PRIALT
(ZICONOTIDE)
INTRATHECAL INFUSION

TerSera SupportSource

PRIALT Enrollment and Authorization Form

Call toll free 1-855-686-8725
Mon-Fri 9:00 AM to 6:00 PM ET
Fax to 1-855-836-3066
PRIALT.com

Check for services requested:

☐ **Coverage Support (benefits investigation, prior authorization/precertification information, and/or appeals support)**

☐ **PRIALT Savings Program**

TerSera SupportSource is here to assist your patients.
Please see accompanying or click for Full Prescribing Information, including Boxed Warning.

Eligibility information:
For eligible, commercially insured patients, card carries a maximum annual benefit of $8,000 per calendar year. Patients are not eligible if prescriptions are paid for by any state or federally funded program, including, but not limited to, Medicare or Medicaid, Medigap, VA or DOD or TriCare, or where prohibited by law.

1. PATIENT INFORMATION

Patient name:_____

Gender: ☐ Male ☐ Female Date of birth (MM/DD/YY): _____

Address: _____

City/State/ZIP:_____

Home phone:_____ Cell phone:_____

Preferred phone: ☐ Home ☐ Cell

Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening

2. INSURANCE INFORMATION

Primary insurance:_____

Policy ID #:_____Group #:_____ Phone #:_____

Subscriber's name (if not self): _____

Employer:_____

Secondary insurance (if applicable): _____

Policy ID #:_____ Group #:_____ Phone #: _____

3. PRESCRIBER INFORMATION

Prescriber name:_____

Address:_____

Phone:_____

Practice name:_____

NPI #:_____ State Med Lic #:_____

Office contact name:_____

City/State/ZIP:_____

Fax:_____

Specialty:_____

Tax ID #:_____ PTAN:_____

Setting of care: ☐ Physician's office: ☐ Hospital outpatient ☐ ASC ☐ Other (explain):_____

4. DIAGNOSIS, CLINICAL, AND TREATMENT INFORMATION

Diagnosis:_____ ICD-10 code:_____

Has this patient been diagnosed with severe chronic pain for which intrathecal (IT) therapy is warranted? ☐ Yes ☐ No

Currently taking PRIALT? ☐ Yes ☐ No If yes, start date:_____

Existing IT pump? ☐ Yes ☐ No If no, provide implantation date:_____

5. PRESCRIBER'S SIGNATURE

TerSera Therapeutics and its contractors and agents (together "TERSERA"), will use the information you provide to administer and improve TerSera SupportSource (the "Program"). By signing below, you represent, covenant, and certify as follows: (i) My patient has provided all required written authorization(s) as required by HIPAA 164.508 and other federal or state laws to release to TERSERA and the Program all patient information needed for this application, including without limitation financial and personally identifiable information in order to (1) conduct coverage support services, and (2) determine eligibility and enroll patient for financial assistance; (ii) All of the information provided in this application is complete and accurate; (iii) PRIALT® (ziconotide) intrathecal infusion was prescribed based on my medical judgment or the medical judgment of another healthcare professional in my office; (iv) I understand and have explained to my patient that TERSERA may modify or terminate the Program at any time without notice and that completion of this application does not guarantee enrollment in any particular part of the Program; (v) I understand and agree that any medications supplied by TERSERA under the Program are for use of the named patient only and shall not be sold, traded, bartered, transferred, returned for credit, submitted to any third party payor (private or government) for reimbursement, or counted toward the patient's Medicare Part D out-of-pocket costs; (vi) I have not received nor will I seek or accept payment from my patient for any co-insurance amount paid for by the Program; (vi) I understand that I am under no obligation to prescribe any TERSERA drug and I have not received and will not receive any benefit from TERSERA for prescribing a TERSERA drug; and (viii) if I become aware of any errors in the information provided, I will promptly notify TERSERA of those errors.

I authorize TERSERA and the Program to act as my representative, and on behalf of myself and my patient, to initiate any benefits investigation (BI), prior authorization (PA) and appeals support, co-pay card, and co-pay assistance foundation referrals. By signing below, I request that TERSERA and the Program assist my office in providing the requirements of this patient's health plan related to prior authorization for treatment with the product noted in the Drug Therapy portion of this form. I understand that assistance includes obtaining the health plan-specific prior authorization form, and providing it based upon the patient-specific information provided on this form. I understand that the partially completed forms will be provided to my office by TERSERA and the Program for possible completion and submission to the health plan. I request that TERSERA and the Program actively monitor the status of the prior authorization submission. I request that TERSERA and the Program provide status updates to my office with respect to this patient's prior authorization for treatment with the product noted in the Drug Therapy portion of this form.

Prescriber's Signature (NO STAMPS):_____ **Date:**____/____/_____

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FINANCIAL ASSISTANCE

This section should only be completed for enrollment into the Patient Assistance Program (PAP).

1. PATIENT INFORMATION

Patient name:_____

Gender: ☐ Male ☐ Female Date of birth (MM/DD/YY): _____

Address: _____

City/State/ZIP:_____

Home phone:_____ Cell phone:_____

Preferred phone: ☐ Home ☐ Cell

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2. INSURANCE INFORMATION

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Policy ID #:_____Group #:_____ Phone #:_____

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Address:_____

Phone:_____

Practice name:_____

NPI #:_____ State Med Lic #:_____

Office contact name:_____

City/State/ZIP:_____

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Specialty:_____

Tax ID #:_____ PTAN:_____

Setting of care: ☐ Physician's office ☐ Hospital outpatient ☐ ASC ☐ Other (explain):_____

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FINANCIAL ASSISTANCE

This section should only be completed for enrollment into the Patient Assistance Program (PAP).

1. PATIENT FINANCIAL INFORMATION (REQUIRED FOR FINANCIAL ASSISTANCE)

Annual Gross Household Income: $_____ # of Household Members (including patient):_____

Please attach or complete the embedded prescription if you are seeking the PAP for your patient. Please note, eligibility for the PAP is based on the Federal Poverty Level and may change year to year. Income will be verified using tax returns or other alternate financial documentation. In cases where income cannot be verified, or there are discrepancies, additional proof of income may be required.

2. PRESCRIPTION INFORMATION (CHECK BELOW TO APPLY FOR PAP)

☐ **Rx for PRIALT® (ziconotide) intrathecal infusion Patient Assistance Program**

☐ **I authorize the dispensing pharmacy to dispense all doses as one prescription**

Quantity: 1 mL vial_____ 1 for 5 mL vial_____ **Refills:**_____ **Target Start Date:**_____ / _____ / _____

Other Directions:

_____

With signature, I authorize TerSera Therapeutics and the specialty pharmacy to dispense PRIALT as part of the Patient Assistance Program.

Prescriber's Name (please print):_____

Prescriber's Signature (NO STAMPS):_____ Date: _____/____/_____

Please attach a separate prescription if this section does not comply with your state's prescription law.

3. PREFERRED SHIPPING LOCATION

☐ Prescriber's Office

☐ Other Address (eg, infusion center):

Facility Name:_____

Recipient Name:_____

Address:_____ City:_____State:_____ ZIP:_____

☐ **Rx for PRIALT is included or embedded with this fax**

4. REQUIRED: PATIENT SIGNATURE FOR INCOME VERIFICATION

I give my doctor, TerSera Therapeutics LLC (TerSera), and the Program administrator and their employees, agents, and contractors permission to use my personal information related to my medical condition, treatment, and management, as well as all information provided on this form, including contact and any prescription information ("Personal Health Information") to verify the information is true and complete; contact me about the Program and about other products, programs, or services that might interest me or for which I may be eligible; and contact me to ensure that I have received the medicines sent by the Program. I promise that all the information in this application, including all copies of documents proving my income, is true and complete; I am authorized to sign this application; I do not have any assistance or insurance that would help pay for my medicines; and I will contact the Program if any of my information about my prescription drug coverage or insurance changes. I understand that once disclosed to TerSera, my Personal Health Information disclosed under this consent form may be further disclosed and used to determine if I qualify to participate in the Program, administer or improve the Program, and/or communicate with insurance plans. I understand that I can call 1-855-686-8725 at any time to withdraw from the Program; cancel my permission to use my information and withdraw from the Program; and/or get a copy of the TerSera Privacy Policy. I understand that the Program can request more information from me at any time; and TerSera can change or stop the Program at any time for any reason. I understand that once my information has been disclosed, federal privacy laws, including HIPAA, may no longer restrict its use or disclosure. I may refuse to sign this authorization form, and if I refuse, my eligibility for health plan benefits and treatment by my healthcare provider will not change, but I will not have access to the Program. I give the Program, and the Program administrators, permission to contact the person named below with follow-up questions about my application (this only applies if someone completed this application for you). I understand that I may revoke this authorization at any time by sending written notice of revocation to TerSera Therapeutics LLC at 520 Lake Cook Road, Suite 500, Deerfield, IL 60015, except to the extent that action already has been taken in reliance on this authorization. I understand that I have a right to receive a copy of this signed authorization.

This authorization form will be effective for 1 year unless it expires earlier by law or I cancel it in writing. I have a right to receive a copy of this form after I have signed it.

Patient/Guardian Name (please print):_____

Patient's/Guardian's Signature: _____ **Date:**_____/____/_____

Upon receipt of a completed application, the healthcare professional and the patient will be notified of program eligibility. If the patient is eligible for this program, the prescribed quantity of PRIALT will be shipped to the address indicated in Section 3 above.

TerSera SupportSource is here to assist your patients.

Please see accompanying or click for Full Prescribing Information, including Boxed Warning.