XERMELO® (telotristat ethyl) tablets, 250 mg

For questions or to learn more, call: 1-844-XERMELO (937-6356) **fax:** 1-855-215-5318

TerSera SupportSource

1 Patient Information

***Required Field**

*First Name | *Last Name | ○ Male ○ Female | *DOB: MM/DD/YYYY

Email Address

*Street Address | *City | *State | *ZIP Code

*Mobile Telephone | Home Telephone

Caregiver First Name | Caregiver Last Name | Relationship to Patient

Caregiver Telephone

2 Patient Prescription Insurance Information

Please attach copies of both sides of patient's insurance card(s) ☐ **Check if patient does not have insurance**

Policyholder First Name | Policyholder Last Name | Relationship to Patient

*Primary Insurance | *Insurance Telephone | *Policy ID # | Group #

BIN # | PCN # | RxGroup #

Secondary Policyholder First Name | Secondary Policyholder Last Name | Relationship to Patient

Secondary Insurance | Insurance Telephone | Policy ID # | Group #

BIN # | PCN # | RxGroup #

3 Prescribing Physician Information

*First Name | *Last Name | Tax ID | Site Name

*Street Address | *City

*State | *ZIP Code | *Telephone | *Fax

Office Contact | *NPI #

4 Patient Diagnosis and Prescription

*ICD-10 Code/Diagnosis: ☐ E34.0 ☐ Other: _____

PRESCRIPTION

XERMELO® (telotristat ethyl) tablets

250 mg TID, 28-day supply

***Number of refills:** ☐ 3 months ☐ 6 months ☐ 12 months

Special Instructions: _____

I appoint TerSera, its affiliates and their representatives (collectively "TerSera") to convey on my behalf the prescription described herein to the pharmacy selected.

Sign here _____ _____

***Prescriber Signature** (stamps not acceptable) | *Date

Preferred pharmacy:

☐ Biologics

☐ In-office/clinic dispensing pharmacy or hospital/health system dispensing pharmacy

Pharmacy name: _____ Pharmacy phone: _____

☐ **PAP coverage (11 refills)†**

†Indicating a prescription for PAP does not guarantee patient will be eligible for PAP. Terms and conditions apply.

TID=three times per day.

5 Patient Financial Information (For PAP Application Only)‡

‡Income documentation will be required in order to assess program eligibility (ie, written patient attestation, 1040 tax return, SSA-1099, W-2 form).

Annual Household Income: $ _____

Source of Income: ☐ Job ☐ Family ☐ Public Assistance ☐ SSI/SSDI

☐ Other (Please explain): _____

Number of Household Members Dependent on Income (include applicant): _____

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6 Patient Authorization and TerSera SupportSource Enrollment

Please read and sign below.

I authorize my health plans and health care providers ("Health Care Entities") to disclose my personal health information ("PHI") to TerSera Therapeutics LLC ("TerSera Therapeutics"), its affiliates, their representatives, agents, and contractors (collectively, "TerSera") regarding my participating in the TerSera SupportSource Program ("Program") and use of Xermelo. My PHI shall include information about me, my medical condition, treatment, medications, family history, coverage, and payment, and other information relevant to the Program.

My PHI may be used by the TerSera to communicate with my Health Care Entities, anyone else I may designate, or me regarding the Program or any TerSera Therapeutics medications or therapies. It may be used regarding any prior authorizations ("PAs"), appeals and denials; insurance and other coverage and benefits investigations and verification; copayment, coinsurance, free medications, or patient or other assistance regarding my use or prescribed need for Xermelo. It may be used by TerSera to administer, evaluate, and improve the Program and for general business and administrative purposes. I also authorize my PHI to be used for clinical nurse educator, other education, and marketing activities in connection with the Program or my use of Xermelo.

I understand that certain persons or entities may receive remuneration for using or disclosing my PHI regarding Program and other TerSera Therapeutics activities. Once my PHI has been disclosed under this Authorization, it may no longer be subject to protections and safeguards under the HIPAA Privacy Rule or other privacy laws.

I may refuse to sign this Authorization. My refusing to sign this Authorization shall not impact my right to treatment, payment, enrollment in a health plan, or eligibility for benefits. However, if I revoke or decline to sign this Authorization, I will no longer be eligible to receive Program services. I understand that I may revoke this Authorization at any time by sending written notice of such to TerSera Therapeutics LLC, c/o TerSera SupportSource, 520 Lake Cook Road, Suite 500, Deerfield, IL 60015. Any revocation shall become effective upon receipt of such by any Health Care Entity, except to the extent that action already has been taken in reliance on this Authorization. I understand that I am entitled to receive a copy of this signed Authorization, which shall expire as of five (5) years from the date I have executed this Authorization, unless otherwise specified by State or other applicable law or revoked by me earlier in writing.

Patient Name	*Signature	*Date (MM/DD/YYYY)

***If Personal Representative signing:**

Name	Relationship to Patient/Legal Authority of Personal Representative†	Date (MM/DD/YYYY)

7 Consent for TerSera SupportSource Programs and Communications

Check box to accept.

By signing below, I authorize TerSera Therapeutics LLC, its affiliates, their representatives, agents, and contractors (collectively, "TerSera") to enroll me in the following programs, if I am eligible, to support the use of my Xermelo prescription. This may include the following programs: the clinical nurse educator program, copay assistance, and Patient Assistance program ("PAP"). Terms and conditions apply and can be found at TerSeraSupportSource.com. If I am enrolled in the PAP program, I hereby provide "written instructions" authorizing TerSera Therapeutics LLC and its vendor, under the Fair Credit Reporting Act, to obtain information from my credit profile or other information from EXPERIAN, solely for the purpose of determining financial qualifications for programs administered by TerSera Therapeutics LLC. I understand that I must affirmatively agree to these terms to proceed in this financial screening process.

☐ Text Consent: I consent to allow TerSera Therapeutics LLC (or its agents) ("TerSera") to send marketing and other text messages ("Texts") to any cell phone number(s) I have provided or may provide regarding the TerSera SupportSource Program ("Program"). Texts may be by automatic telephone dialing system ("ATDS") on a recurring basis regarding TerSera programs, products, goods, or services. Signing this Consent is not a condition of participating in the Program or obtaining or purchasing any programs, products, goods, or services from TerSera. I understand that my cell phone service provider may charge me fees for Texts sent to me. Message and data rates may apply; message frequency may vary; text HELP for help. Except as required by law, TerSera shall have no liability for the cost of any such Texts. TerSera Privacy Policy and Terms of Service shall apply. See Privacy Policy at TerSera.com/Privacy-Policy; Terms of Use at TerSera.com/Terms-of-Use. I may withdraw my consent to receive Texts by replying "STOP," "QUIT," "OPT OUT," "END," "CANCEL," "UNSUBSCRIBE," or "PLEASE OPT ME OUT" via return Text, or by contacting TerSera in writing at TerSera SupportSource, 520 Lake Cook Road, Suite 500, Deerfield, IL 60015.

Patient Name	*Signature	*Date (MM/DD/YYYY)

***If Personal Representative signing:**

Name	Relationship to Patient/Legal Authority of Personal Representative†	Date (MM/DD/YYYY)

To join separated form pages

Patient DOB

Patient ZIP Code

†A patient's Legally Authorized Representative is a person who is authorized under applicable law to act on behalf of the patient in making healthcare-related decisions.

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