SENTYNL CARES | Nulibry® (fosdenopterin) for injection

The Sentynl Cares program

Provided by Sentynl Therapeutics, with a commitment to help bring NULIBRY to those who need it

Instructions for Prescribers

Discuss the Sentynl Cares program with your patient's parents or caregivers

Once enrolled in the Program they are evaluated for access options based on individual needs

Fill out personal and practice information

- Include NPI number
- Primary facility contact information
- NICU/PICU information if applicable

Indicate prescription information and sign

- Indicate ICD-10 codes and other relative information

Sign, where applicable, for all program opportunities

Fax completed form to Sentynl Cares: 877-977-0011

- Include all completed and signed pages (6)
- Medical coverage information

Instructions for Parents/Caregivers

Discuss the Sentynl Cares application with your healthcare provider

Sentynl Cares offers programs that provide a high level of support during every step of the treatment journey

Read and sign to give consent for access to Sentynl Cares

- Insurance benefits verification and appeals support
- Patient affordability programs, which can help qualified patients get NULIBRY

Provide insurance information

- Include primary and secondary insurance information
- Include medical and pharmacy information
- Preferred method of contact

Please call 1-888-251-2800 with any questions

NULIBRY.com

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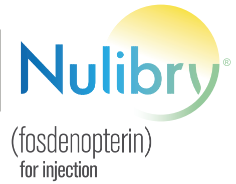
SENTYNL THERAPEUTICS, INC.



NULIBRY Enrollment Form

In order to obtain your prescription for NULIBRY, you must enroll in the Sentynl Cares | NULIBRY Patient Support Program. Print and fax completed enrollment forms to 877-977-0011. All pages must be received to process enrollment.

Phone: 1-888-251-2800
Fax: 877-977-0011
Web: NULIBRY.com/sentynlcares

SUPPORT OFFERED TO PATIENT AND/OR THEIR CAREGIVER

In addition to dispensing your medication, the Sentynl Cares | NULIBRY Access and Support program is your source to help you feel supported on your child's path with NULIBRY.

Based on your selections below, your child will be enrolled in the Sentynl Cares | NULIBRY Patient Support Program.

Sentynl Therapeutics, Inc. has designed this support program to help you learn more about your child's condition and treatment, and to help your child get started on their NULIBRY treatment journey.

Please complete the form and let us know which support programs you would like to be enrolled in:

☐ **By checking this box, the patient will be evaluated for all Sentynl Cares | NULIBRY Programs listed below and is opting in to receive program-related communication (phone, text, email, mail). Otherwise, please check the programs you are interested in being evaluated for.**

☐ **Insurance Support and Financial Assistance**
May include benefits verification, prior authorization, appeals support, and potential financial assistance options. Additional information may be required to determine eligibility.

☐ **NULIBRY Copay Assistance Program**
Helps patients manage out-of-pocket copay coinsurance costs for those with commercial insurance or private prescription drug coverage. This offer is not valid for prescriptions reimbursed under Medicaid, a Medicare drug benefit plan, or other federal or state programs (such as medical assistance programs).

☐ **Nurse and Educational Support**
Sentynl Cares clinical staff may provide educational information on your child's condition and information on NULIBRY.

PATIENT/CAREGIVER AUTHORIZATION TO SHARE HEALTH INFORMATION

Please read the consent details on page 5 that explain how your information will be used. If you have any questions, please feel free to reach out to our program staff at the number listed above. After you read the information on page 5, please sign below.

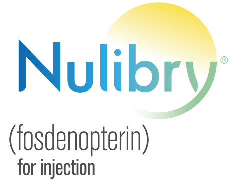
Please legibly complete all required fields.

SIGN HERE ____________________ Parent/Caregiver or Legal Representative ____________________ Print Name __________ Date

PATIENT/CAREGIVER CONSENT TO ENROLL IN SENTYNL CARES PATIENT ASSISTANCE PROGRAM

Please read the consent details on page 6 that explain the consent and agreement to share financial information if needed. If you have any questions, please feel free to reach out to our program staff at the number listed above. After you read the information on page 6, please sign below.

SIGN HERE ____________________ Parent/Caregiver or Legal Representative ____________________ Print Name __________ Date



PATIENT INFORMATION

Name: ______________________________ (First, MI, Last) DOB: ______________ (mm/dd/yyyy)

Street: ______________________________

City: ______________________ State: ______________ ZIP: ______________

Gender: ☐ Male ☐ Female Today's Date: ______________ Current Weight: ______________

PARENT/CAREGIVER INFORMATION (PARTY RESPONSIBLE FOR PATIENT)

Parent/Caregiver Name: ______________________________ (First, MI, Last)

Relationship to Patient: ______________________________

Primary Phone: ______________________ Primary Email: ______________________

I consent to allow Sentynl Cares to leave me a voicemail about access information.: ☐ Yes ☐ No

Primary Email: ______________________________

Street: ______________________________

City: ______________________ State: ______________ ZIP: ______________

DOB: ______________ (mm/dd/yyyy) Gender: ☐ Male ☐ Female Preferred Language (If Not English): ______________

Additional Contact Permitted to Receive Patient Information

Name: ______________________________

Email: ______________________________

Relationship to Patient: ______________________________

Phone: ______________________________

PRIMARY INSURANCE INFORMATION

Please attach copies (front and back) of all available insurance and prescriptions cards. **No Insurance?** ☐

Primary Medical Insurance Name: ______________________

____

Insurance Phone: ______________________

Policy ID #: ______________________

Group #: ______________________

Primary Rx Insurance Name (If Different): ______________________

____

Rx Insurance Phone: ______________________

Policy ID #: ______________________

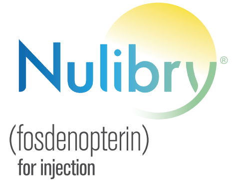
Group #: ______________________

Policy Holder Name: ______________________ (First, MI, Last) Social Security #: ______________

Relationship to Patient: ______________ Rx BIN #: ______________ Rx PCN #: ______________

Street: ______________________________

City: ______________________ State: ______________ ZIP: ______________



SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Please attach copies (front and back) of all available insurance and prescriptions cards.

Secondary Medical Insurance Name: ____________________________

____

Insurance Phone: ____

Policy ID #: ____

Group #: ____

Secondary Rx Insurance Name (If Different): __________________

____

Rx Insurance Phone: ____

Policy ID #: ____

Group #: ____

Policy Holder Name: ____ Social Security #: ____________________
(First, MI, Last)

Relationship to Patient: ________________________ Rx BIN #: ______________________ Rx PCN #: ______________________

Street: ____

City: ____ State: ______________ ZIP: ________________

PRESCRIBER INFORMATION (PRESCRIBER TO FILL OUT)

Prescriber Name: ________________________________ Group Tax ID (NPI #): ____________________________________

Prescriber Facility Name: ____

Specialty: ____ Primary Facility Contact Email: _______________________

Street: ____ Primary Contact Phone: ___________________________

City: _________________________ State: _______ ZIP: _________ Primary Facility Contact Fax: ________________________

Hospital Admission Date (if different from DOB): ____

Complete below if the patient is currently hospitalized:

Hospital Name: ____

Hospital Contact Name: _______________________________ Hospital Contact Email: ______________________________

Street: ____

City: _________________________ State: _______ ZIP: _______ Phone: ___________________ Fax: ___________________

NICU/PICU INFORMATION

NICU ☐ PICU ☐

NICU/PICU Contact Name: ______________________________

NICU/PICU Contact Email: ______________________________

Phone: ______________________________ Fax: ______________________________

Best Time to Contact: ______________________________

DIAGNOSIS AND ICD-9/ICD-10 CODE

Diagnosis: ______________________________

ICD-9/ICD-10: ______________________________

TREATMENT AND PRESCRIPTION INFORMATION

Fill out this section to write your patient's prescription. Please submit a separate prescription if required by state law (New York prescribers).

Prescription for NULIBRY Date: ______________________________

An infusion pump and supplies are required for adequate administration of NULIBRY. Please see the full Prescribing Information for details, specifically the Instructions for Use section.

Patient Name: ______________________________ DOB: ______________________________
(mm/dd/yyyy)

NULIBRY for injection 9.5 mg fosdenopterin hydrobromide per vial:

SIG: ______________________________

Quantity: ______________ Refills: ______________

NULIBRY for injection 9.5 mg fosdenopterin hydrobromide per vial:
QuickStart Prescription
(Provides up to 2 months of free treatment to patients if their insurance coverage is delayed by more than 5 days.)

SIG: ______________________________

Quantity: ______________ Refills: ______________

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HEALTHCARE PROVIDER CONSENT

I certify that (1) the prescribed medicine is medically necessary for this patient and the treatment decision was based solely on my independent medical judgement, (2) services provided by Sentynl Therapeutics, Inc. ("Sentynl") on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use any Sentynl product or service, (3) the patient provided me with an authorization to release their personal health information to Biologics Specialty Pharmacy (together with its affiliates, including but not limited to its third party business partners, vendors, and other agents) for purposes of enrollment in the Program and receipt of patient support services, and;

If my patient is eligible for free product, I understand that receiving free product is not contingent on any purchase obligations. I also understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; nor should it be sold, traded, or distributed for sale. I will notify Biologics immediately if NULIBRY is no longer medically necessary for this patient's treatment or if my patient's insurance status changes. I agree to comply with my state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. I understand that noncompliance with state-specific requirements could result in outreach to me as the prescriber.

SIGN HERE ______________________ Prescriber Signature Required – No Stamps ______________________ Print Name ______________ Date

PATIENT & CAREGIVER AUTHORIZATION TO SHARE HEALTH INFORMATION

By signing on above, I authorize my healthcare providers, insurers and pharmacies ("Healthcare team") to disclose information often referred to as protected healthcare information ("Health Information") to Biologics, Inc and agents (the "Parties"). Health Information includes information such as: (1) name, address, telephone, and other personal and contact information, (2) health insurance coverage related information, and (3) treatment-related information.

I authorize the Parties to use my Information for the following purposes:

- Enrolling me in the Sentynl Cares Patient Assistance Program (the "Program")
- Providing me with educational information, nursing educational calls (if selected), and other treatment-related educational support
- Verifying, investigating, assisting, and helping with coordinating my health insurance coverage for NULIBRY
- Assessing my initial and continued eligibility for various financial assistance programs
- Coordinating prescription fulfillment
- Contacting me regarding the Program
- Assisting with analyses related to the use of NULIBRY

The Parties agree to use and disclose my Information only as allowed by me in this Authorization or as otherwise allowed by law. Once my Health Information and Financial Information (together "Information") has been disclosed to the Parties, I understand that federal privacy laws may no longer protect it from further disclosure.

I understand that I may refuse to sign this Authorization, that I may refuse to disclose all or some of my Information, and that a refusal to sign will not affect my ability to obtain medical care, insurance coverage, or access to health benefits. However, if I do not sign this Authorization, I understand I will not be able to participate in the Program. This Authorization expires ten years from the date signed below, or as otherwise required by state and local law, unless and until I cancel the Authorization before then. I may cancel this Authorization at any time by writing to Sentynl Cares | NULIBRY at 11800 Weston Parkway, Cary, NC 27513, or by sending an email to NULIBRY@mckesson.com. I understand that canceling this Authorization will end my participation in the Program and will not affect any use or disclosure of the Information made before my request is received.

I understand that I have a right to receive a copy of this Authorization when it is signed.

PATIENT & CAREGIVER CONSENT TO ENROLL IN QUICKSTART FREE DRUG PROGRAM IF DEEMED ELIGIBLE

If I enroll in QuickStart Free Drug Program I understand and agree that no free product received via the QuickStart Free Drug Program may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale. I understand that this program is not meant to encourage me or my physician to use or prescribe NULIBRY. I also understand that the program only provides drug and that I will need to find alternative means to support other medical costs associated with the use of this medication. Sentynl Therapeutics, Inc. reserves the right to review patient profiles, grant requests based on patient need, and to change program guidelines or terminate the program at any time without notification.

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