



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 Inforn	nation							
Name (First)								
Street address							-	
Primary cell #		_						
Languages English								
Patient allergies (please list)								
Medical conditions								
2 Incurance Inf	ermation	(Pharmacy) 🗆						
	2. Insurance Information (Pharmacy) No insurance coverage (proceed to next section) Primary insurance namePolicyholder DOB							
Member ID			ber	BIN	PCN _	R	X Grp	
Relationship to policyhold		_ ·						
Secondary insurance nam						holder DOB		
Member ID			ber	BIN	PCN _	RX	X Grp	
Relationship to policyhold		_ · _						
(Please attach copy of front and b	Jack of all insurance	: caros)						
3. Patient Conse	nt and Au	uthorization						
By signing below, I co	nfirm that I l	nave read, understan	d, and agree to th	e HIPAA Authoriz	ation to Share	Health Infor	mation and	
Enroll in Patient Suppo								
Signature of Patient or Legal Representative								
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. 								
	2Ceive importar	It education of marketi	Ig illioithadon nom.	AQINLUNSA Cares.				
4. Prescriber Inf	ormation							
Prescriber name				IPI #		DFA #		
Prescriber specialty								
						Zip		
Email				hone				
LIIIaii			1	10116	i u.	X		
		(NDC 820E2						
5. AQNEURSA Pr		•						
ICD-10-CM diagnosis cod	 -	42 Niemann-Pick Diseas	, ·	r diagnosis code (plea	ase indicate)			
Patient weight	Dose & Direct	ctions (28-Day Supply	/)					
kg	Select One	Weight	Morning	Afternoon	Evening	Daily Tota		
Please indicate if the		15 to <25 kg	1 g	No Dose	1 g	2 g		
patient will be taking		25 to <35 kg	1 g	1 g	1 g	3 g		
AQNEURSA by: Mouth G-Tube		35 kg or more	+		1 g	4 g		
		ļ	2 g	1 g	<u> 1 y</u>	<u> </u>		
Single-use packet contain	ing 1 gram or	granules for oral susper	nsion (informational			147	Dafila	
Prescriber signature				Date	DAV	√ V	Refills	





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,

JA 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 see accompanying Full Prescribing Information for AQNEURSA.

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