JazzCares®

Making a difference in Patients' lives, one Patient at a time

JazzCares® Start & Patient Consent Form | EPIDIOLEX® (cannabidiol)

Getting Started With JazzCares®

1. **Healthcare provider completes** the JazzCares® Start Form, page 2, including signature
2. **Patient, legal guardian, or healthcare provider completes** the JazzCares® Patient Consent Form, page 3, including signature
3. **Prescriber faxes** the signed forms with copies of the insurance cards to 1-855-518-7566
   Submits eRx to: PharmaCord, 11001 Bluegrass Parkway, Suite 200, Louisville, KY 40299

JazzCares® Support Offerings

Complete and sign the Start Form on page 2 and the Patient Consent Form on page 3 for the following offerings:

- **JazzCares® Nurse Navigators –** Personalized one-on-one support for patients and caregivers every step of the way
- **JazzCares® Quick Start –** New patients can get up to a 60-day free supply of EPIDIOLEX while insurance coverage is being processed
- **Patient Assistance Program (PAP) –** Support for uninsured and underinsured patients

Additional Support Offerings

- Benefits Verification
- Specialty Pharmacy Finder
- Prior Authorization (PA) Appeals
- Disease and Product Support Information

Fax completed forms: 1-855-518-7566 **Or** **Complete the form online:** jazzcaresforepidiolex.com **If you have questions, call M-F, 8AM-8PM ET:** 1-833-426-4243

Select services needed: ☐ Quick Start ☐ PA Appeals ☐ Benefits Verification/Specialty Pharmacy Finder ☐ PAP

1 Patient Information

Patient First Name _____ Last Name _____
Date of Birth (month/day/year) _____/_____/_____ Gender: ☐ Male ☐ Female Weight: lbs_____ kg _____
Patient Address _____ City _____ State_____ ZIP Code _____
Full Name(s) of Legal Guardian(s) _____
Primary Phone _____ ☐ Mobile ☐ Home/Other ☐ Email _____
Secondary Phone _____ ☐ Mobile ☐ Home/Other
Group Home/Long-Term Care Facility: ☐ Y ☐ N If Yes, Facility Name and Contact _____
Current Medications _____ Known Allergies _____

2 Insurance Information *(Please provide a copy of both sides of the insurance card)*

Prescription Drug Insurance Provider _____ ☐ **Patient Has No Prescription Drug Coverage**
Insurer Name _____ Insurer Phone _____
Rx ID # _____ Rx BIN_____ Rx PCN_____ Rx Group #_____
Cardholder Name _____ Date of Birth (month/day/year) _____/_____/_____
Patient's Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Does the Patient Have Other Health Insurance? ☐ Y ☐ N
Other Insurance Provider Name _____ Insurer Phone _____
Rx ID # _____ Rx BIN_____ Rx PCN_____ Rx Group #_____
Cardholder Name _____ Date of Birth (month/day/year) _____/_____/_____
Patient's Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

3 Healthcare Provider Information – Please click for full Prescribing Information

Prescriber First Name _____ Last Name _____ Title _____
Supervising Physician (if required) _____
Specialty _____ DEA # _____ NPI # _____
State License # _____ Tax ID # _____ Medicaid Provider # _____
Practice Name _____ Office Contact Name _____
Office Address _____ City _____ State_____ ZIP Code _____
Contact Phone _____ Contact Fax _____ Contact Email _____
Preferred Method of Contact: Primary: ☐ Phone ☐ Fax ☐ Email Secondary: ☐ Phone ☐ Fax ☐ Email

4 Diagnosis and Prescription Information

Preferred Specialty Pharmacy _____
ICD-10 Code _____ Seizures Associated With: ☐ LGS ☐ DS ☐ TSC ☐ Other _____

If choosing "Other" and this medication is being prescribed for a use that is not listed on the FDA-approved label, by signing this Patient Start Form and initialing here, I certify that the Prescriber has determined that EPIDIOLEX is medically necessary and appropriate for this patient, and this patient's treatment will be supervised.

Initial _____ Healthcare Provider Initials _____/_____/_____ Date (month/day/year)

Quick Start/PAP Prescription:

Solution: EPIDIOLEX (cannabidiol) 100 mg/mL Solution
Directions:

☐ **Titration:**
Starting Dose _____ mL PO BID for _____ Days
1st Titration _____ mL PO BID for _____ Days
2nd Titration _____ mL PO BID for _____ Days
3rd Titration _____ mL PO BID for _____ Days
QS/Qty: Sufficient for 30 Days **Refills:** No Refills

☐ **Maintenance:**
_____ **mL PO BID for 30 Days**
QS/Qty: Sufficient for 30 Days **Refills:** _____Times

In-Network Specialty Pharmacy Prescription:* *(required for prescription transfer)*

Solution: EPIDIOLEX (cannabidiol) 100 mg/mL Solution
Directions:

☐ **Titration:**
Starting Dose _____ mL PO BID for _____ Days
1st Titration _____ mL PO BID for _____ Days
2nd Titration _____ mL PO BID for _____ Days
3rd Titration _____ mL PO BID for _____ Days
QS/Qty: Sufficient for 30 Days **Refills:** No Refills

☐ **Maintenance:**
_____ **mL PO BID for 30 Days**
QS/Qty: Sufficient for 30 Days **Refills:** _____Times

**HCP may need to send the prescription and patient information to the EPIDIOLEX In-Network Specialty Pharmacy*

Scan for a helpful dosing calculator

5 Healthcare Provider Authorization

By signing below, I certify that (a) the above-prescribed therapy is medically necessary, and (b) I have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, their personal Health Information to Jazz Pharmaceuticals and its affiliates or vendors for the purpose of providing the patient support services selected on this form. I must comply with all state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. I understand that noncompliance with state-specific requirements could result in outreach to me. I represent that I have explained to the patient, and the patient indicated they understand and have consented to, the following: 1) Jazz Pharmaceuticals and its agents will use the patient's name, date of birth, contact information, prescriptions, and other necessary Health Information listed in this form for reimbursement services related to this prescription, including to verify their insurance benefits and to contact the patient directly for the administration of these patient support services; 2) Jazz Pharmaceuticals will then disclose the patient's personal information to the insurer(s) listed on this form for the same purposes; 3) I authorize Valeris to transmit this prescription on my behalf to the appropriate pharmacy designated by the patient utilizing their benefit plan by any means allowed under applicable law; and 4) the patient can withdraw their consent by contacting Jazz Pharmaceuticals using one of the methods listed in the US Consumer Health Data Privacy Policy (https://privacy.jazzpharma.com/united-states/en/us-consumer-health-data-privacy-policies), but if the patient does not agree to, or withdraws consent for, these uses or disclosures, the patient cannot receive these patient support services that necessarily require Jazz Pharmaceuticals to process their personal information.

Sign _____ Prescriber Signature (dispense as written) ***OR*** _____ Prescriber Signature (substitute permitted) _____/_____/_____ Date (month/day/year)

Patient: Complete online at jazzcares.com ***OR*** print, complete, take a photo, and send to support@jazzcaresforepidiolex.com

1 Patient Information

Patient First Name _____ Last Name _____ ZIP Code _____

Date of Birth (month/day/year) _____/_____/_____ Gender: ☐ Male ☐ Female

Full Name(s) of Legal Guardian(s) _____ Relationship to Patient _____

Primary Phone _____ ☐ Mobile ☐ Home/Other ☐ Email _____

Secondary Phone _____ ☐ Mobile ☐ Home/Other

Prescriber First Name _____ Last Name _____

NPI # _____ Prescriber Phone _____

2 Patient Resources and Additional Information *(optional)*

Completing and signing this form allows you to be contacted by a JazzCares® Nurse Navigator. The JazzCares® Nurse Navigators work with you and your loved one to set personalized goals and stay on track with therapy, and they check in to help keep you motivated, evaluate progress, and address practical challenges. These resources and support offerings are optional, free, and you do not have to sign up for this program to get help with your insurance coverage or learn about financial assistance options.

☐ **Consent to receive email communications from Jazz Pharmaceuticals about educational programs, products, and services. By checking this box,** I confirm that I am 18 years of age or older and a resident of the U.S. I am indicating that I would like to receive information from Jazz Pharmaceuticals about educational programs, products, and services, and I consent to the collection, processing, and sharing of my Health Information by Jazz Pharmaceuticals, its affiliates, and services providers to conduct marketing activities and to communicate with me regarding products and services that may be of interest to me. I understand that Jazz Pharmaceuticals will not sell my Health Information to third parties. I can unsubscribe at any time from future email communications from Jazz Pharmaceuticals by clicking the "unsubscribe" link provided in email communications from Jazz Pharmaceuticals. I can withdraw consent from collection, use, or sharing of my Health Information for marketing purposes at any time using one of the methods listed in the US Consumer Health Data Privacy Policy (https://privacy.jazzpharma.com/united-states/en/us-consumer-health-data-privacy-policies).

☐ **Telephone Consumer Protection Act (TCPA) consent. By checking this box,** I consent to Jazz calling and texting me at the phone number(s) provided with promotional communications relating to Jazz products and services and/or my condition or treatment. Jazz may use automatic dialing machines or artificial or prerecorded messages to contact me and may leave a voicemail or SMS/text message (Standard text messaging rates may apply.) I can reply STOP to cancel SMS messages.

3 Financial Information

(Complete only if applying for the Patient Assistance Program. Please note: an HCP must sign and submit the JazzCares® Start Form.)

☐ **By checking this box and signing this section, I am agreeing to the Terms and Conditions of the JazzCares® Patient Assistance Program.**

Total Household Income _____

Total Number of People Within Household (including applicant) _____

The information within this application will be used to run an income validation using a third-party financial services company to verify income.

Patient Assistance Program Terms and Conditions

I understand that to qualify for free medicine under this program, program eligibility criteria must be met, including income verification. I certify that all the information in this application, or information I am requested to provide in connection with this application, including all copies of documents proving my income and medical expenses, are true and accurate to the best of my knowledge. I attest that I am authorized to sign this application. I attest that I have no or insufficient prescription insurance for the indicated medication that is provided by Medicaid, Medicare, or any other public or private program, and I have insufficient financial resources to pay for the prescribed therapy. In addition, I will contact JazzCares® if any of my information about my prescription drug coverage or insurance changes. I understand and agree that the Patient Assistance Program medication that I receive will not count toward my true out-of-pocket costs as defined under the Medicare Modernization Act. I understand that the Patient Assistance Program medication will be dispensed to me by a Specialty Pharmacy and is provided at no charge to me or any other party; therefore, I agree that I will not submit any claim for the Patient Assistance Application medication to any third party, including my Medicare Part D Plan.

Sign _____ _____/_____/_____

Patient/Legal Guardian Signature — Date (month/day/year)

_____ _____ _____

Print First Name — Print Last Name — Relationship to Patient

4 Patient Authorization Signature *(patient, legal guardian, or healthcare representative)*

By signing this form, I acknowledge that the information provided is true and correct and I have read, understood, and agree with the terms of the Patient Authorization Disclosure form on page 4. I consent to the collection, processing, and disclosure of my Health Information for the purposes described in the Patient Authorization Disclosure form. I understand that participation in Jazz-sponsored patient support programs and activities, including the JazzCares® program is voluntary, and, if I have consented, receipt of marketing communications are optional services. The consent(s) above in no way affects my right to obtain any medications and the patient does not need to provide consent to be able to receive any medications. If I am the legal guardian of the patient, I confirm I am authorized to sign on behalf of the patient.

If I am a healthcare provider representative signing on behalf of the patient, by signing below, I confirm that I have provided all relevant information to the patient or legal guardian, and they clearly indicated they understand and consent to the use and disclosure of their personal information including Health Information as outlined in the Patient Authorization Disclosure on page 4, and they agree with all applicable consents aforementioned.

Sign _____ _____/_____/_____

Patient/Legal Guardian/Healthcare Provider Signature — Date (month/day/year)

_____ _____ _____

Print First Name — Print Last Name — Relationship to Patient

No action required. Please review the important information below prior to signing the Patient Authorization on previous page.

Patient Authorization Disclosure

I. Uses and Disclosure of Health Information

I hereby authorize and direct my prescriber(s) and their staff, my health insurer(s), and the Specialty Pharmacy that will fill my prescription (the "Pharmacy") to disclose my name (and the name of my caregiver if applicable), gender, date of birth, contact information, and the following information (together "Health Information") to Jazz Pharmaceuticals (including its affiliates and services providers acting as data processors) (together "Jazz Pharmaceuticals" or "Jazz") for any Jazz-sponsored patient support programs and activities, including the JazzCares® program:

- Information concerning my treatment with Jazz Pharmaceuticals' products, including relevant diagnoses and prescriptions; and
- Information about my health insurance benefits, including deductibles and out-of-pocket costs

I understand and authorize Jazz Pharmaceuticals to use and further disclose my Health Information it receives as a result of this Form for the following purposes:

(i) operating, administering, enrolling me in, and/or continuing my participation in the JazzCares® program or any other Jazz-affiliated patient support services and activities related to my condition or treatment;
(ii) verifying, investigating, coordinating, and resolving insurance coverage or reimbursement inquiries and payment for Jazz Pharmaceuticals' products;
(iii) coordinating my receipt of and payment for Jazz Pharmaceuticals' products;
(iv) contacting me about any Jazz-sponsored patient support programs and activities, including the JazzCares® program (this may include supplemental educational materials, information, offers, and services related to my therapy or my medical condition or opportunities to participate in focus groups, surveys, or interviews);
(v) contacting and providing my Health Information to patient advocacy organizations, patient assistance programs, co-pay assistance, or similar programs to determine eligibility for coverage and enrollment;
(vi) de-identifying my Health Information by aggregating it for research purposes;
(vii) managing Jazz-sponsored patient support programs and activities, including the JazzCares® program and administrative purposes that support these services and programs

I understand Jazz Pharmaceuticals will not sell my Health Information to third parties, but Jazz Pharmaceuticals may disclose such information to its affiliates and services providers for the purpose described in this Form. I also understand that if I do not consent to the use of my Health Information for the above purposes, I will not be able to participate in Jazz-sponsored patient support programs and activities, including the JazzCares® program.

I understand and authorize Jazz Pharmaceuticals to contact me using the contact information provided to Jazz to enroll me in, operate, and administer any Jazz-sponsored patient support services, including the JazzCares® program, through a variety of means including email, postal mail, phone, fax, or SMS/text unless I opt out of these communications by contacting Jazz Pharmaceuticals using the contact information below. I understand that the operation and administration of certain of these services and/or programs may require that Jazz contact me by telephone or SMS/text.

I understand Jazz Pharmaceuticals may report back to my prescriber(s) and their staff, my health insurer(s), or the Pharmacy any Health Information about me that Jazz Pharmaceuticals may create or receive. I understand that my health insurer(s), Pharmacy, and third-party vendor(s) may receive remuneration (payment) in exchange for disclosing my Health Information to Jazz Pharmaceuticals (including JazzCares®, its affiliates, and services providers acting as data processors) and/or for providing me with support services for the purposes described above.

I understand that after my Health Information is transmitted to Jazz Pharmaceuticals, it may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA). However, Jazz Pharmaceuticals will not disclose my Health Information to a third party that is not related to the patient support programs (such as a family member or friend) unless I specifically authorize Jazz to do so. If I request that a person or an entity other than Jazz Pharmaceuticals receives my Health Information, I understand the receiver may not be subject to HIPAA or other privacy laws, and the Health Information might be re-disclosed by the recipient.

II. No Effect on Treatment

I understand that I may refuse to sign this Form and my refusal will not affect the treatment I receive from my prescriber(s) and their staff, my health insurer(s), and the Pharmacy, nor will it affect my enrollment or eligibility for health insurance benefits to which I am otherwise entitled.

III. Expiration, Right to Obtain a Copy, and Right to Revoke

This Form will remain valid until termination of enrollment in Jazz-sponsored patient support programs and activities, including the JazzCares® program, unless a shorter time is required by state law.

I understand the program may be changed or ended at any time without prior notification. I understand I may request a copy of this Form that is on file with Jazz. I also understand that I can withdraw my consent to the processing of my Health Information for the above purposes and revoke this Form at any time by calling 1-866-997-3688 or sending my request to: Jazz Pharmaceuticals, PO Box 66589, St. Louis, MO 63166-6589. If I do so, I will no longer be eligible to participate in Jazz-sponsored patient support programs and activities, including the JazzCares® program.

I understand that should I revoke this Form, the revocation will not impact uses and disclosures of my Health Information that have already occurred in reliance on this Form.

IV. More Information on Jazz Pharmaceuticals' Privacy Practices

Further information concerning Jazz Pharmaceuticals' privacy practices can be found at https://privacy.jazzpharma.com/united-states/en/jazz-pharmaceuticals-privacy-center. If you are a resident of California, a description of the Health Information collected by Jazz Pharmaceuticals and your rights under the California Consumer Privacy Act can also be found here: https://privacy.jazzpharma.com/united-states/en/jazz-pharmaceuticals-privacy-policy-supplemental-notice-for-california-consumers.