

Complete the entire form and fax to 888-241-3572 Call us 8<sub>AM</sub>-5<sub>PM</sub> ET Monday-Friday at 833-223-2428

www.ENJAYMO.com

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		-
	AREGIVER (IF APPLICABLE)	
PATIENT'S PRIMARY LANGUAGE	NGLISH OTHER IF OTHER, PLEASE	E SPECIFY
2 HOUSEHOLD INCOME		
REQUIRED IF REQUESTING THE PATIE	NT ASSISTANCE PROGRAM.	
NUMBER OF HOUSEHOLD MEMBERS _ (Including patient)		NUAL HOUSEHOLD INCOME \$
(including patient)	and any other source	es of income.)
Please refer to Section 8, Patient Authoriza information about the Recordati Rare Disea		come is required for participation in the Recordati Rare t Solutions Patient Assistance Program. Acceptable
financial assistance programs.		ncludes a W-2, IRS-1040, or 2 recent paystubs.
3 INSURANCE INFORMATION		_
	ACK) OF ALL AVAILABLE INSURANCE AN	
	Ξ	
	POLICY ID #	
	P # POLICYHOLDER NAME (FIRST/LAST)	
EMPLOYER OF POLICYHOLDER	DER RELATIONSHIP TO PATIENT	
PRESCRIPTION DRUG INSURANCE NA	AME (IF DIFFERENT)	
INSURANCE PHONE ( )		
POLICY ID #	GROUP #	
RXBIN #	RXPCN #	
SECONDARY MEDICAL INSURANCE NA	\ME	
INSURANCE PHONE ( )	CE PHONE ( ) POLICY ID #	
GROUP #	POLICYHOLDER NAME (F	IRST/LAST)
l		

Prescriber, please complete page 2 and have patient read and sign page 3.





## **Recordati Rare Diseases Patient Solutions Enrollment Form**

Complete the entire form and fax to 888-241-3572 Call us 8<sub>AM</sub>-5<sub>PM</sub> ET Monday-Friday at 833-223-2428

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PRESCRIBER NAME	PRESCRIBER INFORMATION (R	EQUIRED)—Specialty pharmacy will need to c	ontact the provider prior to dispensing
SPECIALTY       OFFICE CONTACT EMAIL         ADDRESS	PRESCRIBER NAME	PRESCRIBER FACILITY	/ NAME
ADDRESS	OFFICE CONTACT NAME		
CITY	SPECIALTY	OFFICE CONTACT EMAIL	
NPI       TAX ID       STATE LICENSE         INFUSION SITE LOCATION       INFUSION SITE LOCATION       INFUSION SITE LOCATION IF KNOW:       OFFICE       INFUSION CENTER NAME IS KNOWN AND DIFFERENT FROM PRESCRIBER ABOVE, PLEASE PROVIDE:         NAME       PHONE ( )       STREET ADDRESS       SUITE #         CITY       STATE       ZIP         CLINICAL INFORMATION       DIAGONOMINUE HEMOLYTIC ANEMIA       DIATE OF BIRTH         DIAGNOSIS: COLD AUTOIMMUNE HEMOLYTIC ANEMIA       (Iky g / Ik) DATE RECORDED       PRESCRIPTION INFORMATION         PRESCRIPTION INFORMATION       DATE OF BIRTH       (MM/DD/YYY)         VEDICATION: ENJAYMO (sutimimab-jone) 100 mg/22 mL (50 mg/mL)       DATE OF BIRTH         PRESCRIPTION INFORMATION       DATE OF BIRTH       Info/Diagnosities of Vision ONES: Administer 6 visis       Novery2 weeks         Dispense #12 visis       DIAGONOSE: Administer 6 visis       Novery2 weeks       Info/Diagnosities an intravenous put or bolks.         Dispense #14 visis       DIAGONOS FOR USE & ADUANTIXY       The recommended doses of S.500 mg and for patients which ADV for patient	ADDRESS	РНС	DNE ( )
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vials IV weekly for the first 2 weeks       IV every 2 weeks       Dispense #12 vials         J.5g STARTING DOSE: Administer 7       Vials IV weekly for the first 2 weeks       Dispense #12 vials         J.7g STARTING DOSE: Administer 7       Vials IV weekly for the first 2 weeks       Dispense #14 vials         Dispense #14 vials       IV every 2 weeks       Dispense #14 vials         Refill: None       Refill: 12 months       Other         TIMATED DATE OF FIRST INFUSION OF ENJAYMO       Mercentation on this form one and any prescription to Recordati Rare Diseases. Inc. (together with its parents and affiliates, "Recordati") and its third-party business three, wendors, and other agents ("Agents") for the purpose of providing product support services and as otherwise permitted by HIPAA ("the Programs").         Vintorize the use and disclosure of the patient's heatment ("Providers") and health plans/insurers and their respective agents ("Insurers") for treatment, payment and health care erations as permitted by HIPAA. I agree that the patient's Providers and Insurers may contact the Prescriber or the Prescriber's Designated Agent, I certify that I have obtained the prescriber or the Prescriber's destination contained on this form to the patient's other healthcare providers (Including pharmacies and Recordati); ir respective agents involved in the patient's Providers" and health plans/insurers and their respective agents ("Insurers") for treatment, payment and health care erations as permitted by HIPAA. I agree that the patient's Providers and Insurers may contact the Prescriber or the Prescriber's Designated Agent or additional information needed relating to the patient's ENJAYMO therapy.         e unders	_	_	EN IAYMO is for intravenous influsion only. Do
7.5g STARTING DOSE: Administer 7       7.5g ONGOING DOSE: Administer 7 vials         Vials IV weekly for the first 2 weeks       IV every 2 weeks         Dispense #14 vials       Dispense #14 vials         Refill: None       Refill: 12 months       Other	vials IV weekly for the first 2 weeks	IV every 2 weeks	not administer as an intravenous push or bolus. The infusion should be administered over 1 to 2
for patients weighing 75 kg or more, the recommended dose is 7,500 mg. FINATED DATE OF FIRST INFUSION OF ENJAYMO	vials IV weekly for the first 2 weeks	IV every 2 weeks	The recommended dosage of ENJAYMO for patients with CAD is based on body weight.
TIMATED DATE OF FIRST INFUSION OF ENJAYMO recommended dose is 7,500 mg.  PECIAL INSTRUCTIONS FOR INFUSION SITE OR PHARMACY	_ Refill: None	Refill: 12 months Other	
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 ormation, 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 rtners, vendors, and other agents ("Agents") for the purpose of providing product support services and as otherwise permitted by HIPAA ("the Programs"). uthorize 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); eir respective agents involved in the patient's treatment ("Providers") and health plans/insurers and their respective agents ("Insurers") for treatment, payment and health care erations 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 needed relating to the patient's ENJAYMO therapy. e undersigned certifies that: (1) the Prescriber has prescribed ENJAYMO for the identified patient; (2) the Prescriber has determined that ENJAYMO is medically necessary for s patient; (3) 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 half, in accordance with applicable law and medical standards; and (4) the information provided on this form is accurate to the best of their knowledge. nderstand 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 no longer medically necessary for this patient's treatment or if my patient's insurance status changes. e prescriber is to comply with state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with the-specific req	TIMATED DATE OF FIRST INFUSION OF EN	ATED DATE OF FIRST INFUSION OF ENJAYMO recommended dose is 7,500 mg.	
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<ul> <li>Analysis in accordance with applicable law and medical standards; and (4) the information provided on this form is accurate to the best of their knowledge.</li> <li>Inderstand 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 no longer medically necessary for this patient's treatment or if my patient's insurance status changes.</li> <li>Intersecriber is to comply with state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with ate-specific requirements could result in outreach to the prescriber.</li> <li>Dispense As Written"/Brand Medically Necessary/Do Not Substitute/</li> <li>May Substitute/Product Selection Permitted/Substitution Permissible</li> <li>Dispense As Written"/Brand Medically Necessary/Do Not Substitute/</li> </ul>	ormation, the information on this form and any p rtners, vendors, and other agents ("Agents") for t uthorize the use and disclosure of the patient's tr eir respective agents involved in the patient's tre verations as permitted by HIPAA. I agree that the needed relating to the patient's ENJAYMO thera e undersigned certifies that: (1) the Prescriber ha	rescription to Recordati Rare Diseases, Inc. (together with its pare he purpose of providing product support services and as otherw lealth information contained on this form to the patient's other he atment ("Providers") and health plans/insurers and their respectiv patient's Providers and Insurers may contact the Prescriber or th py. s prescribed ENJAYMO for the identified patient; (2) the Prescrib	ents and affiliates, "Recordati") and its third-party business ise permitted by HIPAA ("the Programs"). ealthcare providers (including pharmacies and Recordati); ve agents ("Insurers") for treatment, payment and health care e Prescriber's Designated Agent for additional information er has determined that ENJAYMO is medically necessary for
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ispense As Written"/Brand Medically Necessary/Do Not Substitute/ Substitution/DAW/May Not Substitute			rescription form, fax language, etc. Non-compliance with
escriber's Signature: Date:			ct Selection Permitted/Substitution Permissible
A, MA, NC & PR: INTERCHANGE IS MANDATED UNLESS PRESCRIBER WRITES THE WORDS "NO SUBSTITUTION	Substitution/DAW/May Not Substitute		D-t-:



### **Recordati Rare Diseases Patient Solutions Enrollment Form**

Complete the entire form and fax to 888-241-3572 Call us 8<sub>AM</sub>-5<sub>PM</sub> ET Monday-Friday at 833-223-2428

www.ENJAYMO.com

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

#### 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 Enrollment Form and may provide in the future, "my Information") for the purposes of (1) my ENJAYMO treatment 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 Enrollment 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 Enrollment Form, including, but not limited to: (1) operating and enrolling me in, and/or continuing my participation in the Recordati Rare Diseases Patient Solutions Program ("the 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 <u>https://www.recordatirarediseases.com/us/privacy-policy</u>. 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.

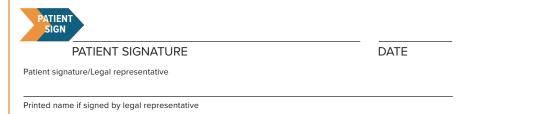
This Authorization will remain valid until termination of enrollment in Recordati-sponsored patient support programs and activities, including the Recordati Programs, unless a shorter time is required by state law. I understand that I may revoke this Authorization at any time by sending a written notice that includes my name, address, and phone number, to Recordati, ATTN: RRD Patient Services 440 Rte 22 Suite 205 Bridgewater, NJ 08807 or by emailing <u>RRDPatientSolutions@recordati.com</u>. 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 8.



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