EIGER one care SUPPORT.CARE.ACCESS

ZOKINVY™ Enrollment Form

Phone: 1-833-MYEIGER (1-833-693-4437)
Fax: 1-888-777-5680
Hours of operation: Monday through Friday 9am-5pm EST

Zokinvy™ (lonafarnib) capsules 50 mg/75 mg

PATIENT INFORMATION

* indicates required field.

First Name*:	Phone*: Home: Work:
Last Name*:	Cell:
Date of Birth (MM/DD/YYYY)*:	Email*:
Gender*: Male Female Neutral Prefer not to say	Legal Guardian Name:
Address Line 1*:	Relationship:
Address Line 2:	Legal Guardian Phone:
City*: State*: ZIP Code*:	Legal Guardian Email:

Primary Insurance:	Secondary Insurance:
Primary Insurance ID #:	Secondary Insurance ID #:
Primary Group #:	Secondary Group #:
Primary Insurance Phone:	Secondary Insurance Phone:
Policy Holder Name:	Secondary Policy Holder Name:
Relationship to Patient:	Relationship to Patient:

Insurance Information: Please include copies of the front and back of insurance card(s) if applicable

Pharmacy Benefit (PBM):	PBM ID #:
BIN #:	PCN #:

Prior treatment(s):
If prior treatment was Zokinvy™ (lonafarnib), how long has the patient been on therapy?
Current number of capsules on hand:
50mg:
75mg:
Known Allergies:

CLINICAL

*indicates required field.

ICD-10:	
Has the patient been genetically confirmed?: [ ] YES [ ] NO	
If genetically confirmed, please indicate status: [ ] Hutchinson-Gilford Progeria Syndrome [ ] Progeroid Laminopathy	
Other:	
Height*:	Weight*:

PRESCRIBER INFORMATION

*indicates required field.

Prescriber First Name*:	Prescriber Last Name*:
NPI #*:	State License #*:
DEA #*:	Practice Name*:
Practice Address Line 1*:	
Practice Address Line 2:	
City*: State*: ZIP*:	
Practice Contact*:	Practice Phone*:
Email*:	Office Fax*:
Preferred contact method: [ ] Phone [ ] Email [ ] Fax	Best time to contact:

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(lonafarnib)
capsules 50 mg/75 mg

PRESCRIPTION INFORMATION

*** indicates required field.**

Patient's Full Name*:

Date of Birth (MM/DD/YYYY)*: | **BSA (m^2)*** | **Dosage* (mg):**

The "Bridge Start Program" is a Free supply of ZOKINVY™ that allows eligible patients to begin therapy immediately while the ZOKINVY™ Eiger OneCare™ program secures appropriate benefit verifications and authorizations. If Bridge Start is selected for the patient, an initial 15-day supply of ZOKINVY™ will be dispensed. The strength, directions and quantity will match per written below. All other Bridge Start deliveries will be supplied in 15-day refills (with a limit of 60 days of Free supply).

[ ] **"Bridge Start"** (Please check box if the above statement applies)

ZOKINVY™ Capsules Prescription*: Please check box/sign for each prescribed Strength/NDC

[ ] **ZOKINVY™ 50 mg Capsules**

Directions:______________________________

Quantity: __________ **Refills:**__________

Date: __________

Dispense as Written: (Prescriber Signature) **X** _______________

----- or -----

Substitution Allowed: (Prescriber Signature) **X** _______________

[ ] **ZOKINVY™ 75 mg Capsules**

Directions:______________________________

Quantity: __________ **Refills:**__________

Date: __________

Dispense as Written: (Prescriber Signature) **X** _______________

----- or -----

Substitution Allowed: (Prescriber Signature) **X** _______________

DOSAGE RECOMMENDATIONS

Table 1 provides the BSA-based dosage recommendations for the recommended starting dosage of 115 mg/m^2 twice daily.

Table 1: Recommended Dosage and Administration for 115 mg/m^2 Body Surface Area-Based Dosing

BSA (m^2)	Total Daily Dosage Rounded to Nearest 25 mg	Morning Dosing Number of Capsule(s)		Evening Dosing Number of Capsule(s)	
		ZOKINVY 50 mg	ZOKINVY 75 mg	ZOKINVY 50 mg	ZOKINVY 75 mg
0.39-0.48	100	1		1	
0.49-0.59	125		1	1	
0.6-0.7	150		1		1
0.71-0.81	175	2			1
0.82-0.92	200	2		2	
0.93-1	225	1	1	2	

Table 2 provides the BSA-based dosage recommendations for the recommended dosage of 150 mg/m^2 twice daily.

Table 2: Recommended Dosage and Administration for 150 mg/m^2 Body Surface Area--Based Dosing

BSA (m^2)	Total Daily Dosage Rounded to Nearest 25 mg	Morning Dosing Number of Capsule(s)		Evening Dosing Number of Capsule(s)	
		ZOKINVY 50 mg	ZOKINVY 75 mg	ZOKINVY 50 mg	ZOKINVY 75 mg
0.39-0.45	125		1	1	
0.46-0.54	150		1		1
0.55-0.62	175	2			1
0.63-0.7	200	2		2	
0.71-0.79	225	1	1	2	
0.8-0.87	250	1	1	1	1
0.88-0.95	275		2	1	1
0.96-1	300		2		2

PRESCRIBER DECLARATION

By signing below, as the treating prescriber, state (i) I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed ZOKINVY™ based on my professional judgment of medical necessity. (ii) all information supplied to Eiger BioPharmaceuticals, Inc or its agents ("Eiger") relating to this enrollment form has been obtained pursuant to a separate, valid, patient authorization that allows Eiger to contact this patient and perform any steps necessary to obtain reimbursement for ZOKINVY™ to provide services relating to (1) treatment and (2) benefit verification and/or preauthorization and appeals. I authorize Eiger. or its affiliated companies or subcontractors, including in-network specialty pharmacies, through the ZOKINVY™ Eiger OneCare™ Patient Support Program ("the Program") to forward this prescription electronically, by facsimile, or by mail to the relevant in-network pharmacy for the above-named patient. I understand that the Program may need additional information, and authorize Eiger or its affiliated companies or subcontractors, including in-network specialty pharmacies to initiate any de minimus authorization process from applicable health plans, if needed, including the submission of any necessary forms and documentation to such health plans, to the extent not prohibited. **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, nor claimed for reimbursement from any third party payer (private or government); (c) I am under no obligation to prescribe any Eiger drug and I have not and will not receive any benefit from Eiger for prescribing an Eiger drug; and (d) Eiger may revise, change, or terminate programs at any time without notice.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

(Prescriber Signature) **X** ____________________ (NPI#) **X** _______________ **(Date) X**____________

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PRIVACY NOTICE AND PATIENT AUTHORIZATION

The protection of your health information is important to Eiger BioPharmaceuticals. The below provides an explanation of how we use your information to assist you and seeks your attestation to prudently use your personal health information (PHI) to help you on therapy.

Eiger OneCare™ has programs available to support patients and will use your information provided to see which programs, based on their criteria, you may qualify for. Please read the following, initial each section, and then sign and date.

Patient Authorization to Release Personal Information. I authorize my healthcare providers (including my doctor(s) and their staff), my pharmacies, my employer and my health insurer(s) to disclose my personal 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 in the Eiger OneCare program ("Personal Information") to Eiger BioPharmaceuticals, Inc., its affiliated companies, contractors, and vendors (together "Eiger") that Eiger can (i) help to verify or coordinate insurance coverage; (ii) coordinate my receipt of therapy; (iii) provide me with information about the therapy; (iv) contact me discuss my therapy and provide clinical support; (v) conduct market research, surveys, quality assurance, and other internal business activities in connection with the Eiger OneCare™ program; and (vi) call, email, text message, and mail materials from Eiger at the telephone number(s) and addresses (physical & e-mail) provided on the enrollment form.

Use. While Eiger will only use my Personal Information for the intended purposes described above, I understand that once my Personal Information is disclosed it may be re-disclosed by recipients and will no longer be protected by federal privacy law. I understand my Personal Information may be used by pharmacies to process my prescription. I understand that I may refuse to provide my authorization or in the future opt out of specific components or services of Eiger OneCare™, and that my refusal will not affect my ability to receive treatment from my healthcare providers. I understand that some pharmacies may receive payment for disclosing my Personal Information in exchange for providing the services associated with the program.

Timeframe, Copy, and Revocation. I understand that this Authorization will remain valid for five (5) years from signature date unless I revoke it earlier. 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 Eiger at 1-833-MYEIGER (1-833-693-4437); by fax to 1-888-777-5680 or by writing to Eiger OneCare™, 50 Bearfoot Road Northborough, MA 01532. I also understand any revocation will only apply to my healthcare provider(s), pharmacies, and health insurer(s) once they receive notification of my revocation. I also understand that any medicines I may receive from this program is only for me and if I am a Medicare Prescription Drug Plan or Medicare Advantage Prescription Drug Plan beneficiary, that I may not submit a claim for payment to Medicare or any third-party payer.

My signature below certifies that I have received, read, understood, and agree to the Privacy Notice and Patient Authorization

PRIVACY NOTICE AND PATIENT AUTHORIZATION

Patient Signature	**Date (mm/dd/yyyy)**
Patient Representative Signature* ***If not signed by the patient**	**Date (mm/dd/yyyy)**
Relationship to Patient	**Patient Date of Birth: (mm/dd/yyyy)***

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