Enjaymo
sutimlimab-jome
Injection for intravenous use
1100 mg/22 mL

Recordati Rare Diseases Patient Solutions Enrollment Form

Complete the entire form and fax to 888-241-3572
Call us 8AM-5PM ET Monday-Friday at 833-223-2428

www.ENJAYMO.com

1 PATIENT INFORMATION (REQUIRED)

PATIENT FIRST NAME _____ LAST NAME _____ MIDDLE INITIAL _____

DATE OF BIRTH _____ LAST 4 DIGITS OF SSN _____ ☐ MALE ☐ FEMALE ☐ OTHER

STREET ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP _____

CELL PHONE ( ) _____ OTHER PHONE ( ) _____ ☐ OK TO LEAVE A MESSAGE

EMAIL ADDRESS _____

CAREGIVER (IF APPLICABLE) _____ PHONE ( ) _____

PATIENT'S PRIMARY LANGUAGE ☐ ENGLISH ☐ OTHER IF OTHER, PLEASE SPECIFY _____

2 HOUSEHOLD INCOME

REQUIRED IF REQUESTING THE PATIENT ASSISTANCE PROGRAM.

NUMBER OF HOUSEHOLD MEMBERS _____
(Including patient)

CURRENT ANNUAL HOUSEHOLD INCOME $ _____
(Please include: after-tax wages, pension, interest/dividends, Social Security benefits, and any other sources of income.)

Please refer to Section 8, Patient Authorization, for additional information about the Recordati Rare Diseases Patient Solutions financial assistance programs.

Verification of income is required for participation in the Recordati Rare Diseases Patient Solutions Patient Assistance Program. Acceptable documentation includes a W-2, IRS-1040, or 2 recent paystubs.

3 INSURANCE INFORMATION

PLEASE ATTACH COPIES (FRONT AND BACK) OF ALL AVAILABLE INSURANCE AND PRESCRIPTION CARDS. ☐ **NO INSURANCE**

PRIMARY MEDICAL INSURANCE NAME _____

INSURANCE PHONE ( ) _____ POLICY ID # _____

GROUP # _____ POLICYHOLDER NAME (FIRST/LAST) _____

EMPLOYER OF POLICYHOLDER _____ RELATIONSHIP TO PATIENT _____

PRESCRIPTION DRUG INSURANCE NAME (IF DIFFERENT) _____

INSURANCE PHONE ( ) _____

POLICY ID # _____ GROUP # _____

RXBIN # _____ RXPCN # _____

SECONDARY MEDICAL INSURANCE NAME _____

INSURANCE PHONE ( ) _____ POLICY ID # _____

GROUP # _____ POLICYHOLDER NAME (FIRST/LAST) _____

Patient to Fill Out

Prescriber, please complete page 2 and have patient read and sign page 3.

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4 PRESCRIBER INFORMATION (REQUIRED)—Specialty pharmacy will need to contact the provider prior to dispensing

PRESCRIBER NAME _____ PRESCRIBER FACILITY NAME _____

OFFICE CONTACT NAME _____

SPECIALTY _____ OFFICE CONTACT EMAIL _____

ADDRESS _____ PHONE ( ) _____

CITY _____ STATE _____ ZIP _____ FAX ( ) _____

NPI _____ TAX ID _____ STATE LICENSE _____

5 INFUSION SITE LOCATION

☐ **I HAVE NOT IDENTIFIED AN INFUSION SITE**

PLEASE SPECIFY INFUSION SITE LOCATION IF KNOWN: ☐ OFFICE ☐ INFUSION CENTER ☐ PATIENT'S HOME (SEPARATE NURSING ORDERS WILL BE REQUESTED)

IF INFUSION CENTER NAME IS KNOWN AND DIFFERENT FROM PRESCRIBER ABOVE, PLEASE PROVIDE:

NAME _____ PHONE ( ) _____

STREET ADDRESS _____ SUITE # _____

CITY _____ STATE _____ ZIP _____

6 CLINICAL INFORMATION

DIAGNOSIS: COLD AUTOIMMUNE HEMOLYTIC ANEMIA

☐ ICD-10 CODE D59.12 ☐ OTHER: _____ WEIGHT: _____ (☐ kg / ☐ lb) DATE RECORDED _____

7 PRESCRIPTION INFORMATION

PATIENT NAME (FIRST, MI, LAST) _____ DATE OF BIRTH (MM/DD/YYYY) _____

MEDICATION: ENJAYMO (sutimlimab-jome) 1100 mg/22 mL (50 mg/mL)

DIRECTIONS FOR USE & QUANTITY

☐ 6.5g **STARTING DOSE:** Administer 6 vials IV weekly for the first 2 weeks
Dispense #12 vials

☐ 6.5g **ONGOING DOSE:** Administer 6 vials IV every 2 weeks
Dispense #12 vials

☐ 7.5g **STARTING DOSE:** Administer 7 vials IV weekly for the first 2 weeks
Dispense #14 vials

☐ 7.5g **ONGOING DOSE:** Administer 7 vials IV every 2 weeks
Dispense #14 vials

☐ Refill: None ☐ Refill: 12 months ☐ Other _____

ENJAYMO is for intravenous infusion only. Do not administer as an intravenous push or bolus. The infusion should be administered over 1 to 2 hours depending on the patient's body weight.

The recommended dosage of ENJAYMO for patients with CAD is based on body weight. For patients weighing 39 kg to less than 75 kg, the recommended dose is 6,500 mg and for patients weighing 75 kg or more, the recommended dose is 7,500 mg.

ESTIMATED DATE OF FIRST INFUSION OF ENJAYMO _____

SPECIAL INSTRUCTIONS FOR INFUSION SITE OR PHARMACY _____

As the undersigned Prescriber, or the Prescriber's Designated Agent, I certify that I have obtained the patient's authorization to use and disclose the patient's personal health information, the information on this form and any prescription to Recordati Rare Diseases, Inc. (together with its parents and affiliates, "Recordati") and its third-party business partners, vendors, and other agents ("Agents") for the purpose of providing product support services and as otherwise permitted by HIPAA ("the Programs").

I authorize the use and disclosure of the patient's health information contained on this form to the patient's other healthcare providers (including pharmacies and Recordati); their respective agents involved in the patient's treatment ("Providers") and health plans/insurers and their respective agents ("Insurers") for treatment, payment and health care operations as permitted by HIPAA. I agree that the patient's Providers and Insurers may contact the Prescriber or the Prescriber's Designated Agent for additional information as needed relating to the patient's ENJAYMO therapy.

The undersigned certifies that: (1) the Prescriber has prescribed ENJAYMO for the identified patient; (2) the Prescriber has determined that ENJAYMO is medically necessary for this patient; (3) if the undersigned is a "Designated Agent", such person is duly authorized by the Prescriber to sign this "Healthcare Provider Authorization" on the Prescriber's behalf, in accordance with applicable law and medical standards; and (4) the information provided on this form is accurate to the best of their knowledge.

I understand that Recordati may revise, change, or terminate any program services at any time without notice to me. I will notify the Specialty Pharmacy immediately if ENJAYMO is no longer medically necessary for this patient's treatment or if my patient's insurance status changes.

The prescriber is to comply with state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

"Dispense As Written"/Brand Medically Necessary/Do Not Substitute/
No Substitution/DAW/May Not Substitute
Prescriber's Signature: _____ Date: _____

May Substitute/Product Selection Permitted/Substitution Permissible
Prescriber's Signature: _____ Date: _____

CA, MA, NC & PR: INTERCHANGE IS MANDATED UNLESS PRESCRIBER WRITES THE WORDS "NO SUBSTITUTION." _____
ATTN: NEW YORK AND IOWA PROVIDERS, PLEASE SUBMIT ELECTRONIC PRESCRIPTION.

Prescriber to Fill Out

Patient: Please read the following carefully, then date and sign where indicated.

8 AUTHORIZATION FOR RELEASE AND USE OF HEALTH INFORMATION

I hereby authorize and direct my health care providers and their staff (including pharmacies that fill my prescriptions), and my health insurer(s) and their staff (collectively, the "Treating Parties") to disclose to Recordati Rare Diseases, Inc. including its parents, affiliates, and its third party business partners and other agents (collectively, "Recordati") information about my disease, treatment, insurance coverage, and payment for my therapy (together with the information I have provided on this Enrollment Form and may provide in the future, "my Information") for the purposes of (1) my ENJAYMO treatment by the Treating Parties and (2) Recordati providing me with patient support services in connection with my ENJAYMO therapy or otherwise sending me communications that I have agreed to receive elsewhere in this Enrollment Form.

I authorize the Treating Parties and Recordati to use and disclose my Information for the purposes permitted by HIPAA and for providing certain support services I agree to in this Enrollment Form, including, but not limited to: (1) operating and enrolling me in, and/or continuing my participation in the Recordati Rare Diseases Patient Solutions Program ("the Program") or any other Recordati-affiliated patient support services and activities related to my condition or treatment; (2) verifying, investigating and coordinating my health insurance coverage or resolving coverage or reimbursement inquiries and payment for Recordati products; (3) coordinating my receipt of and payment for Recordati products; and (4) contacting me for follow-up on any adverse event I may disclose regarding a Recordati product. I further authorize Recordati to de-identify my health information and use it in performing research, education, business analytics, and marketing studies, or for other commercial purposes, including linkage with other de-identified information Recordati may receive from other sources.

I understand that once my Information has been disclosed to Recordati, federal privacy laws may no longer protect the Information. However, Recordati intends to use and disclose my Information only in accordance with this Authorization or as otherwise permitted by law.

Further information regarding Recordati's privacy practices can be found at https://www.recordatirarediseases.com/us/privacy-policy. If you are a resident of California, a description of the personal information collected by Recordati and your rights under the California Consumer Privacy Act can also be found at this link.

I understand that I may refuse to sign this Authorization and that a refusal to sign will not affect my ability to obtain medical care, insurance coverage, or access to health benefits, including access to therapy. However, if I do not sign this Authorization, Recordati cannot provide me with support services.

This Authorization will remain valid until termination of enrollment in Recordati-sponsored patient support programs and activities, including the Recordati Programs, unless a shorter time is required by state law. I understand that I may revoke this Authorization at any time by sending a written notice that includes my name, address, and phone number, to Recordati, ATTN: RRD Patient Services 440 Rte 22 Suite 205 Bridgewater, NJ 08807 or by emailing RRDPatientSolutions@recordati.com. I understand that should I revoke this Authorization, I can no longer participate in the Programs and that such revocation will not impact uses and disclosures of my Information that have already occurred in reliance on this Authorization.

I certify that I have read and understand the Authorization for the Release and Use of Health Information, all the information provided is true and correct, and I agree to its terms. If I am the caregiver for the patient, I confirm I am authorized to sign on behalf of the patient.

PATIENT AUTHORIZATION

REQUIRED:

☐ I have read and agree to the Patient Authorization to Use and Disclose Health Information included in Section 8.

PATIENT SIGN

_____ _____

PATIENT SIGNATURE DATE

Patient signature/Legal representative

_____

Printed name if signed by legal representative