LISRAYA™ my compass support

LISRAYA (brepocitinib) Prescription and My Compass Support Enrollment Form

Please complete and sign the form below. All **BOLDED** fields are required.

Phone: 1-888-736-9788 Fax: 1-844-341-0485
Email: mcs@priovant.com

Patient can submit consent by scanning the QR code or visiting lisraya.com/enrollment

SPECIALTY PHARMACY PREFERENCE: ☑ Orsini Rare Disease Pharmacy Solutions OR ☐ PantheRx RARE Pharmacy ☐ e-Prescription sent to SP (optional)

PATIENT INFORMATION

First name: **Last name:** **Gender:** ☐ **M** ☐ **F** **Date of birth (mm/dd/yyyy):** / /

Phone: Email:

Street address: **City:** **State**: **Zip**:

INSURANCE INFORMATION

Attach **both sides** of the patient's insurance card and prescription card (if applicable).
If you are unable to attach cards, please fill out the information below.

Primary Insurance Name: **Policy ID:** Group Number:

Rx BIN: Rx PCN: Rx Group:

Subscriber first name: Subscriber last name: Subscriber date of birth: / /

Subscriber employer: Relationship of subscriber to patient:

Secondary Insurance Name (if applicable): Policy ID: Group Number:

Rx BIN: Rx PCN: Rx Group:

Subscriber first name: Subscriber last name: Subscriber date of birth: / /

Subscriber employer: Relationship of subscriber to patient:

If allowed by insurance and with prescriber review and approval, I authorize the Specialty Pharmacy to submit the insurance authorization. The Specialty Pharmacy can only use clinical information that is provided directly from the prescriber's office to support insurance authorization.

PRESCRIBER INFORMATION

First name: **Last name:** **Phone:** Email:

Site/office name: **Street address:**

City: **State:** **Zip:** **NPI:**

OFFICE CONTACT

Contact name (First, Last): Email:

Phone: Fax:

LISRAYA PRESCRIPTION INFORMATION

Diagnosis (select one): ☐ ICD-10 M33.1: Other dermatomyositis ☐ ICD-10 M33.9: Dermatopolymyositis

Medication: LISRAYA (brepocitinib) 30 mg Tablets

Directions: 1 (one) tablet by mouth once daily with or without food.

Specialty precautions (e.g. allergies): _____

Supply: Dispense quantity of 30 tablets

Refills (select one): ☐ 12 or Other (specify quantity): _____

Brand Medically Necessary (Dispense as Written): ☐

BRIDGE ATTESTATION

☐ Yes ☐ No If eligible and when all information required for an appeal is submitted to insurance, I request for my patient to participate in the Bridge program that will provide free drug utilizing the prescription above during the insurance appeal process. The Bridge program is available to all insured patients ≥18 years of age who are US residents with a confirmed diagnosis of Dermatomyositis. Eligibility is subject to the terms and conditions of the program. Priovant reserves the right to rescind, revoke, or amend the program at any time without notice. Contact My Compass Support for details.

PRESCRIBER SIGNATURE

Please note: Stamped signatures are not accepted. In states such as NY, CA, FL, IA, MI, MN, electronic prescribing is mandated by law.

I hereby designate My Compass Support to act as my agent solely for the administrative purposes of transmitting prescriptions for Priovant's products to the designated pharmacy of my choice.

By signing below, I certify that I (a) the information provided in this form is accurate and complete to the best of my knowledge; (b) I am personally prescribing LISRAYA medication for the patient identified on this form and this prescription medication is medically necessary for the patient; (c) I will be supervising or coordinating the patient's treatments, in accordance with applicable law; and (d) I have received from the patient or his/her representative the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, patient information relating to the above prescribed therapy.

By signing below, I also authorize Priovant and its agents to use my NPI/TID and the patient information provided in this form so that My Compass Support may conduct a benefits investigation to determine the patient's insurance coverage for brepocitinib. I acknowledge and agree that calls between my office and My Compass Support may be recorded for quality assurance and training purposes.

Prescriber Signature **Date**

Please triage to ORSINI

This patient consent section is optional. You may leave this page blank, and a Patient Access Liaison (PAL) will follow up with the patient to obtain consent.

PATIENT AUTHORIZATION AND COMMUNICATIONS CONSENT

Protected Health Information Disclosure Authorization and Consent

I authorize my healthcare providers (including pharmacies) and health insurers to use and disclose information about me, my health, my treatment, my insurance coverage, my payment information, and my medication history ("PHI") to Priovant Therapeutics and its affiliates, agents, and service providers (collectively, "Priovant") so Priovant can: (1) enroll me in My Compass Support and facilitate my participation; (2) determine my insurance coverage and help me secure reimbursement for brepocitinib; (3) provide financial assistance if I am eligible; (4) send me educational materials related to my participation and other communications; and (5) administer and evaluate My Compass Support and other programs at Priovant. Once disclosed to Priovant under this Authorization, my information may no longer be subject to HIPAA protections. I also understand that my pharmacy provider may receive remuneration from Priovant in exchange for therapy support services. I understand that my decision to sign this Authorization is voluntary and will not affect my ability to receive medical treatment, payment for treatment, or eligibility for health benefits from my healthcare provider or insurer. However, enrollment in My Compass Support – including eligibility for copay assistance and other program – requires this signed Authorization.

Program Communications Consent (Non-Marketing)

By signing below, I agree that Priovant and their agents may use my contact information to communicate with me by mail, telephone, text message, and/or e-mail (if provided) regarding Priovant products, services, and patient support programs. These communications may include treatment reminders, information about the support program, motivational or educational messages, requests for information, discussion of application process, administration of the program, and evaluation of treatment progress and program effectiveness. Message frequency may vary. I can text STOP to opt out and HELP for help at any time; message and data rates may apply. I acknowledge and agree that calls between me and My Compass Support may be recorded for quality assurance and training purposes.

Marketing Consent

I agree to receive emails and texts from and on behalf of Priovant at the email address/phone number I provide. I understand my consent is not required to receive goods or services, and that message and data rates may apply. I can opt out at any time.

Revocation and Expiration of Authorization

I may revoke this Authorization at any time by contacting My Compass Support in writing at MyCompassSupport@priovant.com or 1007 Slater Road, Suite 250, Durham, NC 27703. Revocation will stop further uses/disclosures based on this Authorization but will not affect uses/disclosures already made in reliance on it. Unless I revoke earlier, this Authorization expires ten (10) years from my signature date (or earlier if required by applicable state law). I am entitled to a copy of this signed Authorization.

Acknowledgment & Signature

By signing below, I acknowledge that I have read and understand this Authorization and Consent and agree to its terms. Electronic signatures, including those provided through an approved electronic signature platform, will be treated the same as original signatures.

- ☐ **I have read and agree to the Protected Health Information Disclosure Authorization and Consent**
- ☐ **I have read and agree to the Program Communications Consent**
- ☐ I have read and agree to the Marketing Consent

Patient Signature _____ Date _____