KEBILIDI™ Prescription Start Form

Contact us: 1-844-4PTCCARES (1-844-478-2227)
Fax completed form to: 1-877-204-2180

> **Step 1:** **Complete ALL fields** on this form including the prescription to prevent delays in processing.
> **Step 2:** If possible, obtain patient or guardian's signature for the Patient Authorization and PTC *Cares*™ Program Participation.
> **Step 3:** Fax this form, along with copies of both sides of insurance and prescription benefit cards, to PTC *Cares*™ at 1-877-204-2180.

PATIENT INFORMATION

Patient Name (First, MI, Last)	Date of Birth / /	☐ Male ☐ Female	
Guardian/Caregiver's Name	Relationship		
Address	City	State	ZIP
Home Phone ☐ OK to leave message	Mobile	☐ OK to leave message	
Preferred Contact Number ☐ Home ☐ Mobile	Best time to reach me ☐ Morning ☐ Afternoon ☐ Evening		
Email Address	Primary Language ☐ English ☐ Spanish ☐ Other		

INSURANCE INFORMATION

	Primary Insurance	Secondary Insurance
Insurance Name		
Policy Number		
Group Number		
Phone Number		
Policyholder Name		
Rx Member ID		
Rx BIN or PCN (if applicable)		
Rx Group ID		

☐ Patient has no insurance
☐ Send copy front/back of prescription, medical, secondary insurance cards.

Patient Authorization and Program Participation

I have read and agree to the following Patient Authorization to share my health information and participate in the PTC *Cares*™ program. I authorize my healthcare providers and health plans to disclose personal and health information related to my use or potential use of KEBILIDI™ (eladocagene exuparvovec-tneq) to PTC Therapeutics, Inc. and its agents and contractors including, but not limited to, PTC's specialty pharmacy partners and authorize PTC Therapeutics, its agents, and my pharmacies or designated treatment center to use such information to: 1) determine benefit eligibility; 2) communicate with my healthcare providers and health plans about benefit, coverage and medical care; 3) provide me with support services for KEBILIDI™ (eladocagene exuparvovec-tneq); 4) contact me and leave messages about KEBILIDI™ (eladocagene exuparvovec-tneq); 5) provide me with information or materials related to KEBILIDI™ (eladocagene exuparvovec-tneq) or my relevant medical conditions; 6) contact me about the PTC *Cares*™ program, which may include patient services such as education, training, nurse and pharmacy support; and 7) I understand that my pharmacy may receive remuneration in exchange for sharing and using my information pursuant to this authorization. PTC Therapeutics will maintain the confidentiality of my personal and health information in accordance with its privacy policy and will use this information only for the purposes described above or as permitted by law. However, I understand that once information about me is released based on this authorization, federal and state privacy laws may not prevent PTC Therapeutics from further disclosing my information. I understand that PTC Therapeutics has agreed to only use or disclose information it receives for the purposes described in this authorization or as required by law. I further understand that I may refuse to sign this authorization and that my refusal to sign this authorization will have no impact on my eligibility to receive health plan benefits or treatments from my healthcare providers, but I will not have access to support services from the PTC *Cares*™ program. I understand that I have the right to revoke this authorization at any time in the future, by submitting a written notice to PTC Therapeutics via fax to 1-908-222-7231 or by mail to PTC Therapeutics, Inc. **Attention:** Compliance Officer, PTC Therapeutics, 500 Warren Corporate Center Drive, Warren, NJ 07059. I understand that after I have revoked my authorization, PTC Therapeutics will no longer disclose my information, except to the extent that action has been taken in reliance on this authorization or administration of the program for record keeping purposes of my participation. I am entitled to a copy of this authorization, which expires 10 years from the date it is signed by me (unless earlier termination is required by applicable state law). For information about how PTC Therapeutics handles your information, please see our privacy statement at PTCBio.com for Privacy Rights and Choices specific to California residents which are available here. The personal, insurance and information I have provided on this form is complete and accurate to the best of my knowledge. I will update my information promptly if any of the information reflected on this form changes by contacting PTC *Cares*™ at 1-844-478-2227.

Patient/Guardian Signature	
Relationship	Date

Please see **www.KEBILIDI.com** for full Prescribing Information
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Learn more at: www.KEBILIDI.com

Kebilidi™ (eladocagene exuparvovec-tneq)

TO BE COMPLETED BY HEALTHCARE PROVIDER

PTC Cares™

Patient First Name	Patient Last Name	Date of Birth / /

CLINICAL INFORMATION/DIAGNOSIS

Primary Diagnosis		Primary ICD-10
Allergies	Current weight ☐ lbs. ☐ kg.	Date weight obtained
Other medications tried		
Confirmed ICD-10 diagnosis: E70.81 ☐ Yes ☐ No		

PRESCRIPTION INFORMATION

PRESCRIPTION FOR KEBILIDI™ (eladocagene exuparvovec-tneq)

CRITERIA (**ALL <u>must</u>** be checked with supporting documentation included with submission)
☐ Patient has confirmed AADC deficiency due to biallelic mutations in the *DDC* gene . Please include documentation of results.
☐ Clinical note(s) describing medical need included with fax to PTC *Cares*™
Additional information
☐ 1.8×10^{11} vector genomes (vg) of eladocagene exuparvovec-tneq supplied as one single-dose vial that contains 2.8×10^{11} vg
Special instructions

PRESCRIBER INFORMATION

Prescriber Name (First, Last)			Designated Treatment Center Name		
Address			City	State	Zip
Phone	Fax	NPI#	DEA#	Tax ID#	
Office Contact Name		Phone	Best time to contact ☐ Morning ☐Afternoon		
Office Contact Email					

Physician Authorization*:

By signing the Start Form, I certify that I have prescribed KEBILIDI™ (eladocagene exuparvovec-tneq) as described above based on my professional judgment of medical necessity. I authorize the release of medical and/or other patient information relating to KEBILIDI therapy to agents of PTC Therapeutics, Inc., and service providers (including, but not limited to KEBILIDI-dispensing pharmacies) to use and disclose as necessary for prior authorization processing and fulfillment of the prescription. I authorize PTC *Cares*™ to initiate any de minimis authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited. ***NY Prescribers:** must also submit an electronic prescription.

Prescriber Authorization Signature Dispense as Written (No Stamp Allowed)	Date

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