Enjaymo
sutimlimab-jome
Injection for intravenous use
1100 mg/22 mL

ENJAYMO NO COST TRIAL PROGRAM START FORM

Recordati Rare Diseases Patient Solutions

Complete the entire form and fax to 888-241-3572
Call us 8AM-8PM ET Monday-Friday at 833-223-2428

LEARN MORE
SCAN HERE

www.ENJAYMO.com

ELIGIBILITY

- You are using ENJAYMO for the first time.
- You are being treated for ENJAYMO's on-label indication.
- You are 18 years of age or older.
- You are a resident of the United States, Puerto Rico, or other U.S. territories.
- You are being treated by a Healthcare Provider of the U.S. or its territories.

GETTING STARTED

1. Download the ENJAYMO No Cost Trial Program Start Form and bring to your HCP to begin discussions on starting ENJAYMO.
2. Complete all fields and signature requirements and fax the ENJAYMO No Cost Trial Program Start Form to 888-241-3572.

PROGRAM OVERVIEW

- The ENJAYMO No Cost Trial Program can provide a 30-day supply of ENJAYMO at no cost to eligible patients.
- Eligibility for the ENJAYMO No Cost Trial Program is contingent on patient enrollment in RRD Patient Solutions.
- There is no obligation for your patient to continue use of ENJAYMO after the ENJAYMO No Cost Trial Program has been completed.
- Patients are eligible for the ENJAYMO No Cost Trial Program only once per lifetime.
- Shipment of the ENJAYMO No Cost Trial Program product is contingent on patient receiving recommended vaccinations and scheduling the first infusion.
- After the ENJAYMO No Cost Trial Program ends, you may be responsible for out-of-pocket costs from your health insurance.
- The provision of the ENJAYMO No Cost Trial Program product may be disclosed in accordance with transparency reporting requirements in certain states (e.g., VT).
- Recordati reserves the right to change, modify, or discontinue this program at any time without notice.

1 PATIENT INFORMATION (REQUIRED)

PATIENT FIRST NAME _____ LAST NAME _____ MIDDLE INITIAL _____

DATE OF BIRTH _____ LAST 4 DIGITS OF SSN _____ ☐ MALE ☐ FEMALE ☐ OTHER

STREET ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP _____

CELL PHONE ( ) _____ OTHER PHONE ( ) _____ ☐ OK TO LEAVE A MESSAGE

EMAIL ADDRESS _____

CAREGIVER (IF APPLICABLE) _____ PHONE ( ) _____

PATIENT'S PRIMARY LANGUAGE ☐ ENGLISH ☐ OTHER IF OTHER, PLEASE SPECIFY _____

2 INSURANCE INFORMATION

PLEASE ATTACH COPIES (FRONT AND BACK) OF ALL AVAILABLE INSURANCE AND PRESCRIPTION CARDS. ☐ **NO INSURANCE**

PRIMARY MEDICAL INSURANCE NAME _____

INSURANCE PHONE ( ) _____ POLICY ID # _____

GROUP # _____ POLICYHOLDER NAME (FIRST/LAST) _____

EMPLOYER OF POLICYHOLDER _____ RELATIONSHIP TO PATIENT _____

PRESCRIPTION DRUG INSURANCE NAME (IF DIFFERENT) _____

INSURANCE PHONE ( ) _____

POLICY ID # _____ GROUP # _____

RXBIN # _____ RXPCN # _____

SECONDARY MEDICAL INSURANCE NAME _____

INSURANCE PHONE ( ) _____ POLICY ID # _____

GROUP # _____ POLICYHOLDER NAME (FIRST/LAST) _____

Patient to Fill Out

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3 PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME _____ PRESCRIBER FACILITY NAME _____

OFFICE CONTACT NAME _____

SPECIALTY _____ OFFICE CONTACT EMAIL _____

ADDRESS _____ PHONE ( ) _____

CITY _____ STATE _____ ZIP _____ FAX ( ) _____

NPI _____ TAX ID _____ STATE LICENSE _____

4 INFUSION SITE LOCATION

PLEASE SPECIFY INFUSION SITE LOCATION ☐ OFFICE ☐ INFUSION CENTER

IF INFUSION CENTER NAME IS KNOWN AND DIFFERENT FROM PRESCRIBER ABOVE, PLEASE PROVIDE:

NAME _____ PHONE ( ) _____

STREET ADDRESS _____ SUITE # _____

CITY _____ STATE _____ ZIP _____

5 CLINICAL INFORMATION

DIAGNOSIS:

☐ ICD-10 CODE: _____ WEIGHT: _____ (☐kg / ☐ lb) DATE RECORDED _____

6 PRESCRIPTION INFORMATION

PATIENT NAME (FIRST, MI, LAST) _____ DATE OF BIRTH (MM/DD/YYYY) _____

MEDICATION: ENJAYMO (sutimlimab-jome) 1100 mg/22 mL (50 mg/mL)

DIRECTIONS FOR USE & QUANTITY

☐ 6.5g **STARTING DOSE:** Administer 6 vials IV weekly for the first 2 weeks, then every other week for a 30 day supply. Dispense #18 vials. No refills.

☐ 7.5g **STARTING DOSE:** Administer 7 vials IV weekly for the first 2 weeks, then every other week for a 30 day supply. Dispense #21 vials. No refills.

ENJAYMO is for intravenous infusion only. Do not administer as an intravenous push or bolus. The infusion should be administered over 1 to 2 hours depending on the patient's body weight.

The recommended dosage of ENJAYMO for patients is based on body weight. For patients weighing 39 kg to less than 75 kg, the recommended dose is 6.5g and for patients weighing 75 kg or more, the recommended dose is 7.5g.

ESTIMATED DATE OF FIRST INFUSION OF ENJAYMO _____

*This should be after ALL recommended vaccinations are administered.

SPECIAL INSTRUCTIONS FOR INFUSION SITE OR PHARMACY _____

As the undersigned Prescriber, or the Prescriber's Designated Agent, I certify that I have obtained the patient's authorization to use and disclose the patient's personal health information, the information on this form and any prescription to Recordati Rare Diseases, Inc. (together with its parents and affiliates, "Recordati") and its third-party business partners, vendors, and other agents ("Agents") for the purpose of providing product support services and as otherwise permitted by HIPAA ("the Programs").

I authorize the use and disclosure of the patient's health information contained on this form to the patient's other healthcare providers (including pharmacies and Recordati); their respective agents involved in the patient's treatment ("Providers") and health plans/insurers and their respective agents ("Insurers") for treatment, payment and health care operations as permitted by HIPAA. I agree that the patient's Providers and Insurers may contact the Prescriber or the Prescriber's Designated Agent for additional information as needed relating to the patient's ENJAYMO therapy.

The undersigned certifies that: (1) the Prescriber confirmed that the patient has never been treated with ENJAYMO; (2) the Prescriber will not bill the patient or any third party for ENJAYMO; (3) ENJAYMO has been prescribed for an on-label indication and dosing regimen; (4) the Prescriber confirmed recommended vaccinations have been completed and an infusion date has been scheduled; (5) if the undersigned is a "Designated Agent," such person is duly authorized by the Prescriber to sign this "Healthcare Provider Authorization" on the Prescriber's behalf, in accordance with applicable law and medical standards; and (6) the information provided on this form is accurate to the best of their knowledge.

I understand that Recordati may revise, change, or terminate any program services at any time without notice to me. I will notify the Specialty Pharmacy immediately if ENJAYMO is no longer medically necessary for this patient's treatment or if my patient's insurance status changes.

The prescriber is to comply with state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

"Dispense As Written"/Brand Medically Necessary/Do Not Substitute/ No Substitution/DAW/May Not Substitute
Prescriber's Signature: _____ Date: _____

May Substitute/Product Selection Permitted/Substitution Permissible
Prescriber's Signature: _____ Date: _____

CA, MA, NC & PR: INTERCHANGE IS MANDATED UNLESS PRESCRIBER WRITES THE WORDS "NO SUBSTITUTION." _____
ATTN: NEW YORK AND IOWA PROVIDERS, PLEASE SUBMIT ELECTRONIC PRESCRIPTION.

Prescriber to Fill Out

Patient: Please read the following carefully, then date and sign where indicated.

7 AUTHORIZATION FOR RELEASE AND USE OF HEALTH INFORMATION

I hereby authorize and direct my health care providers and their staff (including pharmacies that fill my prescriptions), and my health insurer(s) and their staff (collectively, the "Treating Parties") to disclose to Recordati Rare Diseases, Inc. including its parents, affiliates, and its third party business partners and other agents (collectively, "Recordati") information about my disease, treatment, insurance coverage, and payment for my therapy (together with the information I have provided on this ENJAYMO No Cost Trial Program Start Form and may provide in the future, "my Information") for the purposes of (1) my ENJAYMO treatment during the ENJAYMO No Cost Trial Program by the Treating Parties and (2) Recordati providing me with patient support services in connection with my ENJAYMO therapy or otherwise sending me communications that I have agreed to receive elsewhere in this ENJAYMO No Cost Trial Program Start Form.

I authorize the Treating Parties and Recordati to use and disclose my Information for the purposes permitted by HIPAA and for providing certain support services I agree to in this ENJAYMO No Cost Trial Program Start Form, including, but not limited to: (1) operating and enrolling me in, and/or continuing my participation in the ENJAYMO No Cost Trial Program or any other Recordati-affiliated patient support services and activities related to my condition or treatment; (2) verifying, investigating and coordinating my health insurance coverage or resolving coverage or reimbursement inquiries and payment for Recordati products; (3) coordinating my receipt of and payment for Recordati products; and (4) contacting me for follow-up on any adverse event I may disclose regarding a Recordati product. I further authorize Recordati to de-identify my health information and use it in performing research, education, business analytics, and marketing studies, or for other commercial purposes, including linkage with other de-identified information Recordati may receive from other sources.

I understand that once my Information has been disclosed to Recordati, federal privacy laws may no longer protect the Information. However, Recordati intends to use and disclose my Information only in accordance with this Authorization or as otherwise permitted by law.

Further information regarding Recordati's privacy practices can be found at https://www.recordatirarediseases.com/us/privacy-policy. If you are a resident of California, a description of the personal information collected by Recordati and your rights under the California Consumer Privacy Act can also be found at this link.

I understand that I may refuse to sign this Authorization and that a refusal to sign will not affect my ability to obtain medical care, insurance coverage, or access to health benefits, including access to therapy. However, if I do not sign this Authorization, Recordati cannot provide me with support services.

This Authorization will remain valid until termination of enrollment in Recordati-sponsored patient support programs and activities, including the Recordati Programs, unless a shorter time is required by state law. I understand that I may revoke this Authorization at any time by sending a written notice that includes my name, address, and phone number, to Recordati, ATTN: RRD Patient Solutions 440 Rte 22 Suite 205, Bridgewater, NJ 08807 or by emailing RRDPatientSolutions@recordati.com. I understand that should I revoke this Authorization, I can no longer participate in the Programs and that such revocation will not impact uses and disclosures of my Information that have already occurred in reliance on this Authorization.

I certify that I have read and understand the Authorization for the Release and Use of Health Information, all the information provided is true and correct, and I agree to its terms. If I am the caregiver for the patient, I confirm I am authorized to sign on behalf of the patient.

PATIENT AUTHORIZATION

REQUIRED:

☐ I have read and agree to the Patient Authorization to Use and Disclose Health Information included in Section 7.

PATIENT SIGN

_____ _____
PATIENT SIGNATURE DATE

Patient signature/Legal representative

_____

Printed name if signed by legal representative