Nobelpharma connect

Nobelpharma Connect
PHONE: 1-877-649-3867 | FAX: 1-877-240-3022
PO BOX 221133, Charlotte, NC 28222
Monday–Friday 8AM–6PM ET

Prescription and Enrollment Form – Please read instructions below

All patients should complete Sections 1-4 (**blue**) and healthcare providers should complete Sections 5-7 (**green**).
Patients applying for the Patient Assistance Program should also complete Sections 8-9 (**orange**)
Please fax to 877-240-3022 or you may complete and electronically sign at www.nobelpharmaconnectenrollment.com.
For assistance, please call Nobelpharma Connect at 1-877-649-3867

SECTION 1: PATIENT INFORMATION TO BE COMPLETED BY ALL PATIENTS * INDICATES A REQUIRED FIELD

SEX ☐ M ☐ F

* PATIENT NAME (FIRST, MI, LAST)

* STREET ADDRESS | * CITY | * STATE | * ZIP

* DATE OF BIRTH (MM/DD/YY) | * PRIMARY PHONE | ALTERNATE PHONE | ☐ OKAY TO LEAVE MESSAGE

LANGUAGE PREFERENCE | CAREGIVER NAME | RELATIONSHIP TO PATIENT | CAREGIVER PHONE

SECTION 2: INSURANCE INFORMATION TO BE COMPLETED BY ALL PATIENTS INCLUDE A COPY OF INSURANCE

	PRIMARY INSURANCE	SECONDARY INSURANCE	PRESCRIPTION INSURANCE
INSURANCE / PAYER NAME			
INSURANCE PLAN NAME			
POLICYHOLDER NAME			
POLICYHOLDER DOB			
POLICY ID NUMBER			
GROUP NUMBER			
INSURANCE PHONE NUMBER			
RX BIN	Not Applicable	Not Applicable	
PCN	Not Applicable	Not Applicable	

SECTION 3: PATIENT CONSENT AND AUTHORIZATION TO BE COMPLETED BY ALL PATIENTS

I acknowledge and certify that I agree to comply with the terms and conditions described below and that I understand the following:

- I am over the age of 18 years and I am a permanent legal resident of the U.S. or U.S. Territory (including Guam, Puerto Rico, and the Virgin Islands).
- I have a current prescription for HYFTOR™ for an FDA-approved indication.
- I understand that completing this enrollment form does not guarantee enrollment.
- Nobelpharma America, LLC and their affiliates and vendors reserve the right to modify or discontinue any of the Nobelpharma Connect Programs or my enrollment at any time and to verify the accuracy of information submitted. Completing this application does not ensure that I will qualify for this program.
- I understand that I must be commercially insured in order to be eligible for the **CoPay** Program.
- I certify that I will not seek reimbursement or credit for this prescription requested under the **Quick Start** or **Bridge** Program from any insurer, health plan, or government program, and if I am a member of a Medicare Part D plan, I will not seek to have this prescription, or any cost associated with it, counted as part of my out-of-pocket cost for prescription drugs.
- I understand that any drugs provided under the Nobelpharma Connect Programs shall not be sold, traded, bartered, or transferred.
- I authorize Nobelpharma Connect, Nobelpharma, and/or parties working on their behalf to contact me by mail, phone, or email with information about the Program, my eligibility for the Program, my condition, promotions, services, and research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys. If I have a caregiver, he or she has also agreed to receive such communications from Nobelpharma Connect on behalf of the patient for the purposes described herein and I hereby give my permission for Nobelpharma Connect to contact my caregiver for

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such purposes. If I have a caregiver, he or she has also agreed to receive such communications.

- I further authorize Nobelpharma Connect, Nobelpharma, and/or parties working on their behalf to de-identify my health information and use it in performing research, education, business analytics, marketing studies or for other commercial purposes, including linkage with other de-identified information Nobelpharma Connect receives from other sources. I understand that I do not have to enroll in the Program or receive Communications, and I can still receive HYFTOR™ (sirolimus topical gel), as prescribed by my Healthcare Providers.
- Further, I understand that if I refuse to sign this Authorization, I will not be able to participate in the Nobelpharma Connect Programs, but it will not affect my eligibility to obtain medical treatment, my ability to seek payment for this treatment, or my insurance enrollment or eligibility for insurance coverage. However, if I do not sign this form, Nobelpharma Connect may not be able to provide me / the patient with assistance.
- I may opt out (withdraw) my authorization at any time from receiving Communications or opt out entirely from the Nobelpharma Connect Program by notifying a Program representative by phone at 1-877-649-3867 or by sending a letter to Nobelpharma Connect, PO Box 221133, Charlotte, NC 28222. I also understand that the services provided under the Program may be revised, changed, or terminated at any time. Withdrawal of this Authorization will end my participation in the Nobelpharma Connect Program(s) and will not affect any disclosure of my information based on this Authorization made before my request is received and processed by my Healthcare Providers, Health Insurers, and Specialty Pharmacies.
- This Authorization expires twenty-four (24) months from the authorization date under any Nobelpharma Connect Program, subject to applicable law, unless I withdraw it earlier. I understand that I may request a copy of this Authorization.

Nobelpharma Connect Terms and Conditions: By using this program and signing below, I acknowledge and confirm that the information I am providing is correct, and that I currently meet the eligibility criteria and will comply with these terms and conditions:

- The **CoPay** Program is not a health insurance benefit plan. Patient must have private insurance that covers the prescribed medicine, but the insurance plan does not cover the full cost. Not valid when the entire cost of the prescription drug is eligible to be reimbursed by a private insurance plan or other private health or pharmacy benefit programs. Offer is not valid for cash paying patients. For any reimbursement requests submitted to a private insurance plan, either by the patient or on behalf of the patient, the patient must deduct the value of any Copay Assistance received. The patient is responsible for reporting use of the **CoPay** Program to any private insurer, health plan, or other third party who pays for or reimburses any part of the prescription filled using the copay program, as required. The patient should not use the **CoPay** Program if the insurer or health plan prohibits use of manufacturer **CoPay** Programs.
- If eligible and enrolled in the **CoPay** Program, the patient's copay information will be shared with the patient's physician or the designated specialty pharmacy, and any assistance with the patient's applicable cost-sharing or copay will be made in accordance with the program terms and conditions.
- I authorize the Nobelpharma Connect **CoPay** Program to provide payment directly to my healthcare provider for my out-of-pocket drug cost when my healthcare provider submits a copay claim. I also authorize my healthcare provider to contact Nobelpharma Connect on my behalf and I understand that I will be responsible for any out-of-pocket expenses for the drug if my healthcare provider does not request payment within the required timeframe.
- Patients are not eligible to participate in the **CoPay** Program if they are enrolled in a state or federally funded insurance program, including but not limited to Medicare, Medicare Part D, Medicaid, Medigap, TRICARE, Veteran Affairs health care, CHAMPUS, Department of Defense (DoD), a state prescription drug assistance program, or the Government Health Insurance Plan available in Puerto Rico.
- Patient will be responsible for any out-of-pocket expenses if deemed ineligible for reimbursement from the **CoPay** Program and will not seek payment for or accept reimbursement from any third-party payer, including any federal healthcare program such as Medicare or Medicaid, or any private or other insurance plan for any free HYFTOR™ supplied under this program.
- This **CoPay** Program is not valid where prohibited by law, and cannot be combined with any other savings, free trial, or similar offer for the specified prescription. The **CoPay** Program will be accepted only at participating pharmacies. If the patient's pharmacy does not participate, the patient may be able to submit a request for a rebate in connection with this offer.
- I understand that the **CoPay** Program is limited to one per person during its term and is not transferable. Use of a **CoPay** Program card may not be redeemed more than once per 13 days per patient. No other purchase is necessary. No membership fee applies. Annual limits apply. Limitations apply.
- To be eligible for the **Quick Start** Program, I am new to HYFTOR™ therapy and experienced an insurance-related delay in access to therapy of at least five (5) business days. As indicated above, I will not seek reimbursement or credit for this prescription.
- To be eligible for the **Bridge** Program, this is not my first prescription for HYFTOR™ and have experienced an unexpected loss of coverage or authorization in my insurance, e.g.: (1) A current patient who started therapy with insurance coverage but no longer has coverage, or, (2) A current patient who is transitioning from one insurance program to another and is waiting for coverage determination. I will not seek reimbursement or credit for this prescription.

All Patients must check this box and sign below **If patient is under 18 years of age, provide legal guardian signature and date.:**

☐ I have read the program enrollment consent and authorization, and the terms and conditions for the Nobelpharma Connect Programs above. I certify that the information provided is true and correct and provide my authorization for participation in Nobelpharma Connect.

* **PRINT NAME OF PATIENT**	* **PRINT NAME OF LEGAL GUARDIAN** (IF PATIENT IS < 18 YEARS OF AGE)	* **LEGAL GUARDIAN RELATIONSHIP TO PATIENT**
PATIENT SIGNATURE (IF ≥ 18 YEARS OF AGE)	**LEGAL GUARDIAN SIGNATURE** (IF PATIENT IS < 18 YEARS OF AGE)	* **SIGNATURE DATE** (MM/DD/YYYY)

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SECTION 4: PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION TO BE COMPLETED BY ALL PATIENTS

By signing below, I agree and authorize my physicians, pharmacies, laboratories, and other healthcare providers and staff ("Healthcare Providers"); my health insurer, health plan or programs that provide my healthcare benefits (together, "Health Insurers"); and any specialty pharmacies ("Specialty Pharmacies") that dispense my medication to disclose Nobelpharma America, LLC, the Nobelpharma Connect Programs and their respective parents, affiliates, subsidiaries, officers, directors, employees, agents, representatives or vendors (collectively, "Nobelpharma") health information about me, including information related to my medical condition, treatment with HYFTOR™ (sirolimus topical gel), health insurance coverage, claims, prescription, and referral to and enrollment in the Nobelpharma Connect Programs, as well as identifying information about me (including, for example, my name, address, social security number, and date of birth, and my financial and insurance information) (together, "My Information"). My Healthcare Providers, Health Insurers, Specialty Pharmacies, and Nobelpharma may use and disclose "My Information" for the purposes of providing certain support services, including:

- Determine if I am eligible to participate in Nobelpharma Connect reimbursement and coverage assistance programs, CoPay Programs, Patient Assistance Programs, Quick Start or Bridge Programs, and other support programs (together, "Nobelpharma Connect Programs");
- To investigate my insurance coverage benefits and obtain prior authorization for coverage and reimbursement of HYFTOR™;
- To coordinate my receipt of and payment for HYFTOR™;
- To provide me with educational information and materials related to my enrolled services;
- To invite me to participate in optional surveys about my treatment;
- To operate and administer the Nobelpharma Connect Programs; and/or
- Refer me to, or to determine eligibility for, other programs and/or alternate sources of funding — such as Medicaid, Healthcare Exchanges, Medigap, state pharmaceutical assistance programs, and charitable foundations — that may be available to provide assistance to me with the costs of my medications.
- I understand that if I refuse to sign this Authorization, I will not be able to participate in the Nobelpharma Connect Program, but it will not affect my eligibility to obtain medical treatment, my ability to seek payment for this treatment, or my insurance enrollment or eligibility for insurance coverage
- I understand that, once "My Information" has been disclosed to Nobelpharma Connect, federal and state privacy laws may no longer protect it from further disclosure. However, Nobelpharma Connect has agreed to protect "My Information" by using and disclosing it only for the purposes authorized in this Authorization or as otherwise required by law.
- I understand that I may be contacted by Nobelpharma Connect in the event that I report an adverse event. I understand that "My Healthcare Providers", "Health Insurers", and "Specialty Pharmacies" may receive remuneration from Nobelpharma in exchange for disclosing "My Information" to Nobelpharma Connect and providing me with support services in connection with HYFTOR™ or the Nobelpharma Connect Program.
- This Authorization expires twenty-four (24) months from the authorization date under any Nobelpharma Connect Program, subject to applicable law, unless I provide written notice that I would like to withdraw my approval to share "My Information" sooner. If I would like to withdraw my approval, I may contact my physician or I may contact Nobelpharma Connect by phone at 1-877-649-3867 or by sending a letter to Nobelpharma Connect, PO Box 221133, Charlotte, NC 28222. I understand that such a withdrawal of my approval will not apply to such uses or disclosures made before Nobelpharma Connect receives my statement of withdrawal. I understand I may receive a copy of this Authorization.

If patient is under 18 years of age, print name should be of the legal guardian along with the legal guardian signature and date.

* PRINT NAME OF PATIENT	* PRINT NAME OF LEGAL GUARDIAN (IF PATIENT IS < 18 YEARS OF AGE)	* LEGAL GUARDIAN RELATIONSHIP TO PATIENT

SECTION 5: PRESCRIBER INFORMATION TO BE COMPLETED BY THE HEALTHCARE PROVIDER ONLY

* PRESCRIBER NAME (FIRST, MI, LAST)		* PRACTICE / INSTITUTION NAME	
* STREET ADDRESS	* CITY	* STATE	* ZIP
* OFFICE PHONE	* OFFICE FAX	* OFFICE CONTACT	
* OFFICE CONTACT PHONE NUMBER	* GROUP TAX ID	* NPI NUMBER	* STATE LICENSE NUMBER

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SECTION 6: PRESCRIPTION INFORMATION TO BE COMPLETED BY THE HEALTHCARE PROVIDER ONLY

PRESCRIPTION: HYFTOR™ (sirolimus topical gel) SEE FULL PRESCRIBING INFORMATION AT HYFTORPI.COM INFORMATION FOR DOSING INSTRUCTIONS

Prescribers in all states must comply with the prescription requirements of their state. For prescribers in states with official prescription form requirements, such as New York, please submit prescriptions on an official state prescription form, in addition to this enrollment form. Prescribers may need to submit an electronic prescription to the Specialty Pharmacy.

* **PATIENT NAME** (FIRST, MI, LAST) * **PATIENT DOB** (MM/DD/YYYY) * **PRIMARY DIAGNOSIS CODE:** _____
SECONDARY DIAGNOSIS CODE: _____

DRUG ALLERGIES ☐ NO KNOWN DRUG ALLERGIES **CONCURRENT MEDICATIONS** ☐ NO KNOWN CONCURRENT MEDICATIONS

Please use the checkboxes to indicate the medication being requested, and if applicable, check the quantity and number of refills being requested.

☐ **HYFTOR™ QUICK START** **Dispense:** ☐ 1 TUBE (10 g / 1 tube) REFILLS = 1
STARTER is LIMITED and available for eligible patients at no cost (dispensed by Nobelpharma Connect)

☐ **HYFTOR™ BRIDGE** **Dispense:** ☐ 2 TUBES (10 g / 1 tube) ☐ 4 TUBES (10 g / 1 tube) REFILLS = Ø
BRIDGE is available AS NEEDED for eligible patients at no cost (dispensed by Nobelpharma Connect)

☐ **HYFTOR™ MAINTENANCE** **Dispense:** _____ TUBE(S) (10 g / 1 tube) REFILLS = ____

DIRECTIONS:
☐ Apply topical gel to the affected area of the face twice a day, at morning and bedtime

If Other Directions:

* **PRESCRIBER SIGNATURE** (NO STAMPS) * **PRESCRIBER SIGNATURE DATE**

* **PRINTED NAME OF PRESCRIBER** **COLLABORATIVE PHYSICIAN NAME** (IF APPLICABLE)

SECTION 7: PRESCRIBER CERTIFICATION TO BE COMPLETED BY THE HEALTHCARE PROVIDER ONLY

By signing below, I represent and warrant the following:

- This Enrollment Form has been prepared exclusively by the healthcare provider identified in this Enrollment Form and/or support staff of the healthcare provider. I understand that completing this enrollment form does not guarantee enrollment and that the Programs may be modified or discontinued at any time and without notice
- I represent and warrant that I am authorized pursuant to the laws of my state of license to prescribe HYFTOR™ (sirolimus topical gel).0.2%.I have prescribed HYFTOR™ to the patient indicated on this form in the exercise of my independent medical judgment for an indication approved by the Food and Drug Administration. I certify that, to the best of my knowledge, the patient meets the criteria set forth in the Terms and Conditions, and that the information I am providing on this form is true and correct.
- I, or others in my healthcare provider practice group, ("my Practice") have obtained written authorization from the patient named in this Enrollment Form that complies with the requirements of the HIPAA Privacy Rule, 45 C.F.R. § 164.508, and authorizes me and the Practice, as well as the patient's health insurance plan(s), to disclose the patient's personal health information ("PHI"), including information relating to the patient's medical condition and prescription medications and the information disclosed in this Enrollment Form to Nobelpharma, Nobelpharma Connect and the Nobelpharma Connect Programs collectively, "the Programs" and authorizes the Programs (together with their respective administrators, contractors, or other affiliates) to use and disclose the PHI for purposes of benefits investigation and reimbursement support.
- I certify that I, or a healthcare provider in my Practice, have determined that the prescribed product is medically appropriate for the patient identified above and that I, or a healthcare provider in my Practice, will be supervising the patient's treatment.
- I certify that I/my office have not and will not charge any fee to complete this form.
- If my patient obtains Nobelpharma prescription products via the **Quick Start**, **Bridge, or Patient Assistance** Program, I attest that I understand and agree to the following: (i) No third party or patient can be charged for such products under such program; (ii) No free product should be sold, traded, distributed for sale, transferred, returned for a credit, or submitted to any third party (such as Medicare, Medicaid or other benefit provider) for reimbursement and will not apply any such product towards the patient's True-Out-Of-Pocket (TrOOP) costs; (iii) Any free drug provided is not contingent upon future purchase or prescribing of any Nobelpharma prescription product
- I will notify Nobelpharma Connect immediately if the product is no longer medically necessary for treatment or if my patient's insurance or financial status changes.
- I understand that information concerning Program participants may be summarized for statistical or other purposes and provided to Nobelpharma Connect and/or the Programs only for use in an aggregated, de-identified format.
- I and my Practice grant Nobepharma Connect the right to conduct periodic audits of my Practice's records to verify the information provided herein, excluding patient-identifiable data (unless the auditor enters into an appropriate agreement with my Practice to protect an individual's medical privacy).
- I certify that I/my office will not consider the fact that the patient may receive a benefit from the **CoPay** Program when determining the amount of any charge(s) to the patient and I/my office will not advertise or otherwise use the **CoPay** Program as means of promoting my services or HYFTOR™.
- I understand that I am/my office is responsible for reporting receipt of **CoPay** Program benefits to any insurer, health plan, or other third party that pays for or reimburses any part of the medication cost paid for by the **CoPay** Program, as may be required.
- I understand and agree that the certifications I am providing in this Healthcare Provider Certification apply to the patient indicated on this form and to any other patient enrolled in the Program who I treat with HYFTOR™ and any claim I submit/my office submits under the Program benefits on the patient's behalf. I understand that I may be asked to sign a new Healthcare Provider Certification if the Terms and Conditions of the Nobelpharma Connect Programs change.

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- I consent to receive communications related to the Programs by phone, email, and fax.
- I understand that Nobelpharma Connect may provide an initial, limited free product starter shipment (**Quick Start**) for eligible patients for two weeks. If a Prior Authorization is required from the insurer and extends beyond the 14 days for the initial starter product, a refill may be sent.
- Prescriber Declaration: I certify that the information provided above is true and that HYFTOR™ is being prescribed for the patient listed above. I hereby certify that, for any insured patient seeking assistance under the **CoPay** Program, in the absence of financial support from such program, any applicable copay, coinsurance, or other out-of-pocket cost for HYFTOR™ would be collected from the patient upon treatment. I appoint Nobelpharma Connect, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. **Special Note**: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.
- The information provided is complete and accurate to the best of my knowledge.

*** SIGNATURE OF HEALTHCARE PROVIDER** *** HEALTHCARE PROVIDER SIGNATURE DATE**

SECTION 8: PATIENT FINANCIAL INFORMATION TO BE COMPLETED BY PATIENT ONLY IF ENROLLING IN THE PATIENT ASSISTANCE PROGRAM (PAP)

Annual Pretax Household Income: $

Number Living in the Household
(Including members under 18 years)**:**

Please submit documentation to support the financial information you've listed. Attached is:

☐ **Most recent federal tax return** ☐ **W-2 form** ☐ **Other**

SECTION 9: PATIENT CONSENT AND AUTHORIZATION TO BE COMPLETED BY PAP PATIENT ONLY

By signing below, I acknowledge and certify, *in addition to the Consent and Authorization in Sections 3 and 4 above* as follows:

- I certify that the financial information provided is true and accurate and I will notify Nobelpharma Connect immediately if my financial information changes.
- I certify that I will not seek reimbursement or credit for this prescription requested under the Programs from any insurer, health plan, or government program, and if I am a member of a Medicare Part D plan, I will not seek to have this prescription, or any cost associated with it, counted as part of my out-of-pocket cost for prescription drugs. I will not seek reimbursement or credit for the medicine(s) from my prescription insurance provider or payor, including Medicare Part D plans for any costs of medications. I will notify my insurance provider of the receipt of any medicines through Nobelpharma Connect.
- I understand that any drugs provided under the Nobelpharma Connect Programs shall not be sold, traded, bartered, or transferred

Nobelpharma Connect Patient Assistance Program and Fair Credit Reporting Act (FCRA) Authorization::

- I understand that I am authorizing the Nobelpharma Connect Program, under the FCRA, to obtain information from my credit profile or other information from consumer reporting agencies for the purposes of determining financial qualifications for programs administered by Nobelpharma Connect Program. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I promise that any information, including financial and insurance information that I provide are complete and true and, unless I have indicated otherwise, I have no drug insurance coverage, which includes Medicaid, Medicare, or any public or private assistance programs or any other form of insurance. I understand that, upon request, Nobelpharma Connect will tell me whether an individual consumer report was requested and the name and address of the agency that furnished it.
- I also understand that to qualify for the Nobelpharma Connect Patient Assistance Program that I must meet certain income and other eligibility requirements, and further confirm my agreement with the conditions and certify that the information I have set forth in this application, including in Section 3, and including the number of people in my household and my household income, are true and accurate to the best of my knowledge. Nobelpharma Connect may ask for proof of income at any time for the purpose of an audit or verification. If requested, I agree to provide proof of income within 30 days of the request. Continuation in the program is conditioned upon timely verification of income.

All Applicants must check this box:

☐ I have read the foregoing consent and authorization and provide my authorization for participation in the Patient Assistance Program

If patient is under 18 years of age, print name should be of the legal guardian along with the legal guardian signature and date.

*** PRINT NAME OF PATIENT**	*** PRINT NAME OF LEGAL GUARDIAN** (IF PATIENT IS < 18 YEARS OF AGE)	*** LEGAL GUARDIAN RELATIONSHIP TO PATIENT**
PATIENT SIGNATURE (IF ≥ 18 YEARS OF AGE)	**LEGAL GUARDIAN SIGNATURE** (IF PATIENT IS < 18 YEARS OF AGE)	*** SIGNATURE DATE** (MM/DD/YYYY)