

Prescription and Enrollment Form



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 _____

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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 _____

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*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.

Patient/Caregiver Consent Agreements for Enrollment in Egetis RareLink™



Please review the Egetis RareLink Patient Support Program Consents below before signing.

Consent to Enrollment in Egetis RareLink Patient Support Program (Required)

I am enrolling in the Egetis RareLink Patient Support Program (the "Program") and I authorize Egetis Therapeutics US, Inc. and its affiliates, vendors, agents, and representatives including PANTHERx Rare Pharmacy (collectively, "Egetis") to provide me services under the Program. Such services include: disease state and product education (including starter kit), medication and adherence communications, insurance coverage and financial assistance support, product administration training support, free drug (if eligible), coordination of medication delivery, surveys to evaluate, improve, or develop the Program's services and other internal business purposes, and provide me with patient support services under the Program (the "Services").

Consent to Process Personal and Sensitive Information (Required)

I understand that my/my child's health information, contact information, and other sensitive or identifying information that I or my child's healthcare provider or others share with Egetis is collected for the provision of the Program's Services and for other business purposes of Egetis, as described in the Egetis Therapeutics US, Inc. Privacy Policy at <https://www.egetis.com/us-privacy-notice/>. I further understand that my consent is required to process my sensitive personal information or that of my child under certain US state privacy laws, and by signing below, I consent to the collection, use, disclosure, and processing of my/my child's personal and sensitive information, including my/my child's personal health data, as described in the Egetis Therapeutics US, Inc. Privacy Policy at <https://www.egetis.com/us-privacy-notice/> and the Egetis Consumer Health Data Privacy Policy at <https://www.egetis.com/us-consumer-health-data-privacy-notice/>. I understand that I have the right to withdraw my consent at any time by contacting Egetis by email at privacy@egetis.com, or by mail to Egetis RareLink, 1120 Stevenson Mill Road, Suite 400, Coraopolis, PA 15108, USA. Depending on where I live, I may have certain rights with respect to the privacy of my personal information, including the right to access or delete my personal information. I am aware that Egetis may not be required to fulfill my requests in certain circumstances. I understand that to exercise these rights, I may contact Egetis by phone at 1-844-4EGETIS / 1-844-434-3847 (Option 1), or by email at privacy@egetis.com.

Call and Text Opt-In (Optional)

By checking the box on page 5, I consent to receive automated and recurring phone calls and text messages from Egetis RareLink, Egetis Therapeutics US, Inc., and PANTHERx Rare Pharmacy, including communications about my enrollment, prescription, and support services, to the mobile phone number I provided on this form. Message and data rates may apply. Message frequency varies. I understand that I am not required to consent as a condition of enrolling in the Program, purchasing any goods or services, or receiving EMCITATE. I can reply STOP to opt out at any time and HELP for help.

See the Egetis Privacy Policy at <https://www.egetis.com/us-privacy-notice/>.

Power of Attorney documentation is required if an adult other than the legal representative signs.

You may fax the documents to 1-877-912-0737 or call 1-844-4EGETIS / 1-844-434-3847 (Option 1), for further assistance.

Authorization to Disclose Information to Individuals Involved in Care (Optional)

I authorize Egetis and the Program to discuss the coordination of my child's care with the family member(s) and/or caregiver(s) I list below. These individuals have my full permission to obtain and disclose personal and medical information about my child from Egetis and the Program.

Authorized Representative Name: _____ Relationship to Patient: _____

Authorized Representative Name: _____ Relationship to Patient: _____

Patient/Caregiver Consent Agreements for Enrollment in Egetis RareLink™



Please review the PATIENT PRIVACY AUTHORIZATION below before signing.

Authorization to Use and Disclose Protected Health Information (Required)

By signing this Authorization, I authorize each of my/my child's physicians, pharmacies, other healthcare providers ("Healthcare Providers"), and each of my/my child's health insurers to use and disclose health information related to my taking EMCITATE that identifies me/my child personally, including my/my child's name, address, and telephone number(s) and information about my/my child's insurance, prescriptions, medical condition and health ("My/my child's Information"), with Egetis Therapeutics US, Inc., its affiliates, vendors, agents, and representatives, including PANTHERx Rare Pharmacy (collectively, "Egetis"), for the purposes of enrolling me/my child in and providing services through the Egetis RareLink Patient Support Program (the "Program"), including to: (1) process my/my child's request for enrollment in the Program and determine if I/my child am/is eligible to participate in the Program and receive its services; (2) verify, assist with, and coordinate insurance coverage or otherwise obtain payment for my treatment with EMCITATE; (3) coordinate my receipt of, and payment for, EMCITATE; (4) evaluate, improve, or develop the Program's services and for other internal business purposes; (5) provide me/my child with adherence reminders and support for EMCITATE; (6) determine my/my child's eligibility for and enroll me in the Egetis RareLink Copay Card Program, if eligible; I understand that copay card details (such as card identification number and processing information) will be sent to my specialty pharmacy so the copay benefit can be applied when my prescription is filled, and any assistance with my cost-sharing or co-payment for EMCITATE will be made in accordance with the Egetis RareLink Copay Card Program's Terms and Conditions. The Copay Card Program Terms and Conditions are available at emcitate.com or by calling 1-844-4EGETIS / 1-844-434-3847 (Option 1).

I understand that once my/my child's Information has been disclosed to the Program, state and federal privacy laws may no longer protect the Information and that it may be subject to further disclosure by the Program. I also understand that the Program intends to use and disclose my/my child's Information only for the purposes described in this Authorization and that results of any analytics will only be shared outside of the Program after being de-identified. I understand that my/my child's pharmacy, health insurance company, and healthcare providers may receive payment from Egetis in exchange for disclosing my/my child's Information to the Program and/or for providing me/my child with therapy support services. I understand that I do not have to sign this Authorization and that my/my child's treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be affected if I do not sign it. I also understand, however, that if I do not sign this Authorization, the Program cannot provide me/my child with assistance.

This Authorization will remain in effect for ten (10) years from the date of signature, or for a shorter period required by applicable state law, unless I cancel my enrollment before then. I understand that I may cancel (revoke) this Authorization at any time by sending a written notice of cancellation to: privacy@egetis.com. I understand that if I do cancel this Authorization, the cancellation will be effective for each of my healthcare providers and health plans/insurers upon receipt by each such entity, respectively, but will not affect any information already disclosed. I understand that I am entitled to a copy of this Authorization after signing on the next page.

I understand that I may revoke my Authorization at any time by informing Egetis in writing by email at privacy@egetis.com or by mail to Egetis RareLink, 1120 Stevenson Mill Road, Suite 400, Coraopolis, PA 15108, USA. I can also revoke my Authorization by informing my/my child's Healthcare Providers and health insurers in writing that I do not want them to share any protected health information with Egetis. I further understand that if I cancel my permission, it will not affect how Egetis uses and shares my/my child's protected health information received by Egetis prior to the receipt of my Revocation by Egetis.

**CONFIRMATION OF PATIENT CONSENT AND AUTHORIZATION
(ALWAYS COMPLETE IF ENROLLING)**

Patient name: _____

My signature below certifies that I have provided accurate and complete information and that I have read, understood, and agree to the PATIENT SUPPORT PROGRAM CONSENTS including any optional consents identified with a checked box.

☐ By checking this box, I consent to the optional Text Messaging and Automated Communications as described above. I have provided my mobile number in the Parent/Guardian/Caregiver Information section.

Required – Patient Signature (or Legal Representative[†]):

Sign
here

_____ Date ____ / ____ / ____

My signature below certifies that I have read, understood, and agree to the release of my protected health information pursuant to the PATIENT PRIVACY AUTHORIZATION.

Required – Patient Signature (or Legal Representative[†]):

Sign
here

_____ Date ____ / ____ / ____

[†]Only representatives with legal authority for healthcare decisions may certify on a patient's behalf.