PRODUCT ENROLLMENT FORM

CrinetiCARE

Please fax completed form to: 844-CRN-FAXX (844-276-3299)

Call CrinetiCARE™ Monday – Friday 8am to 8pm EST at
844-CRN-HELP (844-276-4357)

Palsonify™ (paltusotine) tablets

Please triage to ORSINI

PATIENT INFORMATION

(* Required Field)

First Name* _____ Last Name* _____ DOB* (mm/dd/yyyy)

Sex: ☐ Male ☐ Female Street Address* _____ City* _____ State* ____ Zip* _____

Primary Phone #* _____ Alt Phone # _____ Email Address* _____

Alt Contact Person _____ Alt Contact Phone # _____ Prior surgery: ☐ Yes ☐ Surgery Not An Option

PATIENT INSURANCE AND PHARMACY PREFERENCE

Please copy both sides of the patient's insurance card(s) and include with fax.

Primary Health Insurance

Plan Name _____
Phone # _____
Policy ID # _____
Group # _____
_____
Policy Holder Name (if other than patient)

Prescription Drug Insurance

Plan Name _____
Phone # _____
Policy ID # _____
Group # _____
Rx BIN _____
PCN _____

Secondary Insurance

Plan Name _____
Phone # _____
Policy ID # _____
Group # _____

PRESCRIBER INFORMATION & PRESCRIPTION

Prescriber Name* _____
Practice Name* _____
Phone* _____ Fax* _____
Email* _____
NPI #* _____ Best Time to Contact _____
Supervisory Prescriber's Name _____

Prescriber Specialty _____
Practice Contact _____
Street Address* _____
City* _____ State* _____ Zip* _____
State License # _____ Tax ID#* _____
Supervisory Prescriber's NPI # _____

PREVIOUS MEDICATIONS USED*

☐ cabergoline	☐ lanreotide acetate	☐ Mycapssa	☐ octreotide acetate	☐ Sandostatin	☐ Sandostatin LAR	☐ Signifor	☐ Signifor LAR	☐ Somatuline Depot	☐ Somavert
Dose:_____	Dose:_____	Dose:_____	Dose:_____	Dose:_____	Dose:_____	Dose:_____	Dose:_____	Dose:_____	Dose:_____

PATIENT DOSAGE FOR PALSONIFY™ (paltusotine) TABLETS* - SELECT ONE DOSE ONLY

☐ PALSONIFY™ 20mg tablets

Dose: 40mg (20mg Tablets x2)
Directions: Take 2 (two) tablets by mouth once daily, as directed.
QUANTITY: _____ REFILLS: _____

☐ PALSONIFY™ 30mg tablets

Dose: 60mg (30mg Tablets x2)
Directions: Take 2 (two) tablets by mouth once daily, as directed.
QUANTITY: _____ REFILLS: _____

☐ PALSONIFY™ tablets (alternate)

Dose: _____
Directions: _____
QUANTITY: _____ REFILLS: _____

ICD-10 Code: ☐ E22.0 (Acromegaly & Pituitary Gigantism) ☐ Other ICD-10: _____

Pharmacy Preference: ☐ Biologics ☑ Orsini ☐ PTC Pituitary Treatment Center Pharmacy

☐ Quick Start Supply (Please check box if the statement applies) The "Quick Start Program" is a free supply of PALSONIFY™ that allows eligible patients to begin therapy while insurance is verified.

By signing below, I, as the treating healthcare practitioner, state: (i) This prescription is medically appropriate for this patient and I will be supervising this patient's treatment; (ii) all information supplied to Crinetics or its agents ("Crinetics") relating to this enrollment form is accurate, and has been obtained pursuant to a separate, valid patient authorization that allows Crinetics to contact this patient to provide services relating to (1) treatment and (2) benefit verification and/or pre-authorization. Further, I understand that: (a) any free product provided is for the use of this patient only and shall not be sold or transferred to anyone else, or returned for credit; (b) free product may not be counted toward Medicare Part D out-of-pocket costs, free product may not be claimed for reimbursement from any third-party payer; and (c) Crinetics may revise, change, or terminate this or any other program at any time without notice. I authorize the Specialty Pharmacy to initiate any medical authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not related to seeking reimbursement, credit or other prohibited activities related to the free product..

Please Sign* **Prescriber Signature:** _____ **Date:*** / /

No Substitution / Dispense as Written / DAW / Brand Name Medically Necessary / Do Not Substitute

(Stamps & Electronic Signatures Not Allowed) **Prescriber Signature:** _____ **Date:** / /

Substitution Permissible / Product Selection Permitted

CA, MA, NC & PR:* *Interchange is mandated unless Prescriber writes the words 'No Substitution'* _____

***Attention:** New York & Iowa providers, please submit an electronic prescription per state prescribing laws & regulations. Send an electronic RX via by searching for: AllCare Plus Pharmacy (NPI: 1902167596)*

(* Required Field)

Please visit www.palsonify.com for Full Prescribing Information.

First Name _____ Last Name _____ DOB _____

Dear patient, we want to support you! Please read the following, then sign and date. Thank you.

PERSONAL INFORMATION FOR PATIENT SUPPORT

- I authorize my healthcare providers (including my doctor(s) and their staff), my pharmacies, my employer and my health insurer(s) to disclose and re-disclose my individually identifiable health information, which may include any information related to healthcare insurance, benefits, coverage limits, appeals and health records related to my treatment or other relevant information needed to support me through the CrinetiCARE® program ("Health Information") to affiliated companies, business partners, contractors, and vendors (together "Crinetics") so that they can:
  - operate, administer, enroll me in, and/or continue my participation in the CrinetiCARE® program or any other Crinetics-affiliated patient support services and activities related to my condition or treatment (for example, co-pay card programs, reimbursement assistance programs, drug coverage verification, nurse partner services, adherence program and disease management support or to coordinate delivery of the product to my home or other preferred location);
  - contact, with my permission, my doctor and the rest of my health care team and share with them my health information that may be useful for my care;
  - provide me with informational and promotional materials relating to Crinetics products and services, and/or my condition or treatment; and/or
  - improve, develop, and evaluate Crinetics' products, services, materials and programs related to my condition or treatment.
- I understand and agree that my HEALTH INFORMATION transmitted by email and cell phone cannot be secured against unauthorized access. If I qualify for any CrinetiCARE® Patient Support Programs, I understand that any assistance provided under their programs is contingent upon my ability to meet the eligibility criteria for such program.

CONSENT TO HEALTH DATA PROCESSING FOR CrinetiCARE® PROGRAM SUPPORT

- I consent to Crinetics processing my Health Data for the following purposes: To enroll me and manage my participation in the CrinetiCARE® program, which includes activities related to my condition or treatment (for example but not limited to, co-pay card programs, payer medication coverage verification, nurse partner support, disease management support), and to manage Crinetics' products, services, and programs related to my condition or treatment.
- Crinetics uses the following when it administers the program: Health Data - my name (and the name of my caregiver if applicable), gender, date of birth, contact information and information relating to my health condition or treatment.

TIMEFRAME, COPY, AND REVOCATION

- I understand and agree that by signing below, I am authorizing those who rely on this Authorization to disclose my protected health information for the earlier of five (5) years or until my participation in the CrinetiCARE® program ends through my cancellation, unless a shorter time period is required by state law.
- I understand that the programs may change or end at any time without prior notification.
- I also understand that I can obtain a copy of my signed Authorization upon request and that I can revoke this Authorization at any time by calling **844-CRN-HELP (844-276-4357)**, or by writing to CrinetiCARE®, 6055 Lusk Blvd, San Diego, CA 92121. Such revocation will not apply to any information already authorized under this form.

I HAVE READ THIS AUTHORIZATION AND AGREE TO ITS TERMS. PATIENT'S AUTHORIZATION AND SIGNATURE:

Patient Name (print)

Representative Name (print, if applicable)

Patient or Representative Signature

Date (mm/dd/yyyy)

Relation to Patient

Please have patient sign above and check the box to confirm approval for cell phone use below. If the patient is not in office, please send this form to CrinetiCARE® without the patient's signature and we will obtain patient consent and signature.

PATIENT CONSENT FOR CELL PHONE CALLS AND TEXTING

☐ I understand that my cell phone carrier's standard rates may apply for calls and texts to my cell phone.

☐ I authorize voicemail messages to be left at the phone number(s) provided.

Please visit www.palsonify.com for Full Prescribing Information.

CrinetiCARE®