AQNEURSA™ CARES

AQNEURSA™ (levacetylleucine)

Patient Enrollment Form

Fax completed enrollment packet to 470-751-8639

Complete the Patient Enrollment Form on the next page

Step 1 – Patient Inputs

1. Complete Patient Information section
2. Complete Insurance Information section
3. Obtain Patient Consent within Authorization section

Step 2 – Prescriber Inputs

1. Complete the Prescriber Information section
2. Complete the AQNEURSA Prescription section
3. Sign and date Prescription section

Step 3 – How the prescriber submits the enrollment packet to AQNEURSA Cares

Fax complete AQNEURSA patient enrollment packet to 470-751-8639, including:

1. Enrollment Form
   NOTE: If the patient/caregiver is unable to complete and sign the consent portion of the Enrollment Form in the prescriber's office, the AQNEURSA Cares team will contact them to obtain consent separately
2. Copy of the front and back side of patient's insurance card
3. Clinical documentation for Prior Authorization (see Prior Authorization Checklist)

Step 4 – The AQNEURSA Cares Journey: Let your patient know what to expect

1. Give your patient and/or caregiver the AQNEURSA Cares Patient Brochure
2. Let your patient/caregiver know you have completed and submitted the AQNEURSA Cares patient enrollment packet and that the AQNEURSA Cares team will be calling them from the phone number 866-200-0419
3. Suggest that the patient/caregiver add the AQNEURSA Cares phone number to their phone contacts to speed up the enrollment process

Fax the complete enrollment packet to AQNEURSA Cares at 470-751-8639.

Questions? Call 866-200-0419 between 8:30 am and 8 pm ET, Monday through Friday, for additional assistance.

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1. Patient Information

Name (First) _____ (MI) ____ (Last) _____ DOB _____ Sex ☐ Male ☐ Female SSN_____

Street address _____ City_____State____ Zip_____

Primary cell #_____ Alternate phone #_____Email _____

Languages ☐ English ☐ Spanish ☐ Other*(please list)*_____

Patient allergies *(please list)* _____

Medical conditions _____

2. Insurance Information (Pharmacy) ☐ No insurance coverage *(proceed to next section)*

Primary insurance name _____ Policyholder name _____Policyholder DOB_____

Member ID_____Group number _____ BIN _____ PCN _____ RX Grp_____

Relationship to policyholder ☐ Self ☐ Spouse ☐ Child

Secondary insurance name _____ Policyholder name _____Policyholder DOB_____

Member ID_____Group number _____ BIN _____ PCN _____ RX Grp_____

Relationship to policyholder ☐ Self ☐ Spouse ☐ Child

(Please attach copy of front and back of all insurance cards)

3. Patient Consent and Authorization

By signing below, I confirm that I have read, understand, and agree to the HIPAA Authorization to Share Health Information and Enroll in Patient Support Services shown on page 2.

Signature of Patient or Legal Representative _____ Date_____

Printed name of Patient or Legal Representative _____

If legal representative, what is the relationship to the patient? ☐ **Parent ☐ Legal Guardian

*** By indicating Parent, I hereby declare that I have not been denied physical placement of this child nor have my parental rights been terminated by court order.*

☐ I **DO NOT** want to receive important messages about obtaining AQNEURSA via text.

☐ I **DO NOT** want to receive important education or marketing information from AQNEURSA Cares.

4. Prescriber Information

Prescriber name _____NPI #_____ DEA #_____

Prescriber specialty _____Office contact name _____

Address _____City _____State _____ Zip _____

Email_____Phone_____Fax_____

5. AQNEURSA Prescription (NDC: 83853-101-01)

ICD-10-CM diagnosis code ☐ E75.242 Niemann-Pick Disease Type C ☐ Other diagnosis code *(please indicate)*_____

Patient weight _____kg

Dose & Directions (28-Day Supply)

Select One	Weight	Morning	Afternoon	Evening	Daily Total
☐	15 to <25 kg	1 g	No Dose	1 g	2 g
☐	25 to <35 kg	1 g	1 g	1 g	3 g
☐	35 kg or more	2 g	1 g	1 g	4 g

Single-use packet containing 1 gram of granules for oral suspension (informational purposes only)

Prescriber signature _____ Date_____ ☐ DAW _____Refills

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Authorization by Patient/Legal Representative to Share Health Information and Enroll in Patient Support

HIPAA Authorization

My signature on page 1 certifies that I have read, understand, and agree to this HIPAA Authorization to release my/the patient's protected health information to IntraBio, and companies working on their behalf, including vendors, other affiliates, and other service providers supporting IntraBio (collectively, "AQNEURSA Cares Program Consent"). I authorize the disclosure of my/the patient's protected health information to IntraBio and AQNEURSA Cares to provide me/the patient with additional support for patients and caregivers.

I authorize my/the patient's healthcare providers, health plans, and pharmacy providers, including, but not limited to Curant Health, to disclose my/the patient's personal health information and personal identifiable information, including, but not limited to, information relating to my/the patient's medical condition, genetic testing results, treatment, care management, prescription information, and health insurance prescription reimbursement status, as well as any information about my/the patient's prescriptions ("Personal Health Information") to IntraBio and its personnel, representatives, contractors, and affiliates (collectively, "IntraBio") in order for IntraBio and AQNEURSA Cares to provide product support services.

- I understand that my/the patient's Protected Health Information, once disclosed under this Authorization, may no longer be protected by federal or state privacy laws and could be disclosed by IntraBio as well as other recipients of the information to others not identified in this Authorization.
- I understand that I may choose not to sign this Authorization and that my/the patient's treatment, payment, enrollment in a health plan, or eligibility for benefits, including my/the patient's access to therapy, is not conditioned on my signing this Authorization.
- I understand that I am entitled to a signed copy of this Authorization.
- I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to AQNEURSA Cares representatives, 200 Technology Ct SE, Suite B, Smyrna, GA 30082.
- I also understand, however, that any such cancellation will not apply to any information already used or disclosed based on this Authorization prior to receipt of the cancellation by AQNEURSA Cares.

This Authorization expires ten (10) years from the date signed below, unless a shorter period is required by the law of the patient's state of residence or the Authorization is canceled.

Text Message Authorization

By leaving the box unchecked on page one, I AUTHORIZE AQNEURSA Cares to deliver, or cause to be delivered to me, text messages using an automated system to the cell phone number provided above. These messages provide valuable information concerning my/the patient's medications, education regarding my/the patient's conditions, and other information related to my/the patient's health. For texts, I understand that message and data rates may apply. Telephone calls may be monitored or recorded for quality and other purposes. Consent to such calls and text messages is not a condition of receipt of services. I agree to promptly alert AQNEURSA Cares program whenever I stop using a particular telephone number. You may reply STOP to opt out of text messaging or by contacting Curant Health at 866-200-0419. I am not required to directly or indirectly sign this written agreement or to agree to enter into such an agreement as a condition of purchasing any property, goods, or services.

Marketing Communication Authorization

By leaving the box unchecked on page one I AUTHORIZE AQNEURSA Cares to opt me in to receive marketing communications and hereby agree to receive information on behalf of AQNEURSA Cares. I understand that message and data rates may apply to cell phone communications.

Please click here for Full Prescribing Information for AQNEURSA.