Enrolling in Veloxis Transplant Support

Veloxis has created the Veloxis Transplant Support program to assist patients in obtaining access to Veloxis medications. Applications are reviewed and eligibility is verified. Determinations are made on a case-by-case basis using pre-determined eligibility requirements regarding coverage and financial criteria.

After the Form has been submitted, including Financial Documentation and Insurance Cards, your Veloxis Transplant Support (VTS) Specialist will review the application and then notify both provider and patient of next steps.

ENROLLMENT INSTRUCTIONS

- **Provider completes Page 2 of this form, including prescriber signature**

  Patient demographics may be sent on a separate attachment if the EMR system includes required information.

  Prescriptions may be on a separate form. 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.

- **Patient completes Page 3 of this form, including patient or patient representative's signature**

  Financial disclosure, including verification of income, is only required if applying for the Patient Assistance Program.

  All other Veloxis Transplant Support services may be obtained without financial disclosure, but will still require the patient consent signature on the bottom of Page 3.

- **Fax complete application package to Veloxis Transplant Support at 1-844-475-8931**

  - ✓ Page 2 with HCP Signature
  - ✓ Prescription (if not included on Page 2)
  - ✓ Page 3 with Patient Signature
  - ✓ Copies of both sides of all Insurance Cards
  - ✓ Income verification documents if applying for the Patient Assistance Program (details on page 3)

  If the Application is incomplete, VTS will attempt to contact the patient and provider to request the missing information or documentation.

Patient Assistance Program Details

Patients enrolled in patient assistance are approved for a maximum of 12 months of eligibility at a time and must reapply to re-validate their eligibility annually. VTS will contact you to re-validate your eligibility for Patient Assistance before the current eligibility period expires.

Note for Medicare Part D Participants: When interfacing with a Medicare Part D beneficiary, the Veloxis PAP will operate outside of the Medicare Part D benefit. Any assistance provided to a patient for drugs that would have been covered under their Part D plan will not count as an incurred cost that would be applied toward the enrollee's TrOOP balance or total drug spend.

Veloxis | Transplant Support
1-844 VELOXIS (835-6947)

ENROLLMENT FORM
Please complete and fax to 1-844-475-8931.

For assistance or additional information, call 1-844-VELOXIS, M-F, 9 am-7 pm EST.

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

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: ENVARSUS XR® (tacrolimus extended-release tablets) 30-day Voucher Provided? ☐ Yes ☐ No Date _____

☐ 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 ENVARSUS XR® (tacrolimus extended-released tablets) prescribing information. I certify to the best of my knowledge that therapy with ENVARSUS XR is medically necessary for this patient. I will supervise the patient's treatment with ENVARSUS 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 ENVARSUS 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 ENVARSUS 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.

7. PATIENT FINANCIAL DISCLOSURE (OPTIONAL *UNLESS* APPLYING FOR PATIENT ASSISTANCE)

Note: This section is required for patients requesting to enroll in the Patient Assistance Program in order to verify eligibility.

TOTAL ANNUAL HOUSEHOLD INCOME $_____ NO. OF MEMBERS IN HOUSEHOLD (INCLUDING PATIENT AND DEPENDENTS) _____

SOURCES OF INCOME: (Check all that apply)

☐ Social Security Income (SS, SSI, SSDI) ☐ Wages ☐ Interest/Dividends ☐ Pension ☐ Disability/Unemployment Compensation

PLEASE LIST ANY OTHER INCOME SOURCES: _____

PROOF OF INCOME: Please provide proof of household income. Include one or more of the following documents to provide proof of all income numbers reported above.

- A copy of last year's federal income tax returns for yourself, spouse, and dependents (eg, IRS Form 1040)
- W2 or 1099 from all jobs last year
- Two current paystubs
- Current Social Security Income Yearly Benefits Statement
- If current household income is zero, a letter explaining your financial situation from a family member, clergy member, social worker, healthcare provider, or yourself

8. PATIENT CONSENT (REQUIRED FOR ALL VELOXIS TRANSPLANT SUPPORT SERVICES)

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. I authorize my healthcare providers, pharmacies, health plans, or payers ("my healthcare organizations") to share personal and health information about me related to my immunosuppressive therapies ("my information") with Veloxis Pharmaceuticals, its affiliates, agents, and contractors (collectively, "Veloxis Transplant Support") 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 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 FINANCIAL VERIFICATION AUTHORIZATION & FCRA CONSENT

☐ I AGREE

I understand that by check the "I Agree" box, I am providing "written instructions" to Veloxis Pharmaceuticals and/or their agents and contractors under applicable federal and/or state law, including, but not limited to, the Fair Credit Reporting Act (FCRA), authorizing them to perform electronic income verification, on an ongoing basis as needed, by obtaining information from my personal credit profile or other information Experian Health. I authorize Veloxis and/or their agents and contractors to obtain such information solely to validate my income for the purpose of determining my eligibility for my prescription in the program. I understand that I must affirmatively agree to these terms in order to proceed in this optional financial screening process.

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.

☐ OPT OUT FROM MARKETING COMMUNICATIONS

PATIENT SIGNATURE: _____ DATE: ____/____/____

PATIENT NAME (PRINTED): _____

PATIENT'S EMAIL ADDRESS:_____

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

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