FENNEC HEARS™
Hearing Education, Access & Reimbursement Support

pedmark®
(sodium thiosulfate injection)

This page is for instructional/educational use only.

Questions? Call 1-833-7PEDMARK (1-833-773-3627)

To learn more about Fennec HEARS Patient and Reimbursement Support, please call us between 9 am and 6 pm ET, Monday–Friday, or visit us at [www.pedmark.com].

ENROLL IN FENNEC HEARS PATIENT AND REIMBURSEMENT SUPPORT PROGRAMS

INSTRUCTIONS FOR PATIENT/LEGAL GUARDIAN

Fill out the following two sections completely. Missing information could delay your enrollment.

- ◯ **PATIENT INFORMATION** (section 1) on page 1
- ◯ **INSURANCE INFORMATION** (section 2) on page 1
- ◯ **Please sign the Fennec HEARS Patient Authorization line on page 4, after you read the information on page 3**

Your provider will complete the remainder of the form and fax pages 1, 2, and 3 to Fennec HEARS.

INSTRUCTIONS FOR PRESCRIBERS

Fill out the following three sections completely. Missing information could delay your patient's enrollment.

- ◯ **PRESCRIBER INFORMATION** (section 3) on page 1
- ◯ **STATEMENT OF MEDICAL NECESSITY** (section 4) on page 2
- ◯ **PRESCRIPTION** (section 5) on page 2
- ◯ **Please include your signature and date at the bottom of page 2**

FAX THE COMPLETED FORM TO 1-888-481-0561.
FENNEC HEARS MUST RECEIVE PAGES 1, 2, AND 3 IN ORDER FOR THE ENROLLMENT FORM TO BE COMPLETE.

FENNEC HEARS PATIENT AND REIMBURSEMENT SUPPORT OFFERINGS

- **Insurance-Related Support** (Benefits Investigation, Prior Authorization, and/or Appeal Process)
- **Patient Assistance Program (PAP):** Provides eligible patients with access to free product in accordance with the treating physician's on-label prescribing decision. Eligible patients have a financial need, and are uninsured, rendered uninsured, or underinsured as determined by the program
- **Quick Start Program:** If there is a delay in determining coverage approval for new patients, we may be able to provide a one-time free, limited supply of PEDMARK for an FDA-approved use. No purchase contingencies or other obligations apply
- **Bridge Program:** For existing patients who experience an insurance coverage interruption, we may be able to provide a free, limited supply of PEDMARK for an FDA-approved use
- **Pedmark Copay Savings Program:** Provides eligible patients with financial assistance to cover out-of-pocket copayment or co-insurance cost associated with their prescription

Click here **for Terms, Conditions, and Eligibility Criteria.**

FENNEC HEARS™
Hearing Education, Access & Reimbursement Support

ENROLLMENT FORM

FAX THE COMPLETED AND **SIGNED FORM** (See red dot • below)
TO **1-888-481-0561.** PHONE: 1-833-7PEDMARK **(1-833-773-3627)**
Hours: Monday–Friday (9 am to 6 pm ET)

pedmark® (sodium thiosulfate injection)

Prescriber: Please fax pages 1, 2, and 3 to avoid delays.

PLEASE CHECK ALL SUPPORT SERVICES FOR WHICH YOU ARE APPLYING (see cover sheet).

○ Insurance-related support ○ Financial support ○ Patient Assistance Program ○ Quick Start/Bridge Program

GUARDIAN OR PATIENT (>18 YR) COMPLETES

1 PATIENT INFORMATION*

Patient Name (First/Last)__________

○ Male ○ Female DOB (MM/DD/YY)__________

Home Address__________

City__________State______Zip______

Primary Language ○ English ○ Spanish ○ Other______

Legal Guardian Name (First/Last)__________

Primary Phone__________ ○ Cell ○ Home

Email__________

Best time to contact ○ Morning ○ Afternoon ○ Evening

Preferred way to contact ○ Phone ○ Email

*Form cannot be processed without this information.

2 INSURANCE INFORMATION*

○ Patient is uninsured

Primary

Primary Medical Insurance__________

Insurance Phone__________

Policy ID #__________Group #__________

Prescription Insurance (if different)__________

Prescription Insurance Phone__________

Policy ID #__________Group #__________

Rx Bin #__________Rx PCN #__________

Examples of primary medical insurance: Anthem, Aetna, and Cigna.

Your prescription insurance may be different than your medical insurance. The name may be on the back of your health insurance card or on a separate card.

Secondary (Does the patient have secondary insurance?) ○ Yes ○ No

Secondary Medical Insurance__________

Insurance Phone__________

Policy ID #__________Group #__________

Policyholder's Name (First/Last)__________

Relationship to Patient__________

Policyholder's DOB (MM/DD/YY)__________

Policyholder's Home Address (if different from patient's)

____

____

Please include copies of insurance cards — the patient may have different cards for medical and prescription benefits.

*Form cannot be processed without this information.

PRESCRIBER COMPLETES

3 PRESCRIBER INFORMATION*

Prescriber Name (First/Last)__________

Site / Facility__________

NPI #__________State Lic #__________

Tax ID #__________

Medicaid Provider # (if Medicaid patient)__________

Address__________

City__________State______Zip______

Office Contact + Title__________

Phone #__________Fax__________

Email__________

*Form cannot be processed without this information.

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pedmark® (sodium thiosulfate injection)

PRESCRIBER COMPLETES

Patient Name (First/Last)______________________________

Prescriber Name (First/Last)______________________________ NPI #______________

4 STATEMENT OF MEDICAL NECESSITY

Diagnosis Date______________________________

Primary ICD-10 Code______________________________

Secondary ICD-10 Code______________________________

Patient Weight ______________ ◯ lb ◯ kg

Other clinical notes______________________________

____

____

Site of care

- ◯ Hospital Inpatient
- ◯ Hospital Outpatient
- ◯ Outpatient Infusion Center
- ◯ Physician Office
- ◯ Home Infusion
- ◯ Other ______________

Address (if different than Section 3)______________________________

____

____

5 PRESCRIPTION

Rx PEDMARK® (sodium thiosulfate injection)

◯ Dispense______vial(s) Dispense______Refills

Start Date______________ Frequency______________

QUICK START Rx or BRIDGE

If eligible. **Click here** for Terms, Conditions, and Eligibility Criteria.

◯ Dispense______vial(s)

Start Date______________ Frequency______________

Administer as a 15-minute infusion, 6 hours after completion of each cisplatin administration, when cisplatin is infused for no longer than 6 hours.

Additional directions______________________________

By signing below, I hereby represent, covenant, and certify as follows: (1) The above therapy (or medicine) is medically necessary; (2) I have obtained from my patient his or her consent and any required written authorization as required by HIPAA and other federal or state laws to release to Fennec Pharmaceuticals, Inc. and its representatives/agents ("Fennec") all patient information needed for processing this application, including, without limitation, my patient's financial and medical information; (3) I understand and my patient has authorized that this information may be used by Fennec to assess the patient's eligibility for participation in Fennec Patient & Product Support (the "Program") and for other purposes as outlined in the Patient Authorization below; (4) Fennec is authorized to contact me about the information provided on this form and as needed to facilitate my patient's enrollment and participation in the Program; (5) I have not received, nor will I seek or accept reimbursement from any federal, state, or private payers for any drug provided for my patient through the Program's free-drug support ("Fennec Product Support"); (6) If the above-named patient is enrolled in Fennec Product Support, free PEDMARK (sodium thiosulfate) will be provided to this eligible and enrolled patient at no charge of any kind; free PEDMARK that is supplied as a result of this enrollment form is for the use of the patient named on this form only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (such as Medicare, Medicaid, or other benefit provider) for reimbursement. I understand that Fennec may, if authorized by the patient, contact the patient directly to verify Program eligibility and updates to insurance coverage as well as to confirm the receipt of free PEDMARK through the Program; (7) I have not received, nor will I seek or accept payment from my patient or any other payer for any co-insurance or other cost-sharing amount paid for by the Program; (8) I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible under this Program. I will promptly notify Fennec by calling 833-773-3627 if I become aware of any such changes; (9) I understand that any Fennec products and other support provided by the Program are complimentary and for the benefit of the patient; that I am under no obligation to prescribe any Fennec drugs, including because of my patient's participation in the Program; and I have not received and will not receive any benefit from Fennec for prescribing a Fennec drug; (10) I understand that if I receive free Fennec product, I will only administer it to the patient for whom it was prescribed or return the product to Fennec; (11) the information contained in this form is complete and accurate to the best of my knowledge; and (12) I will promptly notify Fennec of any errors by calling 833-773-3627, and will make every effort to correct those errors.

X______________________________ Date______________

Prescriber Signature (Dispense as written) **Attn: New York Prescribers.** Please submit prescription on original **NY state prescription forms**.

PATIENT AUTHORIZATION

I hereby authorize my health care professional, my health insurance company, and my pharmacy to disclose my protected health information ("PHI") including, but not limited to, my name, address, telephone number, medical records, health insurance coverage, and financial information to Fennec Pharmaceuticals, Inc., and its representatives/agents (collectively "Fennec") so that Fennec may use my information: (a) to contact me, or the person legally authorized to sign on my behalf, by phone or mail, regarding this application, my participation in the Program, and my use or potential use of PEDMARK®, including through messages left for me that disclose that I take or may take PEDMARK; (b) to contact my insurance company on my behalf to verify my coverage for PEDMARK; (c) to determine my eligibility for enrollment into Fennec Patient & Product Support (the "Program"); (d) to enroll me into the Program, if I am eligible, and provide applicable support through the Program, including information on third-party sources that may be able to assist me; (e) to coordinate my Fennec treatment with my health care professionals and specialty pharmacy, and send me educational materials or other information that may be of interest to me related to my Fennec treatment; and (f) to conduct market research for marketing purposes and other activities as appropriate to administer the Program. I understand and authorize that the information provided by me, my health care professional, pharmacy, or insurance company may be used for marketing purposes about Fennec, its products, or its patient support programs. I understand that my health care and/or pharmacy provider(s), and/or my insurance company, may receive remuneration in exchange for the provision of my PHI for use in marketing and for other authorized purposes. Once my health information has been disclosed to Fennec, I understand that federal privacy laws may no longer protect the information. However, I understand that Fennec, and other companies authorized to receive my health information pursuant to this Authorization, agree to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. I understand that this Authorization does not affect treatment from my health care professional or coverage for PEDMARK through my insurance. I understand that this Authorization is voluntary. However, if I refuse to sign, or cancel my Authorization, Fennec may not be able to determine my eligibility for the Program, and I may not be eligible to participate in the Program. I may cancel this Authorization at any time by contacting Fennec at 833-773-3627. If I do not cancel the Authorization, it will remain valid for 3 years (or at such lesser time as state law may require). I understand that I am entitled to receive a copy of this Authorization.

PATIENT ASSISTANCE PROGRAM (PAP)/ QUICK START / BRIDGE ENROLLMENT (IF APPLICABLE)

I certify that the information provided on this form is complete and accurate, to the best of my knowledge, and I will promptly call Fennec Pharmaceuticals, Inc. at 833-773-3627 with any updates, including any changes to my insurance. I understand that all support provided through Fennec Patient & Product Support (the "Program") is complimentary, and there is no purchase requirement associated with the Program. To determine my eligibility to enroll into the Patient Assistance Program, Fennec and its representatives/agents ("Fennec") will assess my income with the appropriate level of evidence set forth by verification of financial information (including W-2 and tax return documentation). I will not seek (or allow others to seek on my behalf) payment or reimbursement for any free drug or other support provided to me through the Program(s). I will comply with all Program terms and conditions and with any requirements from my insurance provider.

I have read and understood the Fennec HEARS Patient Authorization on page 3 and certify that the information I have provided is complete and correct.

Cannot process form without signature

Signature of patient or parent/legal guardian

X____ Date____________________

Print name (First/Last)____

Patient Name (First/Last)____

Prescriber Name (First/Last)____ NPI #____________________

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