Prescription and Patient Support Program Enrollment Form

For timely processing, please complete all fields marked required.* **Fax completed form and copy of patient medical and prescription drug insurance cards to 866-725-7218**. For questions, call 844-JASCAYD (844-527-2293).
For details about the CARECONNECT4ME Patient Support Program, visit https://pro.boehringer-ingelheim.com/us/products/jascayd/access.

This form is used to facilitate enrollment for the CARECONNECT4ME Patient Support Program, including, if applicable, the Copay Program that helps defray the out-of-pocket costs for Jascayd® (nerandomilast) tablets for eligible commercially insured patients, and the Bridge Program that provides free JASCAYD to eligible patients experiencing coverage delays (all together, "the Program"). See terms and conditions on pages 4 & 5.

For Patient to Complete

Please triage to ORSINI

*Required to process enrollment.

1 Patient Information

First Name* | Last Name* | Date of Birth* | Sex* (M F)

Shipping Address* | City, State, ZIP*

Mobile Phone* | Home Phone | Preferred Contact (Mobile Home) | Best Time (Morning Afternoon Evening)

OK to leave voicemail message

Email | Preferred Language (if not English)

Notice and Consent to Use and Disclose Personal and Consumer Health Data

Boehringer Ingelheim Pharmaceuticals, Inc. ("Boehringer Ingelheim") will process your Personal Data, including that which may be considered Consumer Health Data under certain privacy laws (i.e., name, contact info, medical symptoms/condition, diagnosis, and prescription medication), in accordance with the Boehringer Ingelheim US Privacy Statement (boehringer-ingelheim.com/us/us-privacy-statement).

I understand that my participation in the Program, including, if applicable, the Copay Program and/or Bridge Program, requires Boehringer Ingelheim and its affiliates and service providers ("Partners") to collect, use and disclose my Personal and Consumer Health Data for purposes including:

- To facilitate my participation and assist in the general administration of the Program, to conduct any additional services related to the Program, including clinical and educational services by a Boehringer Ingelheim Patient and Community Clinical Educator ("PaCE"). PaCEs do not provide medical advice and I will direct any questions about my health or medical care to my physician.
- To communicate with me about my medication and treatment, including education, support, and other related information the Program may determine to be relevant to my participation in the Program; communications may be customized based on my Personal and Consumer Health Data.
- To conduct quality assurance and other internal business activities and ask for feedback related to the services or my treatment.
- To comply with applicable rules and regulatory requirements related to safety information received in the course of administering the Program, where such information is collected in the interest of patient safety. Such information will be filed in a global database and the information may be reported to regulatory authorities.
- To communicate with me about possible financial assistance and, if enrolled, administer my participation in any sponsored financial assistance program, including the Copay Program, and including referrals to other third-party resources.

I further understand that:

- Boehringer Ingelheim and its Partners have implemented reasonable safeguards to keep my Personal and Consumer Health Data secure.
- Boehringer Ingelheim and its Partners will retain my Personal and Consumer Health Data for as long as permitted or required by applicable rules and regulations.
- I may revoke my consent to participate in the Program at any time by contacting the Program at 844-JASCAYD (844-527-2293).

To enroll in the Program, please check this box.

YES,* I agree to the use, disclosure and other related processing of my Personal and Consumer Health Data by Boehringer Ingelheim and its Partners for the purposes of participating in the Program as described above.

Consent to Receive Communications via Automated Text Messaging

(Optional) YES, I authorize Boehringer Ingelheim and its Partners to send automated text messages to the cell phone number listed above to convey important information regarding the Program. I understand that opting in to receive text messages is not a requirement to participate in the Program and that standard text messaging rates will apply to any messages received from Boehringer Ingelheim or its Partners. I also understand that I may revoke this permission at any time. Message frequency varies. I agree that if my cell phone number changes, I will inform Boehringer Ingelheim. Text STOP to stop. Text HELP for help. View our Terms and Conditions: https://cloud.mail.careconnect4me.com/sms-terms-and-conditions and the Boehringer Ingelheim U.S. Privacy Statement: https://www.boehringer-ingelheim.com/us/us-privacy-statement.

Please see Important Safety Information on page 6 and accompanying Prescribing Information and Patient Information for JASCAYD.

JASCAYD (nerandomilast) tablets 18 mg

First Name and Last Name | Shipping Address | Date of Birth

*Required to process enrollment.

You may also opt-in to receive non-Program related emails or agree to the use of your data for analytical and marketing purposes by agreeing to the below.

- (Optional) YES, I agree to allow Boehringer Ingelheim and its Partners to collect and process my Personal and Consumer Health Data to send me email communications about services, products, optional surveys, or special opportunities that Boehringer Ingelheim or its Partners believe may be of interest to me. I understand that I can withdraw at any time through the unsubscribe link in the footer of each email.
- (Optional) YES, to the extent allowable by law, I agree to allow Boehringer Ingelheim and its Partners to collect and process my Personal and Consumer Health Data to perform marketing, including statistical analysis related to my use of products and participation in programs offered by Boehringer Ingelheim. This includes any information I may share with my PaCE. I understand that this information may be combined with data provided by me and others to create a profile about me to enable personalized communications and other related advertising efforts and used by Boehringer Ingelheim to deliver future services and products, and/or advertising efforts. I understand I may revoke this permission at any time as outlined in the Boehringer Ingelheim US Privacy Statement (boehringer-ingelheim.com/us/us-privacy-statement).

Alternate Contact

First Name and Last Name

Relationship | Phone | Email

- OK to discuss my condition, program participation, and related services with this person.

2 Insurance Information

Copy of insurance card(s) should be included when this form is submitted.

- Check if patient does not have prescription drug insurance.

Prescription Drug Insurance* | Phone*

Policy/Member ID #* | Rx BIN # | Rx PCN #

Medical Insurance | Phone

Policy/Member ID #

Subscriber First Name (if not patient) | Subscriber Last Name (if not patient)

Relationship

Patients continue to page 4 to review and sign the Patient Authorization section and to review Terms and Conditions for programs in which you're enrolling.

First Name and Last Name | Shipping Address | Date of Birth

For Healthcare Professionals to Complete

*Required to process enrollment.

3 Prescription for Jascayd® (nerandomilast) tablets*

Use this section to write your patient's prescription. Attach a separate prescription only if required by applicable state law.

Patient Name* | Date of Birth*

JASCAYD*

○ 9 mg ○ 18 mg

Take one tablet by mouth twice per day

Quantity*: ○ 30-day supply Refills*:

Preferred Specialty Pharmacy*

- ○ **Accredo Health Group Inc.** Fax: (888) 445-4581
- ○ **CenterWell Pharmacy Inc.** Fax: (855) 201-4396
- ○ **CVS/Caremark** Fax: (877) 943-1000
- ○ **OPTUM Specialty Pharmacy** Fax: (877) 746-9166
- ● **Orsini** Fax: (847) 423-6217
- ○ **Walgreens Specialty Pharmacy** Fax: (866) 773-0143
- ○ Other:

Bridge Rx† (Optional)

JASCAYD ○ 9 mg ○ 18 mg

Take one tablet by mouth twice per day. See accompanying JASCAYD full Prescribing Information for additional dosing and safety information.

Quantity: 30-day supply

Refills (1 maximum):

†Bridge Program provides a limited supply of JASCAYD at no cost and with no purchase obligation to eligible patients experiencing a coverage delay. See Terms and Conditions on page 4.

4 Clinical Information

Indication (ICD-10 code) for which you're prescribing JASCAYD

○ **J84.112 Idiopathic Pulmonary Fibrosis (IPF)*** ○ **Other:**

Allergies ○ None known

Prior Therapies ○ None known

Concurrent Therapies ○ None

If patient has been on JASCAYD in the past, date of last dose.

5 Prescriber Information

First Name* | Last Name* | Facility Name

Address* | City, State, ZIP*

Phone* | State License #* | NPI#*

Office Contact Name | Phone (ext) | Fax | Email

6 Prescriber Certification*

By signing this form, I certify that, pursuant to HIPAA and other applicable privacy laws, I have this patient's authorization and consent on file to disclose their Protected Health Information to Boehringer Ingelheim and its Partners, including the dispensing pharmacy. I understand that Boehringer Ingelheim will use the information within this form to administer the Program, which provides logistical and non-medical treatment support for enrolled patients prescribed JASCAYD and education about the insurance process and product. I understand that Boehringer Ingelheim may modify or terminate the Program at any time without notice and makes no representation or guarantee concerning coverage or reimbursement for any item or service. I confirm that I have read the terms and conditions for the programs described in this form and I certify that the requirements of the terms and conditions for each program selected are met. I further agree that (a) any product or service provided through the Program as a result of this form is for the named patient only and is not being provided in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use JASCAYD or any other Boehringer Ingelheim product or service, for any other person; (b) my decision to prescribe JASCAYD was based solely on my professional determination of medical necessity; and (c) I will not seek reimbursement for any product or service provided by or through the Program from any government program or third-party insurer. If this patient is deemed eligible for the Bridge Program (due to a coverage delay or pending appeal for coverage of JASCAYD), I also agree to dispense or administer the temporary supply of product only to the prescribed patient and will not sell, trade, or distribute for sale any product provided under the program. I authorize the Program to transmit this prescription on my behalf to the designated pharmacy by any means allowed under applicable law.

Prescriber Signature (Dispense as written) | **Date**

or **Prescriber Signature** (Substitutions allowed) | **Date**

Please see Important Safety Information on page 6 and accompanying Prescribing Information and Patient Information for JASCAYD.

JASCAYD (nerandomilast) tablets 18 mg

First Name and Last Name	Shipping Address	Date of Birth
		/ /

For Patient to Complete

*Required to process enrollment.

7 Patient Authorization

By signing below, I authorize my health care practitioners, pharmacies, health plan and insurers to disclose and re-disclose my Protected Health Information (PHI) that may include information relating to my medical condition, treatment, care management, health insurance, medication history and prescription details with the Program, including, if applicable, the Copay Program and/or Bridge Program, Boehringer Ingelheim, and its Partners so they can provide the following support services:

- To help coordinate insurance coverage for, access to, and receipt of my medication.
- To communicate with me about my medication, treatment, possible financial assistance and, if enrolled, administer my participation in any sponsored financial assistance program, including the Copay Program, and including referrals to other third-party resources.
- To facilitate my participation, assist in the general administration of the Program, and to conduct educational services.
- To conduct quality assurance and other internal business activities and ask for feedback related to the services or my treatment.

In delivering the services, Boehringer Ingelheim and its Partners may share my PHI with my providers, payors or with government agencies or with other financial assistance programs that might help me pay for my medication. I also understand the Program may, from time to time, provide financial remuneration to certain of my Providers in exchange for receipt of my PHI. My pharmacies or other health care providers may receive payment from Boehringer Ingelheim for providing certain of the services based on my enrollment or participation. Boehringer Ingelheim and its Partners respect my privacy and implement safeguards to protect against any unauthorized use, but once my PHI is disclosed, it may no longer be protected by HIPAA. I understand I do not have to sign this Authorization to get my medication or insurance coverage, that I have a right to a copy of this Authorization, and I can revoke this Authorization at any time by calling 844-JASCAYD (844-527-2293) or mail to CareConnect4Me™, P.O. Box 251, Columbus, OH 43216.

This Authorization will expire 5 years after I sign it, or earlier if required by state law, unless I cancel my Authorization sooner. If I cancel it, I may no longer qualify for services from the Program, but it will not impact my Providers' treatment or insurance benefits. I also understand that if a Provider is disclosing my PHI to the Program on an authorized, ongoing basis, my cancellation with the Program will be effective with respect to that Provider as soon as they receive notice of my cancellation. Any cancellation will not affect prior uses or disclosures of my PHI.

Patient Signature/Legal Representative*	Relationship to Patient	Date*
		/ /

Bridge Program for Jascayd® (nerandomilast) tablets Terms and Conditions

Bridge Program applies to JASCAYD ("Product"). Patients must be 18 years of age or older with a valid prescription for an FDA-approved use of the Product. Patients must be a resident of the United States or its territories. Patients must be enrolled in the CARECONNECT4ME Patient Support Program with a valid Patient Authorization. The Patient must have insurance that covers specialty medications; uninsured or cash-paying patients are not eligible. The Patient must be experiencing a delay in a payor insurance coverage determination, as defined in the Bridge Program rules. The Bridge Program does not constitute insurance. The provision of Product through the Bridge Program does not constitute any guarantee of coverage or reimbursement under any insurance plan or program. For each eligible Patient, the Bridge Program provides Product, without charge, on a monthly basis for up to a two (2) month supply or until the Patient receives insurance coverage approval, whichever occurs first. Exceptions may occur on a case-by-case basis as defined in the Bridge Program rules. After eligibility is confirmed, the Bridge Program may ship a supply of the Product, in amounts to be determined in the sole discretion of CARECONNECT4ME Patient Support Program, to the HCP office or directly to the Patient. By submitting a request for Product under the Bridge Program or by participating in the Bridge Program, the healthcare provider acknowledges and agrees that he or she: (1) will not submit any claim or other request for payment or reimbursement for Product provided under the Bridge Program to the Patient or any third-party plan or program, including any commercial or government insurance plan; (2) will advise the Patient that he or she may not submit a claim to any third-party plan or program but should report his or her receipt on the Product to the Patient's insurer if required by his or her plan; (3) will dispense or administer Product solely to the eligible Patient for whom such Product was requested; and (4) will not sell, transfer, or otherwise dispense Product to any other third party. By submitting a request for Product under the Bridge Program or by participating in the Bridge Program, the Patient acknowledges and agrees that he or she: (1) will not submit any claim or other request for payment or reimbursement for Product provided under the Bridge Program to the patient or any third-party plan or program, including any commercial or government insurance plan; (2) will not submit any claim for Product to count towards his or her True Out-of-Pocket (TrOOP) costs for Medicare Part D beneficiaries (3) will report his or her receipt of Product to his or her insurer if required by his or her plan; and (4) will not sell, transfer, or otherwise dispense Product to any other third party. Patients and/or their healthcare provider must submit complete information and/or documentation required under the Bridge Program and attest to the truthfulness and accuracy of the information and/or documentation. By submitting a request for Product under the Bridge Program or by participating in the Bridge Program, the Patient and healthcare provider acknowledge, understand, and agree to the benefit, eligibility, and other Bridge Program limitations. The availability of Product under the Bridge Program is not conditional on any past, present, or future purchase, including any future refills of the Product. Offer void where prohibited by law, taxed, or restricted. Boehringer Ingelheim has sole discretion to determine Bridge Program eligibility. Boehringer Ingelheim reserves the right to modify the Bridge Program, including as to the benefits, length, and eligibility criteria, or to terminate the Bridge Program at any time for any reason without notice.

Copay Program for Jascayd® (nerandomilast) tablets Terms and Conditions

Patients who meet the eligibility criteria may pay as little as $0/month for their JASCAYD prescription; per prescription savings may vary. Under the Copay Program for JASCAYD, you may be required to pay a copay. The total patient out-of-pocket cost is dependent on your health insurance plan. The Copay Program assists with the cost of JASCAYD only – not with your costs for other medicines, procedures or office visit fees. After reaching the maximum annual Copay Program benefit amount, you will be responsible for all remaining out-of-pocket expenses. The Program benefit amount cannot exceed your out-of-pocket expenses for JASCAYD. The maximum Copay Program benefit will reset every calendar year.

Eligibility: You, the Patient, must have a prescription consistent with the FDA-approved indication for JASCAYD. You must be a resident of the United States or its territories. You must be at least 18 years of age. You must have commercial health insurance that covers part but not all of the cost of JASCAYD. You may not be receiving reimbursement in whole or in part under any Federal, state or government-funded insurance programs (for example, Medicare, Medicare Advantage, Medicaid, Medigap, TRICARE, Department of Defense, Veterans Affairs programs or state pharmaceutical assistance programs). If at any time you begin receiving prescription drug coverage under any such federal, state, or government-funded healthcare program, you will no longer be able to use the Copay Program and you must call 1-844-550-5683 to stop participation. The Copay Program is not valid for JASCAYD that is eligible to be reimbursed in its entirety by private insurance plans or other programs. It is not available for cash paying and uninsured patients.

Additional Terms & Conditions: The Copay Program benefit cannot be combined with any other rebate, free trial, or other offer for JASCAYD. No party may seek reimbursement for all or any part of the benefit received through the Copay Program. Patients receiving assistance from charitable free medicine programs (such as BI Cares) or any other charitable organizations for the same expenses covered by the Copay Program are not eligible. Once you are enrolled, the Copay Program will honor claims with a date of service on or after your Copay Program enrollment date. Claims must be submitted within 90 days from the date of service or dispense date unless otherwise indicated. The Copay Program is not health insurance or a benefit plan. The Copay Program does not obligate the use of any specific medicine or provider. The Copay Program is void where prohibited or restricted by law. In Massachusetts and California, the validity of the Copay Program and its use are subject to state law. Other restrictions may apply. It is not available where prohibited by your health insurance provider. Use of the Copay Program must be consistent with all relevant health insurance requirements. Participating patients, providers and pharmacies are responsible for making any required disclosures regarding your participation in the Copay Program, including reporting the receipt of Copay Program benefits, as required by any insurer or by law. This Copay Program is intended to comply with all applicable laws and regulations, including, without limitation, the federal Anti-Kickback Statute, its implementing regulations, and related guidance interpreting the federal Anti-Kickback Statute. The Copay Program may not be used in VA pharmacies. Copay Program benefits may not be selling, purchasing, trading, or counterfeiting of the offer is prohibited by law. The Copay Program has no cash value.

If you have an insurance plan that is participating in an alternate funding program ("AFP") (examples include, but are not limited to, ImpaxRX, Payer Matrix, SHARx, Script Sourcing, and Paydhealth) that requires you to apply to the Copay Program or otherwise pursue drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of your JASCAYD, you are not eligible for and are prohibited from using the Copay Program. Insurance plans, Pharmacy Benefit Managers (PBMs) and other third-party companies are prohibited from enrolling or assisting in the enrollment of patients in the Copay Program. You as the Patient, or your legal representative, must personally request participation in the Copay Program in order to be eligible for Copay Program benefits. The value of the Copay Program is exclusively for the benefit of patients and is intended to be credited towards patient out-of-pocket obligations and maximums, including applicable co-payments, coinsurance, and deductibles. By using the Copay Program, you agree that this program is intended solely for the benefit of you, the Patient. Some insurance plans have established programs referred to as 'accumulator adjustment' or 'copay maximizer' programs which requires you to enroll in a manufacturer copay assistance program. An accumulator adjustment program is one in which payments made by you that are subsidized by manufacturer assistance do not count toward your deductibles and other out-of-pocket cost sharing limitations. Copay maximizers are programs in which the amount of your out-of-pocket costs is increased to reflect the availability of support offered by a manufacturer assistance program, and they may not count toward your deductibles and other out-of-pocket cost sharing limitations. Except where prohibited by applicable state law, if your insurance company, health plan or other company implements either an accumulator adjustment or copay maximizer program, you will not be eligible for, and agree not to use, the Copay Program because these programs are inconsistent with our agreed intent that this Copay Program is solely for your benefit. Since you may be unaware whether you are subject to a copay maximizer program when you enroll in the Copay Program, if Boehringer Ingelheim suspects or is made aware that you are subject to one of these programs, we reserve the right to discontinue your participation in the Copay Program at any time. Boehringer Ingelheim in its sole discretion may rescind, revoke, change or discontinue the Copay Program without notice for any reason and at any time. Boehringer Ingelheim reserves the right to disqualify patients who do not comply with the Copay Program Terms and Conditions.

Patient Certification: By utilizing this Copay Program, you hereby attest that you meet the eligibility criteria and accept and agree to abide by these terms and conditions. Any individual or entity who enrolls or assists in the enrollment of a patient in the Copay Program represents that the patient meets the eligibility criteria and other requirements described herein. Further, you agree that you currently meet the eligibility criteria and other requirements described herein every time you use the Copay Program.

What is Jascayd® (nerandomilast) tablets?

- JASCAYD is a prescription medicine used to treat adults with a lung disease called idiopathic pulmonary fibrosis (IPF).
- It is not known if JASCAYD is safe and effective in children.

IMPORTANT SAFETY INFORMATION

Before you take JASCAYD, tell your healthcare provider about all of your medical conditions, including if you:

- have kidney problems.
- have liver problems.
- are pregnant or plan to become pregnant. JASCAYD may cause loss of your pregnancy (miscarriage). It is not known if JASCAYD can harm your unborn baby. Tell your healthcare provider right away if you become pregnant or think you are pregnant while taking JASCAYD.
- are breastfeeding or plan to breastfeed. It is not known if JASCAYD passes into your breastmilk. You and your healthcare provider should decide if you will take JASCAYD or breastfeed.

Tell your healthcare provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements. JASCAYD may affect the way other medicines work, and other medicines may affect how JASCAYD works. Know the medicines you take. Keep a list of them and show it to your healthcare provider or pharmacist when you get a new medicine.

What are the possible side effects of JASCAYD?

The most common side effects of JASCAYD include: diarrhea, COVID-19, upper respiratory tract infection, depression, weight loss, decreased appetite, nausea, fatigue, headache, vomiting, back pain, and dizziness.

These are not all the possible side effects of JASCAYD. For more information, ask your healthcare provider or pharmacist. Call your doctor for medical advice about side effects. **You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.**

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Please see accompanying Prescribing Information and Patient Information for JASCAYD.

Boehringer Ingelheim