LEGACY PHARMA

Legacy Patient Program Enrollment
Customer Service Phone: 855-518-7562
Customer Service Fax: 866-598-0117

1 PATIENT INFORMATION

First Name*: _____ Last Name*: _____ Date of Birth*: _____Sex at Birth*: ☐ Male ☐ Female

Address*: _____ City*: _____ State*: _____ Zip Code*: _____

Email Address*: _____ Home Phone: _____ Mobile Phone*: _____

Alternate Contact Name:_____Alternate Contact Phone:_____ Relationship:_____

Permission to leave detailed message via phone and/or email*: ☐ Yes ☐ No Annual Household Income*:_____ Household Size (including Patient)*: ___

☐ Check this box if no insurance coverage exists for patient.

INSURANCE INFORMATION: IF PATIENT HAS ANY INSURANCE, COMPLETE THIS SECTION OR ATTACH COPIES OF INSURANCE CARD(S).

	Primary Insurance	Secondary Insurance	Pharmacy Benefit
Insurance Name			
Type (Comm, Medicare, Medicaid, Other)			
Subscriber Name (if not patient)			
Subscriber/Policy ID			
Group #			
Insurance Phone			
Maximum Out of Pocket			

2 PATIENT CONSENTS & AUTHORIZATIONS – PLEASE CHECK ALL THAT APPLY

☐ **The following consents are a requirement of the Legacy Patient Program. By attesting to the below, I understand that I must meet all of the criteria in order for the Program Team to contact me and enroll me in the Program.**

- I understand that by being enrolled to the Legacy Patient Program, I am agreeing to receive communication for the program via phone and/or email throughout the duration of the time period I am enrolled.
- I understand that I will need to meet all necessary criteria discussed with me and the member of the Legacy Patient Program Team to be approved for the Program and that the submission of an application does not guarantee eligibility for the Legacy Patient Program.
- I understand that if my enrollment is approved, I will receive Esbriet™ Treatment and prescribed refills, free of charge, as part of the program, over the span of my enrollment period.
- I understand that the Patient Program is a limited time program and by enrolling, I will be enrolled for a successive period of up to 12 months, commencing on or after January 1 and ending on December 31.
- I understand that if I choose to continue my enrollment into a new calendar year, re-enrollment in the Legacy Patient Program will be required at the end of each calendar year.
- I am at least 18 years of age.
- I am currently a patient diagnosed with Idiopathic Pulmonary Fibrosis.
- I understand that this program may change or be discontinued at any time and I will be notified.
- I do not have prescription insurance coverage (including Medicaid, Medicare, or other public or private programs) for the Legacy medicine listed above, or I am unable to afford the cost-sharing requirements associated with my insurance coverage for this medication.
- I will not seek reimbursement for any products dispensed from the Legacy Patient Program from any source, including any third-party insurance carrier.
- In order to receive Esbriet™ free of charge, I am agreeing to the Legacy Pharma Inc SEZC Terms and Conditions outlined below.
- I understand that if approved for the Legacy Patient Program, I will be required to call the program to request refills of Esbriet™ when needed, per the program requirements.

☐ **Patient Consent to allow the Legacy Patient Program Team to work together with your insurance provider, pharmacy, advocacy organization and others to provide support on your behalf.**

By signing this authorization, I authorize my physician(s), my health insurance company and my pharmacy providers (collectively, "Designated Parties") to use, disclose, and redisclose to Legacy Pharma Inc SEZC, the distributor of Esbriet™, and its agents, authorized designees and contractors, including Legacy Patient Program Team support personnel or any other operator of Legacy Patient Support Program on behalf of Legacy Pharma Inc SEZC , health information relating to my medical condition, treatment and insurance coverage (my "Health Information") in order for them to (1) provide certain services to me, including coverage support, patient access programs, medication shipment tracking, and training/education, (2) provide me with support services and information associated with my Esbriet™ therapy, (3) serve internal business purposes, such as marketing research, internal financial reporting and operational purposes, and (4) carry out the Manufacturer Parties' respective legal responsibilities. Once my Health Information has been disclosed to Legacy Pharma Inc SEZC Parties, I understand that it may be redisclosed by them and no longer protected by federal and state privacy laws. However, Legacy Pharma Inc SEZC Parties agree to protect my Health Information by using and disclosing it only for the purposes detailed in this authorization or as permitted or required by law. I understand that I may refuse to sign this authorization and that my physician and pharmacy will not condition my treatment on my agreement to sign this authorization form, and my health plan or health insurance company will not condition payment for my treatment, insurance enrollment or eligibility for insurance benefits on my agreement to sign this authorization form. I understand that my pharmacies and other Designated Parties may receive payment in connection with the disclosure of my Health Information as provided in this authorization. I understand that I am entitled to receive a copy of this authorization after I sign it. I may revoke (withdraw) this authorization at any time by contacting Legacy Patient Program Team via phone 855-518-7562. Revoking this authorization will end further disclosure of my Health Information to Manufacturer Parties by my pharmacy, physicians, and health insurance company when they receive a copy of the revocation, but it will not apply to information they have already disclosed to Manufacturer Parties based on this authorization. I also know I may cancel my enrollment in a patient support program at any time via phone by contacting Legacy Patient Program Team at 855-518-7562. This authorization is in effect for 1 year or a shorter period is provided for by state law.

☐ **Financial Information and Fair Credit Reporting Act (FCRA) Authorization**

I acknowledge that Legacy Patient Program will utilize my household income and the number of people in my household listed on my application for determination of eligibility. I attest that I have accurately reported this information to the best of my ability and knowledge. In the event I am unable to provide financial documentation, I authorize the use of my Social Security number and/or additional demographic information to access my credit information and information derived from public and other sources to estimate my income to determine eligibility.

☐ I understand that I am providing written authorization for Legacy Patient Program and its vendor, under the FCRA, to obtain information from my credit profile or other information from the vendor, solely for the purpose of determining financial qualifications for eligibility determination by Legacy Patient Program. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process.

☐ I authorize Legacy Patient Program and its partners to use, disclose, and/or transfer the personal information I supply (1) to contact me and provide me with informational and marketing materials, clinical trial opportunities related to my condition or treatment by any means of communication, information and/or education on Esbriet™ including but not limited to email or telephone; (2) to help Legacy Pharma Inc SEZC improve, develop, and evaluate products, services, materials, and programs related to my condition or treatment; (3) to enroll me in and provide me with Esbriet™ related programs and services that I may select or refuse at any time; (4) to disclose my enrollment and use of these services to my prescriber and insurers; and (5) to use my information that cannot identify me for scientific and market research. This authorization will remain in effect until I cancel it, which I may do at any time in writing by contacting the Legacy Patient Program at 855-518-7562. I may request a copy of this signed authorization.

☐ By checking this box and submitting the completed form, I acknowledge that I have provided accurate and complete information and understand and agree to the terms of this form. I have read, understood, and agree to the release and use of my personal information, including sensitive personal information, pursuant to the Authorization to Use and Disclose Personal Information and as otherwise stated on this form. By refusing to sign this form, I acknowledge that Legacy Pharma Inc SEZC, will be unable to provide me the services under their Program.

Patient Signature: _____ Date: _____

Patient Representative Signature (if applicable): _____ Date: _____

3 PRESCRIBER INFORMATION

First Name*: _____ Last Name*: _____

Prescriber NPI*: _____ Phone*: _____ Fax*: _____

Practice Address*: _____ Practice City*: _____ Practice State*: _____ Practice Zip Code*: _____

4 ESBRIET™ PRESCRIPTION INFORMATION

Patient Name*: _____ Date of Birth* : _____

ICD-10 Code*: ☐ J84.112 (Idiopathic Pulmonary Fibrosis) ☐ J84.10 (Pulmonary Fibrosis, Unspecified) ☐ Other: _____

Must Select Initial Tablet Titration Dose and Maintenance Tablet Dose for New Patients:

INITIAL TABLET TITRATION DOSE

☐ Esbriet® 267-mg 90-day supply (747 tablets)

Treatment Days:	*Dosing Instructions:*
Days 1-7	1 tablet by mouth 3 times/day with meals
Days 8-14	2 tablets by mouth 3 times/day with meals
Days 15+	3 tablets by mouth 3 times/day with meals

☐ NKDA – No Known Drug Allergies

MAINTENANCE TABLET DOSE

☐ Esbriet® 267-mg 90-day supply (810 tablets)
Directions: 3 tablets by mouth 3 times/day with meals

☐ Esbriet® 801-mg 90-day supply (270 tablets)
Directions: 1 tablet by mouth 3 times/day with meals
*If selecting 801-mg maintenance dose, please ensure the patient is currently tolerating 267 mg (3 doses by mouth 3 times/day with meals)

☐ Other special instructions:_____
☐ Refills: 1 year ☐ Refills: Other _____

☐ Allergies: _____ Current Medications: _____

5 HEALTHCARE PROVIDER CONSENTS & AUTHORIZATIONS – PLEASE CHECK ALL THAT APPLY

☐ **Prescriber Authorization:** I certify that Esbriet® is medically necessary for this patient and that I have reviewed this therapy with the patient, and I will be monitoring the patient's treatment. I verify that the Patient and Prescriber information on this form was completed by me or at my direction and that the information contained herein is complete and accurate to the best of my knowledge. I understand that I must comply with my practicing state's specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to me by the dispensing pharmacy. I authorize Legacy Pharma Inc SEZC, the current operator of Esbriet® Patient Program, and other designated operators of the Program, to act on my behalf for the limited purposes of transmitting this prescription to and received by the designated Pharmacy by any means under applicable law, including via a designated third party or other operator of the Program. I understand that representatives from the Program may contact me or my patient for additional information relating to this prescription. I acknowledge and agree that this prescription may be sent to and received by the designated Pharmacy by any means under applicable law, including via a designated third party or other operator of the Program, and that no additional confirmation of receipt of prescription is required by the designated Pharmacy. I can request that Legacy Patient Program Training Services be arranged for my patient. I understand that Esbriet® Training Services are available for training via phone call, by notifying the Legacy Patient Program Team by calling 855-518-7562.

☐ **The following consents are a requirement of the Legacy Patient Program. By attesting to the below, I understand that my patient must meet all of the criteria in order for the Program Team to contact them and enroll them in the Program.**

- The Legacy medicine listed above is medically necessary for this patient.
- I have received authorization to release the information above and other protected health information (as defined by HIPAA) to the Legacy Patient Program and its affiliates.
- I will not seek reimbursement for free product provided to the patient.
- My patient meets the criteria for the Legacy Patient Program and to the best of my knowledge, this patient has no prescription insurance coverage (including Medicaid, Medicare, or other public or private programs) for the Legacy medicine listed above or is unable to afford the cost-sharing requirements associated with his/her/their insurance coverage for this medication. If the patient is enrolled in an insurance plan, the plan does not require the patient's application to the Legacy Patient Program and/or has not changed or hidden the patient's coverage for the Legacy medicine to make them appear to be underinsured and eligible for the Legacy Patient Program.
- I understand that Legacy reserves the right to modify or discontinue the program at any time
- I understand that Legacy reserves the right to verify the accuracy of information submitted.
- If the indication for which you are prescribing a Legacy product is not listed in the FDA-approved label, you are prescribing the medicine for an "unapproved" use, meaning that the FDA has not approved the efficacy, dosage amount or safety of this medicine when used for such a use. The Legacy Patient Program may provide the medicine for your patient, based upon your medical order and within program requirements.
- For insured patients, I understand that the Legacy Patient Program does not provide free drug in the instance of an administrative error.
- I understand that if I am a prescriber in states with electronic prescription requirements, such as New York, prescriptions must be submitted via e-prescription directly to the pharmacy along with this enrollment form.

☐ I understand that I am entitled to receive a copy of this authorization after I sign it. I may revoke (withdraw) this authorization at any time by contacting Legacy Patient Program Team via phone at 855-518-7562. Revoking this authorization will end further disclosure of my Health Information to Manufacturer Parties by my pharmacy, physicians, and health insurance company when they receive a copy of the revocation, but it will not apply to information they have already disclosed to Manufacturer Parties based on this authorization. I also know I may cancel my enrollment in a patient support program at any time via phone by contacting Legacy Patient Program Team at 855-518-7562. This authorization is in effect for 1 year or a shorter period as provided for by state law.

Prescriber Signature: _____ *Date:* _____
Dispense as Written

Prescriber Signature: _____ *Date:* _____
Substitution Permitted

Supervising Physician name (if required) _____ *NPI:* _____