ENROLLMENT FORM

Please complete and fax to 1-844-475-8931
For assistance or additional information,
call 1-844-VELOXIS, M-F, 9 am - 7 pm ET.

Veloxis | Transplant Support
1-844-VELOXIS (835-6947)

Enrolling in Veloxis Transplant Support

Veloxis has created the Veloxis Transplant Support program to assist patients in obtaining access to Veloxis medications. Applications are reviewed and eligibility is verified. Determinations are made on a case-by-case basis using pre-determined eligibility requirements regarding coverage and financial criteria.

After the Form has been submitted, including Financial Documentation and Insurance Cards, your Veloxis Transplant Support (VTS) Specialist will review the application and then notify both provider and patient of next steps.

ENROLLMENT INSTRUCTIONS

- **Patient completes Page 3 of this form, including patient or patient representative's signature**
  Financial disclosure, including verification of income, is only required if applying for the Patient Assistance Program.

  All other Veloxis Transplant Support services may be obtained without financial disclosure, but will still require the patient consent signature on the bottom of Page 3.

- **Fax complete application package to Veloxis Transplant Support at 1-844-475-8931**
  - ☑ Page 2 with Prescriber's Signature
  - ☑ Page 3 with Patient's or Patient Representatives' Signature
  - ☑ Copies of both sides of all Insurance Cards
  - ☑ If applying for the Patient Assistance Program, please sign the optional consent on Page 3 to authorize the electronic income verification and expedite the process through Experian Health **OR** provide income verification documents with this application.

    If the application is incomplete, VTS will attempt to contact the patient and provider to request the missing information or documentation.

Requesting the following, please check all that apply:

- ☐ Benefits Investigation
- ☐ Bridge Supply
- ☐ Patient Assistance Program (PAP) enrollment (based on eligibility; please include the appeal denial if you have it to expedite the process)

PATIENT ASSISTANCE PROGRAM DETAILS

Patients enrolled in the Patient Assistance Program are approved for a maximum of 12 months of eligibility at a time and must reapply to validate their eligibility annually. VTS will contact you to re-validate your eligibility for the Patient Assistance Program before the current eligibility period expires.

Note for Medicare Part D Participants: When interfacing with a Medicare Part D beneficiary, the Veloxis Patient Assistance Program will operate outside of the Medicare Part D benefit. Any assistance provided to a patient for drugs that would have been covered under their Medicare Part D plan will not count as an incurred cost that would be applied toward the enrollee's True Out-of-Pocket Costs (TrOOP) balance or total drug spend.

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PATIENT CONTACT INFORMATION

1. First Name | 2. Middle Name | 3.Last Name | 4. Date of Birth (MM/DD/YYYY)

5. Home Address | 6.City | 7. State | 8. Zip Code

9. Home Phone # | 10. Cell Phone # | 11. Email

12. Preferred contact method (select one): ☐ Phone Call ☐ Text ☐ Email

13. Preferred time to contact (select one): ☐ Morning ☐ Afternoon ☐ Evening

14. OK to Text (select one): ☐ YES ☐ NO

15. OK to leave voicemail (select one): ☐ YES ☐ NO

16. Preferred Language:

PATIENT INSURANCE INFORMATION

(please attach copies of patient applicant's insurance cards)

17. Pharmacy Benefit Plan Name:

17(a) Policy Holder Name: | 17(b). Insurance Phone #:

17(c). RX BIN: | 17(d). RX PCN: | 17(e). ID#: | 17(f). Rx Group#:

18. Patient has (select one): ☐No insurance ☐Medicare B ☐Medicare Advantage ☐Medicaid ☐Private/Commercial ☐ Government (TriCare/VA)

19. Primary Insurance	20. Secondary Insurance
19(a). Primary Insurance Name:	20(a). Secondary Insurance Name:
19(b). Policy Holder Name: First Name / Last Name	20(b). Policy Holder Name: First Name / Last Name
19(c). Insurance Phone #:	20(c). Insurance Phone #:
19(d). Policy ID #:	20(d). Policy ID #:
19(e). Group ID #:	20(e). Group ID #:

HEALTHCARE PROVIDER INFORMATION

21. First Name | 22. Last Name | 23. Specialty

24. Title (select one): ☐ MD ☐ DO ☐ NP ☐ PA ☐ other(specify):

25. NPI #: | 26. Tax ID #:

27. Practice Name:

28. Practice Address: | 29. City: | 30. State: | 31. Zip Code:

32. Practice Office Contact Title: | 32(a). Name:

32(b). Office Phone: | 32(c). Cell Phone: | 32(d). Contact Email: | 32(e). Fax:

32(f). Preferred method of contact (select one): ☐ Office Phone ☐ Cell Phone ☐ Email ☐ Fax

32(g). OK to text Cell Phone (select one): ☐ YES ☐ NO

PATIENT CLINICAL INFORMATION

33. Diagnosis (select one): ☐ Z94.0 Kidney transplant status (ICD-10) ☐ Other (specify)

34. Date of Transplant: | 35. Did Medicare pay for transplant (select one)? ☐ YES ☐ NO

36. Estimated total daily dose of ENVARSUS XR® (tacrolimus extended-release tablets): _____ mgs

37. Has a 30-day voucher of ENVARSUS XR® (tacrolimus extended-release tablets) been provided to the patient? (select one): ☐ YES ☐ NO

37(a). If YES, Date provided:

HEALTHCARE PROVIDER CERTIFICATION

By providing my signature below, I acknowledge and certify that I have received authorization from the patient applicant to release certain patient applicant information (provided herein) to Veloxis Pharmaceuticals and its service providers, agents, and administrators (collectively, the "Companies") to assist the patient applicant in obtaining access to ENVARSUS XR® (tacrolimus extended-release tablets). The Veloxis Transplant Support ("VTS") program may use and disclose the patient applicant information as necessary to enroll my patient in the VTS program should the patient applicant meet the eligibility criteria. I understand that I am under no obligation to prescribe ENVARSUS XR® and that I have not received nor will receive any benefit from Veloxis for prescribing a Veloxis product. I certify that I have prescribed ENVARSUS XR® for the patient for its FDA approved use based on my independent medical judgment that ENVARSUS XR® is medically necessary for the patient and that all information provided on the form is accurate. I attest that I am not on the HHS/OIG list of Excluded Individuals.

X_____ Prescriber's Printed Name

X_____ Prescriber's Signature

X_____ Date

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PATIENT FINANCIAL INFORMATION

38. Total annual household income: $

39. Sources of income (select all that apply):

☐ Salary Wages	☐ Social Security Income (SS, SSI, SSDI)	☐ Unemployment Compensation	☐ Pension/ Retirement	☐ Veterans Benefits	☐ Workers' Compensation	☐ Alimony/ Child Support	☐ Other:

40. Total number of people in household dependent on household income (including Patient):

Note: Proof of household income documentation will be required to determine eligibility for the Veloxis Transplant Support (VTS) Patient Assistance Program (PAP). Acceptable forms of documentation to provide proof of household income reported in this Section include the most recent copy of US federal tax return, Social Security income statements, the two most recent pay stubs, and unemployment or disability statements etc. ***Instead of providing proof of income documentation, you have the option to consent to an electronic financial screening process to verify household income in the section immediately below.***

PATIENT AUTHORIZATION FOR ELECTRONIC INCOME VERIFICATION (optional, but may reduce enrollment review time)

By providing my signature below, I, the patient applicant, understand that I am providing "written instructions" to Veloxis Pharmaceuticals and its service providers, agents, and administrators (collectively, the "Companies") under the Fair Credit Reporting Act, authorizing the Companies to obtain information from my credit profile or other information from Experian Health. I authorize the Companies to use and disclose my information solely for the purpose of determining my eligibility to enroll and participate in the Veloxis Transplant Support (VTS) program. I also agree to provide additional financial documentation in a timely manner, if requested. I understand that I must affirmatively agree to all the terms in this authorization in order to proceed in this optional electronic financial screening process. I understand that I am entitled to a copy of this authorization upon request. I understand that I may revoke this authorization at any time by sending a notice of revocation to patientsupport@veloxis.com. I understand that my revocation must be made in writing. I understand that my revocation shall not apply to any information already used or disclosed through this authorization before the VTS program received notice of my written revocation.

X_____ X_____ X_____
Patient's or Patient Representatives' Printed Name | Patient's or Patient Representatives' Signature | Date
Relationship to Patient: ☐ self ☐ legal guardian ☐ caregiver

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PATIENT'S PERSONAL HEALTH INFORMATION

By providing my signature below, I, the patient applicant, authorize my healthcare providers, pharmacies, insurance providers, and payers to use, share, and disclose my personal and health information, including information about my insurance benefits, prescriptions, medical condition and history, adherence to my treatment, my general health, and my sensitive health (e.g. communicable diseases (HIV, hepatitis), drug/alcohol abuse, mental health, genetic testing, etc.), (collectively, "Personal Information") with Veloxis Pharmaceuticals and its service providers, agents, and administrators (collectively, the "Companies") to: (1) establish my benefit eligibility; (2) provide support services, including facilitating the provision of Veloxis Pharmaceuticals medication to me; and (3) contact me to evaluate therapy and the effectiveness of the VTS program. I understand that once my Personal Information has been disclosed to the Companies, it may no longer be protected by federal privacy law and applicable state laws, and may be subject to redisclosure. I understand that any entity authorized to support the VTS program and any specialty pharmacies providing support to me in connection with the VTS program may receive remuneration from Veloxis Pharmaceuticals.

I understand that I do not need to sign this authorization in order to receive healthcare treatment from my healthcare provider(s), insurance benefits, or enrollment in a health plan. However, I understand that if refuse to sign this authorization, I will not be eligible to participant in the VTS program if I meet the eligibility criteria. I understand that if I give my authorization, I may revoke my authorization at any time by sending a notice of revocation to patientsupport@veloxis.com. I understand that my revocation must be made in writing. I understand that revoking this authorization will end my participation in the VTS program. I understand that my revocation shall not apply to any of my Personal Information that has already been used or disclosed through this authorization before the VTS program received notice of my written revocation. I understand that my revocation shall not apply to any of my Personal Information that has already been used or disclosed by the covered entities through this authorization before the covered entities received notice of my written revocation. I understand my authorizing signature will remain in effect until I am no longer eligible to participate in the VTS program, or Veloxis terminates the VTS program, or the maximum period permitted under state law, if shorter.

X_____ X_____ X_____
Patient's or Patient Representatives' Printed Name | Patient's or Patient Representatives' Signature | Date
Relationship to Patient: ☐ self ☐ legal guardian ☐ caregiver

PATIENT ATTESTATION OF NO INSURANCE COVERAGE (if applicable)

By providing my signature below, I, the patient applicant, attest and certify that I have no health insurance coverage.

X_____ X_____ X_____
Patient's or Patient Representatives' Printed Name | Patient's or Patient Representatives' Signature | Date
Relationship to Patient: ☐ self ☐ legal guardian ☐ caregiver

PATIENT DECLARATION

By providing my signature below, I, the patient applicant, verify that the information provided on this enrollment form is current, complete, and accurate. I understand that such information will be reviewed and relied upon to determine my eligibility for enrollment in the Veloxis Transplant Support ("VTS") program. I understand that completing this enrollment form does not guarantee that I will qualify for the VTS program. I understand that the VTS program may request additional documentation from me to verify my financial or insurance information, and that any assistance in the form of free medication is contingent upon my ability to meet the VTS program eligibility criteria. I understand Veloxis Pharmaceuticals reserves the right at any time and without notice to modify the enrollment form, modify or discontinue the VTS program and its eligibility criteria, or terminate my enrollment in the VTS program. I agree to notify and shall be responsible for notifying the VTS program if my financial information or insurance coverage changes or if I no longer meet the eligibility criteria for the VTS program.

I agree that I will not seek reimbursement or credit from, or submit a claim for Veloxis Pharmaceuticals medication(s) provided through the VTS program to any insurance provider, payer, health plan, or government program, including Medicare Part D Plans, or seek to have Veloxis Pharmaceutical medication(s) or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. I agree I will notify my insurance provider of my receipt of Veloxis Pharmaceuticals medication(s) provided through the VTS program. I understand and agree that if I am enrolled in a Medicare Part D Plan and eligible for the VTS program, the Companies will notify my Part D Plan of my enrollment in the VTS program. I understand that any Veloxis Pharmaceuticals medication supplied by the VTS program shall not be sold, traded or transferred.

X_____ X_____ X_____
Patient's or Patient Representatives' Printed Name | Patient's or Patient Representatives' Signature | Date
Relationship to Patient: ☐ self ☐ legal guardian ☐ caregiver

PATIENT TELEPHONE CONSUMER PROTECTION ACT CONSENT (optional)

By providing my signature below, I, the patient applicant, consent to receive enrollment status updates from VTS via telephone call and/or text message. Message and data rates may apply. The number of messages varies based on VTS program selection. Text STOP to cancel or opt out. I understand my consent is not required or a condition of participation in the VTS program.

X_____ X_____ X_____
Patient's or Patient Representatives' Printed Name | Patient's or Patient Representatives' Signature | Date
Relationship to Patient: ☐ self ☐ legal guardian ☐ caregiver