

1. PATIENT INFORMATION

NAME (First, MI, Last) _____ DOB (MM/DD/YYYY) _____ GENDER _____
 ADDRESS _____ CITY _____
 STATE _____ ZIP CODE _____ E-MAIL _____
 HOME PHONE# _____ CELL PHONE# _____ BEST TIME TO CONTACT: Morning Afternoon Evening

2. INSURANCE INFORMATION [Please attach copies of both sides of patients insurance cards]

PRIMARY INSURANCE _____ INSURANCE PHONE NUMBER _____
 POLICY HOLDER NAME _____ POLICY ID # _____ GROUP ID # _____
SECONDARY INSURANCE _____ INSURANCE PHONE NUMBER _____
 POLICY HOLDER NAME _____ POLICY ID # _____ GROUP ID # _____
PHARMACY BENEFIT PLAN NAME _____ PBM PHONE NUMBER _____
 POLICY ID # _____ GROUP # _____ RX BIN # _____ RX PCN # _____

3. PREFERRED PHARMACY

PREFERRED PHARMACY: AMBER BERGEN BIOLOGICTx OTHER (Specify below) _____
 PHARMACY NAME _____ STORE/LOCATION ID (if known) _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 PHONE NUMBER _____ PREFERRED CONTACT (if known) _____

4. PRESCRIBER INFORMATION

PRESCRIBER NAME (First, Last) _____ MD NP PA SPECIALTY _____
 PRACTICE NAME _____ OFFICE CONTACT _____
 ADDRESS _____ PHONE _____
 CITY _____ STATE _____ ZIP _____ CELL/PAGER _____
 EMAIL _____ FAX _____
 NPI # _____ TAX ID # _____

5. CLINICAL INFORMATION

DIAGNOSIS: Z94.0 Kidney Transplant Status (ICD-10) OTHER (Specify) _____
 Did Medicare pay for the transplant surgery? Yes No Date of transplant (MM/DD/YYYY) _____

6. PRESCRIPTION AND PRESCRIBER CERTIFICATIONS

Please fill out the prescription below or enclose one.

MEDICATION: ENVARUSUS XR® (tacrolimus extended-release tablets)

DOSE 0.75 mg QUANTITY _____ SCHEDULE/FREQUENCY _____ DAYS SUPPLY _____ # OF REFILLS _____
 DOSE 1 mg QUANTITY _____ SCHEDULE/FREQUENCY _____ DAYS SUPPLY _____ # OF REFILLS _____
 DOSE 4 mg QUANTITY _____ SCHEDULE/FREQUENCY _____ DAYS SUPPLY _____ # OF REFILLS _____

DIRECTIONS _____

By signing this form, I certify that I have reviewed the current ENVARUSUS XR® (tacrolimus extended-released tablets) prescribing information. I certify to the best of my knowledge that therapy with ENVARUSUS XR is medically necessary for this patient. I will supervise the patient's treatment with ENVARUSUS XR. I also acknowledge that I have received the authorization to release certain patient information (provided herein) to Veloxis Pharmaceuticals, its affiliates, agents, representatives, and service providers (including CareMetx, its affiliates, and specialty pharmacies) to assist in obtaining access to ENVARUSUS XR. Veloxis Transplant Support may use and disclose the patient information as necessary to enroll my patient in Veloxis Transplant Support and/or the Patient Assistance Program. I further authorize Veloxis Transplant Support to forward the prescription (written above or attached hereto) to a pharmacy for dispensing and (as applicable) to assess my patient's eligibility for financial assistance. I understand that I am under no obligation to prescribe ENVARUSUS XR. I have not received, nor will I receive, any benefit from Veloxis Pharmaceuticals or its affiliates for prescribing this product.

X _____ X _____
 SUBSTITUTION PERMITTED Prescriber Signature Date DISPENSE AS WRITTEN Prescriber Signature Date

Original Signature Required. No Stamps Allowed.

Original Signature Required. No Stamps Allowed.

Prescription is only valid if received by fax.

Special Note: New York prescribers, please submit prescription on an original NY State prescription blank. For all other States, if not faxed, must be on State specific prescription blank if applicable for your State.

Veloxis Transplant Support Patient Consent

APPLICANT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

By signing this authorization form, I certify that the medical, financial, and insurance information provided in this application ("My Information") is accurate and complete. To the extent that I enroll in the Veloxis Transplant Support Program (the "Program"), I consent to My Prescriber using and disclosing My Information to Veloxis Pharmaceuticals ("Veloxis"), its affiliates and service providers, including CareMetx and BiologicTx, their affiliates and subcontractors, for purposes of administering the services associated with the Program. I further consent to the Program, health care providers and contractors, and third-party payers contacting me regarding my participation in the Program. I understand that if I consent to disclosure of My Information, third parties may re-disclose My Information. I understand that My Information, to the extent that I consent to its disclosure, will no longer be protected by Federal privacy laws. I agree to immediately inform the Program, if any of My Information (e.g. financial or insurance status) changes during my participation in the Program. My authorizing signature will remain in effect until I am no longer eligible to participate in the Program, Veloxis terminates the Program, or until I notify Veloxis in writing via USPS (1001 Winstead Dr, Suite 310, Cary, NC 27513) or email (patientsupport@veloxis.com) of my decision to revoke it, in which case I will no longer be allowed to participate in the Program. I understand that any entity authorized to administer the Program (including CareMetx and BiologicTx) and any specialty pharmacies providing support services to me in connection with the Program, may receive remuneration from Veloxis. I understand that it is my responsibility to arrange for medication refills in this Program by contacting My Provider or other health care provider(s). I understand that Veloxis may change the eligibility criteria for the Program or discontinue the Program at any time. I understand that my signature on this authorization form is optional, however, my participation in the Program (but not my treatment, payment, enrollment in a health plan, or eligibility for benefits) is contingent on me signing this authorization form. Upon my request, My Prescriber must provide me with a copy of this signed, authorization form.

APPLICANT DECLARATIONS AND AUTHORIZATION

I certify that all of the information provided to Veloxis Transplant Support, now and in the future, including household income, is complete and accurate. In the event that I apply for Patient Assistance, the following shall apply: I understand that program assistance will terminate if the program becomes aware of any fraud or if this medication is no longer prescribed for me. I understand that submitting an application does not ensure that I will qualify for any particular program. I certify that I will not seek Patient Assistance unless I cannot afford this medication. I certify that I will not seek reimbursement or credit from any insurer, health plan, or government program for any prescriptions dispensed by the Patient Assistance Program. If I am a member of a Medicare Part D plan, I will not seek to have Patient Assistance prescriptions or any costs associated counted as part of my out-of-pocket cost for prescription drugs. I understand that Veloxis Transplant Support reserves the right to modify the application form, modify or discontinue this program, or terminate assistance at any time and without notice. I authorize Veloxis Transplant Support and its affiliates to forward this prescription to a dispensing pharmacy on my behalf. Veloxis Transplant Support is not acting as a dispensing pharmacy. Veloxis Transplant Support is not responsible for verifying any information contained in the Prescription, including without limitation allergies, medical conditions, or other medications being taken by me. With respect to this application, I understand that only the dispensing pharmacy will be responsible for the information contained in the Prescription Section of any applications or of any prescriptions submitted by My Prescriber.

PATIENT RELEASE

I consent to My Prescriber using or disclosing My Information to Veloxis for the purpose of receiving marketing materials and surveys distributed by email using the address provided on this form. I understand that any of My Information used by or disclosed to Veloxis, for the receipt of such marketing or survey activities, may be further disclosed by Veloxis to its affiliates. I may cancel such consent at any time by calling 1-844-835-6947, email (patientsupport@veloxis.com), or USPS (1001 Winstead Dr, Suite 310, Cary, NC 27513) or responding to emails from Veloxis by following the opt-out procedures contained in such emails.

PATIENT SIGNATURE: _____ DATE: ____/____/____

PATIENT NAME (PRINTED): _____

PATIENT'S EMAIL ADDRESS: _____

PERSONAL REPRESENTATIVE SIGNATURE: (IF APPLICABLE) _____ DATE: ____/____/____

PERSONAL REPRESENTATIVE'S BASIS FOR AUTHORITY: (IF APPLICABLE) _____