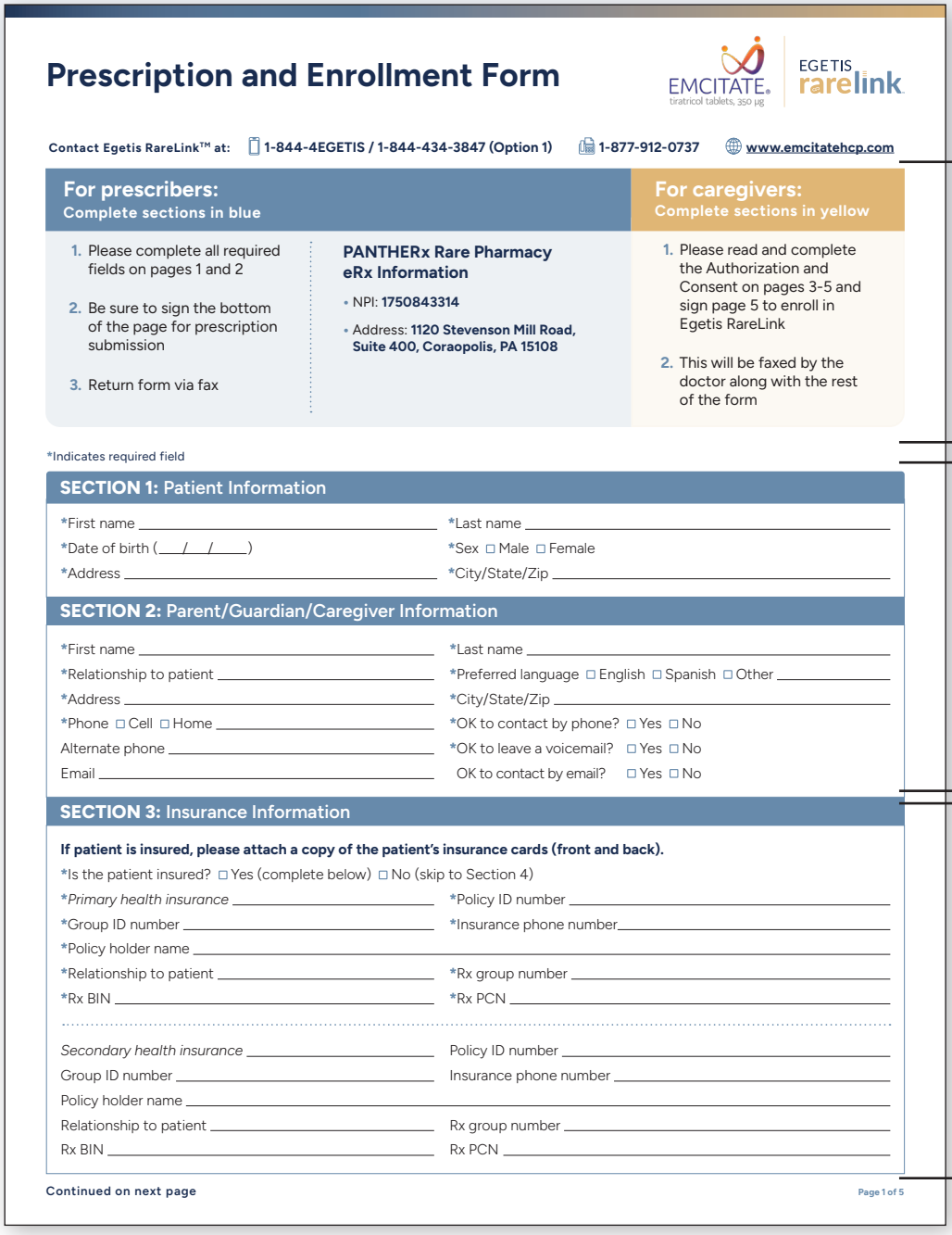
Instructions for Completing the Egetis RareLink™ Prescription and Enrollment Form

Please complete all required fields marked with an asterisk (*) to help streamline prescription processing and support a smooth patient enrollment process. **Be sure to sign the Prescriber Signature line in Section 6, then fax the completed form to 1-877-912-0737.**

EMCITATE® tiratricol tablets, 350 µg | EGETIS rarelink



Prescription and Enrollment Form

EMCITATE® tiratricol tablets, 350 µg | EGETIS rarelink

Contact Egetis RareLink™ at: 1-844-4EGETIS / 1-844-434-3847 (Option 1) | 1-877-912-0737 | www.emcitatehcp.com

For prescribers:
Complete sections in blue

1. Please complete all required fields on pages 1 and 2
2. Be sure to sign the bottom of the page for prescription submission
3. Return form via fax

PANTHERx Rare Pharmacy eRx Information

- NPI: **1750843314**
- Address: **1120 Stevenson Mill Road, Suite 400, Coraopolis, PA 15108**

For caregivers:
Complete sections in yellow

1. Please read and complete the Authorization and Consent on pages 3-5 and sign page 5 to enroll in Egetis RareLink
2. This will be faxed by the doctor along with the rest of the form

*Indicates required field

SECTION 1: Patient Information

*First name _____ *Last name _____
*Date of birth (___/___/____) *Sex ☐ Male ☐ Female
*Address _____ *City/State/Zip _____

SECTION 2: Parent/Guardian/Caregiver Information

*First name _____ *Last name _____
*Relationship to patient _____ *Preferred language ☐ English ☐ Spanish ☐ Other _____
*Address _____ *City/State/Zip _____
*Phone ☐ Cell ☐ Home _____ *OK to contact by phone? ☐ Yes ☐ No
Alternate phone _____ *OK to leave a voicemail? ☐ Yes ☐ No
Email _____ OK to contact by email? ☐ Yes ☐ No

SECTION 3: Insurance Information

If patient is insured, please attach a copy of the patient's insurance cards (front and back).
*Is the patient insured? ☐ Yes (complete below) ☐ No (skip to Section 4)
*Primary health insurance _____ *Policy ID number _____
*Group ID number _____ *Insurance phone number _____
*Policy holder name _____
*Relationship to patient _____ *Rx group number _____
*Rx BIN _____ *Rx PCN _____

Secondary health insurance _____ Policy ID number _____
Group ID number _____ Insurance phone number _____
Policy holder name _____
Relationship to patient _____ Rx group number _____
Rx BIN _____ Rx PCN _____

Continued on next page

Page 1 of 5

A Review, complete, and sign the designated sections in blue.

B All patient information and most caregiver information is required. Please ensure at least one phone number is provided.

C Indicate whether the patient has insurance. If yes, complete all required primary insurance fields and attach copies of the front and back of the patient's insurance card(s). Add secondary insurance details if applicable.

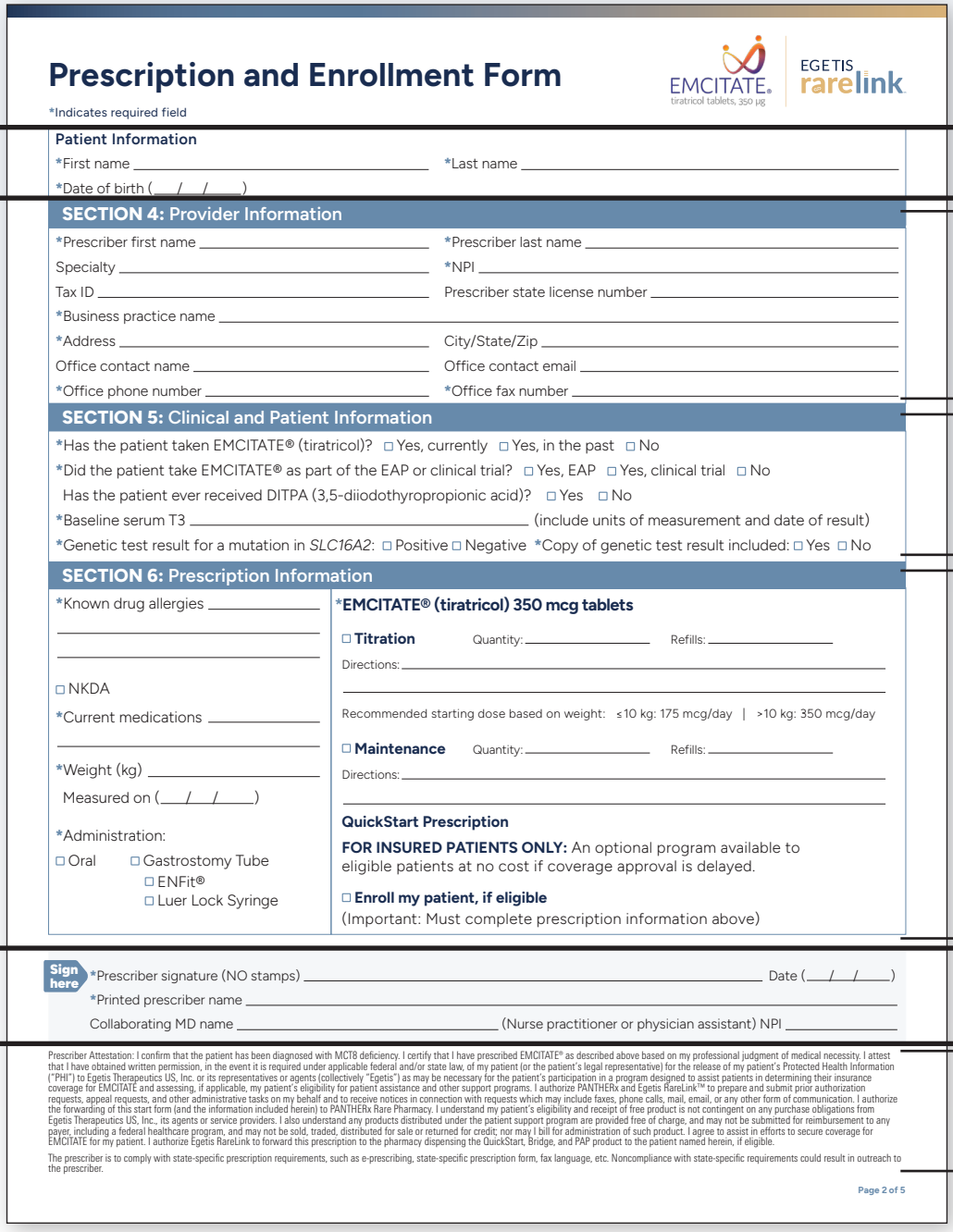
BEFORE YOU FAX THIS FORM TO 1-877-912-0737, CONFIRM THE FOLLOWING ARE INCLUDED:

- Copy of the patient's insurance card(s), front and back
- Results of the *SLC16A2* genetic test
- Lab result supporting the baseline serum T3 value
- Signed Authorization and Consent

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EMCITATE® tiratricol tablets, 350 µg | EGETIS rarelink



Prescription and Enrollment Form

EMCITATE® tiratricol tablets, 350 µg | EGETIS rarelink

*Indicates required field

Patient Information

*First name _____ *Last name _____

*Date of birth (___/___/____)

SECTION 4: Provider Information

*Prescriber first name _____ *Prescriber last name _____

Specialty _____ *NPI _____

Tax ID _____ Prescriber state license number _____

*Business practice name _____

*Address _____ City/State/Zip _____

Office contact name _____ Office contact email _____

*Office phone number _____ *Office fax number _____

SECTION 5: Clinical and Patient Information

*Has the patient taken EMCITATE® (tiratricol)? ☐ Yes, currently ☐ Yes, in the past ☐ No

*Did the patient take EMCITATE® as part of the EAP or clinical trial? ☐ Yes, EAP ☐ Yes, clinical trial ☐ No

Has the patient ever received DITPA (3,5-diiodothyropropionic acid)? ☐ Yes ☐ No

*Baseline serum T3 _____ (include units of measurement and date of result)

*Genetic test result for a mutation in *SLC16A2*: ☐ Positive ☐ Negative *Copy of genetic test result included: ☐ Yes ☐ No

SECTION 6: Prescription Information

*Known drug allergies _____

_____

_____

☐ NKDA

*Current medications _____

_____

*Weight (kg) _____

Measured on (___/___/____)

*Administration:

☐ Oral ☐ Gastrostomy Tube ☐ ENFit® ☐ Luer Lock Syringe

***EMCITATE® (tiratricol) 350 mcg tablets**

☐ **Titration** Quantity: _____ Refills: _____

Directions: _____

_____

Recommended starting dose based on weight: ≤10 kg: 175 mcg/day | >10 kg: 350 mcg/day

☐ **Maintenance** Quantity: _____ Refills: _____

Directions: _____

_____

QuickStart Prescription

FOR INSURED PATIENTS ONLY: An optional program available to eligible patients at no cost if coverage approval is delayed.

☐ **Enroll my patient, if eligible**

(Important: Must complete prescription information above)

Sign here *Prescriber signature (NO stamps) _____ Date (___/___/____)

*Printed prescriber name _____

Collaborating MD name _____ (Nurse practitioner or physician assistant) NPI _____

Prescriber Attestation: I confirm that the patient has been diagnosed with MCT8 deficiency. I certify that I have prescribed EMCITATE® as described above based on my professional judgment of medical necessity. I attest that I have obtained written permission, in the event it is required under applicable federal and/or state law, of my patient (or the patient's legal representative) for the release of my patient's Protected Health Information ("PHI") to Egetis Therapeutics US, Inc. or its representatives or agents (collectively "Egetis") as may be necessary for the patient's participation in a program designed to assist patients in determining their insurance coverage for EMCITATE and assessing, if applicable, my patient's eligibility for patient assistance and other support programs. I authorize PANTHERx and Egetis RareLink™ to prepare and submit prior authorization requests, appeal requests, and other administrative tasks on my behalf and to receive notices in connection with requests which may include faxes, phone calls, mail, email, or any other form of communication. I authorize the forwarding of this start form (and the information included herein) to PANTHERx Rare Pharmacy. I understand my patient's eligibility and receipt of free product is not contingent on any purchase obligations from Egetis Therapeutics US, Inc., its agents or service providers. I also understand any products distributed under the patient support program are provided free of charge, and may not be submitted for reimbursement to any payer, including a federal healthcare program, and may not be sold, traded, distributed for sale or returned for credit; nor may I bill for administration of such product. I agree to assist in efforts to secure coverage for EMCITATE for my patient. I authorize Egetis RareLink to forward this prescription to the pharmacy dispensing the QuickStart, Bridge, and PAP product to the patient named herein, if eligible.

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

Page 2 of 5

D **Include the patient's name and date of birth.**

E Ensure all required prescriber information is complete. Add the office contact's name and email, if available.

F
- Confirm the patient's treatment history
- Record the baseline serum T3 result, with units and date
- Include a copy of the *SLC16A2* genetic test, if available

G
- Providing an accurate weight is important for initial dosing
- Selecting the proper route of administration ensures the pharmacy sends the right medical supplies if needed
- For eligible, commercially insured patients, QuickStart provides a temporary medication supply at no cost if coverage approval is delayed
  – Check the box to enroll your patient

H **The prescriber must sign and date this section by hand and print their name.**
Electronic signatures are not accepted. NP/PA prescribers must also list the collaborating physician's name and NPI.

I Prescribers must follow state-specific prescribing rules per the attestation printed below. Noncompliance may prompt outreach.

Caregivers are required to review, complete, and sign the designated sections in yellow in the Prescription and Enrollment Form

EGETIS THERAPEUTICS™

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