbursement or credit for product I receive under the Gamifant PAP from my insurance provider or payer, and (iv) no payer, third party, or patient may be charged for PAP product provided under the PAP program. 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.

I agree to allow Service Providers to contact me via email or cell phone using the contact information provided in this form, unless I otherwise inform Gamifant Cares that I do not wish to receive text messages. I understand that 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 form 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.