PRIALT (ZICONOTIDE) INTRATHECAL INFUSION

ACCESS & SUPPORT PROGRAM™

PRIALT Enrollment and Patient Authorization Form
ENROLLMENT FORM (PAGE 1 OF 2)

PLEASE NOTE:
- **Complete all fields to avoid delay in benefit investigation processing.**
- **Enrollment form (page 1) must be signed by the Prescriber.**
- **Patient authorization (page 2) must be signed by the Patient.**
- **Include copy of both front and back of patient's insurance card(s).**

Call toll free 1-855-774-2581 (1-855 PRIALT1)
Mon-Fri 8:00 am to 8:00 pm EST
Fax to 1-855-774-2583 (1-855-PRIALT3)
www.prialt.com

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: _____

Worker's Comp Claim: ☐ Yes ☐ No If yes, date of injury: _____

Secondary insurance (if applicable): _____ Policy ID#: _____ Group #: _____ Phone #: _____

3. PRESCRIBER INFORMATION

Prescriber name: _____ Office contact name: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

Practice name: _____ MD specialty: _____

NPI #: _____ State Med Lic #: _____ Tax ID #: _____ PTAN: _____

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

4. DIAGNOSIS, CLINICAL & TREATMENT INFORMATION

Diagnosis: _____ ICD-10 code: _____

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

Check one: ☐ Monotherapy ☐ Other (explain): _____ Currently taking PRIALT? ☐ Yes ☐ No Start date: _____

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

Treatment: PRIALT® (ziconotide) intrathecal infusion (NOTE: Maximum PRIALT dose 19.2 mcg/d (0.8 mcg/hr)

Vial Size: Check one: ☐ 25 mcg/mL ☐ 100 mcg/mL (1 mL vial) ☐ 100 mcg/mL (5 mL vial)

Daily dose (mcg/d): _____ Refill frequency/date: _____

Other drug(s) prescribed with PRIALT: _____

Program options: Select your preferred option(s):

I will order PRIALT: (please select a box and fill in the blank if you have a specific preference(s)

☐ Directly through a wholesaler ☐ From _____ Pharmacy/Home Infusion

☐ I would like the patient to be contacted (once patient authorization is received) for Program Overview (services overview and explanation of benefits investigation report)

5. PRESCRIBER'S SIGNATURE

By signing below, I certify that (a) the above-prescribed therapy is medically necessary and (b) that I have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or patient information relating to the need for the above-prescribed therapy(ies), to TerSera Therapeutics and its agencies or contractors for the purpose of seeking information related to coverage for the therapy(ies) and/or assisting in initiating or continuing therapy.

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

PRIALT Enrollment and Patient Authorization Form
PATIENT AUTHORIZATION FORM (PAGE 2 OF 2)

PLEASE NOTE:
- **Complete all fields to avoid delay in benefit investigation processing.**
- **Enrollment form (page 1) must be signed by the Prescriber.**
- **Patient authorization (page 2) must be signed by the Patient.**
- **Include copy of both front and back of patient's insurance card(s).**

Call toll free 1-855-774-2581 (1-855 PRIALT1)
Mon-Fri 8:00 am to 8:00 pm EST
Fax to 1-855-774-2583 (1-855-PRIALT3)
www.prialt.com

6. PATIENT AUTHORIZATION

To access Patient Authorization Form on-line, please visit prialtehipaa.com

By signing this authorization, I understand I agree to the collection, disclosure and use of my personal health information, including but not limited to, name, address, social security number, telephone number, insurance information, medical condition and treatment (including prescriptions), medical records and other information contained on this form or provided by authorized persons ("Personal Health Information"). I hereby authorize each of my doctor(s) and their staff, health plans, insurers, hospitals, clinics, pharmacies, distributors or other health care providers and those working on their behalf to disclose my Personal Health Information to TerSera Therapeutics, its employees, affiliates and their representatives, its business partners, agents, and contractors, in connection with the PRIALT support program described to me (the "Program"). I understand that my Personal Health Information will be used for the following purposes: (i) verifying, investigating, coordinating and resolving insurance coverage or reimbursement inquiries and payment for PRIALT; (ii) enrolling me in and contacting me about the Program, including providing me with educational materials and information, services related to my therapy or my medical condition; (iii) contacting and providing my Personal Health Information to my insurer, patient advocacy organizations, patient assistance programs, co-pay assistance or similar programs to determine eligibility for coverage and enrolling me in such programs; (iv) managing the Program; and (v) conducting market research or other commercial activity, or aggregating my Personal Health Information with other data for such analysis. I understand that TerSera Therapeutics, through the Program, may report back to my healthcare professional(s) any Personal Health Information about me that they may create or receive. I agree that TerSera Therapeutics may contact me in the future via email, mail, and by text message or live, auto dialed and/or prerecorded messages at the telephone numbers provided by me.

I understand that once my health information is disclosed it may no longer be protected by federal or state law regarding patient privacy and it may be subject to re-disclosure without my permission. I understand that I may refuse to sign this authorization or revoke it at any time in the future, and my refusal or future revocation will not affect my treatment, payment or eligibility for benefits. This authorization will remain valid for ten (10) years after the date of my signature, unless I cancel it earlier by mailing a letter requesting such cancellation to TerSera Therapeutics, P.O. Box 30831, Bethesda, MD 20824, or calling 1-855-PRIALT1 (1-855-774-2581) ; however, revoking this authorization will not impact TerSera Therapeutics ability to use and disclose Personal Health Information it has received prior to the cancellation. I also understand that the Program may be changed or ended at any time without prior notification. I understand that I am entitled to a copy of this Authorization.

I verify that the information provided is true and correct. If I am the caregiver for the patient, I confirm that I am authorized to sign on behalf of the patient.

Patient or Legal Guardian's Original Signature: _____ **Date:** _____

Patient Name: _____ Date of Birth: _____

Patient Representative's Name (if signing for patient): _____

Relationship to patient (spouse, legal guardian, etc.): _____

Patient's Address: _____

City: _____ State: _____ Zipcode: _____ Home Phone: _____

By providing your consent, you are authorizing the release of your personal health information and contact information for patient support services (Prialt Savings Program). The purpose of collecting your information is to allow us to send you information you request or to contact you about TerSera Therapeutics product, programs, and services, or to conduct market research. Your information will not be sold to third parties. This program is optional but if you chose to withhold your contact information, it may not be possible for you to participate. We also offer you the option to discontinue your consent by opting out if you decide you no longer want to participate.

☐ I Agree ☐ I Do Not Agree