

JazzCares partners with a specialty pharmacy to provide benefit verification, prior authorization, claims support, and delivery services.

Please check all that apply for additional services^a:

TEMPORARY SUPPLY

Complete temporary supply prescription in section 5

☐ QuickStart for new patients ☐ Bridge Program for patients with a lapse in supply

UNINSURED/UNDERINSURED PATIENTS

Complete patient financial information in section 3

☐ Patient Assistance Program (no insurance)

1 PATIENT INFORMATION

First name: _____ Last name: _____ DOB: ____/____/____ Sex: ☐ M ☐ F ☐ Prefer not to say

Mailing address: _____ City: _____ State: _____ Zip: _____

Email: _____ Primary phone: (____) ____ - ____ Phone type: ☐ Cell ☐ Home

Authorized contact name: _____ Relation to patient: _____ Phone: (____) ____ - ____

2 INSURANCE INFORMATION – Please attach a copy of the patient's insurance card(s), front and back

Insurance name: _____ Phone: (____) ____ - ____

Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Other Insured name: _____

ID#: _____ Group#: _____ RxBIN#: _____ RxPCN#: _____

3 PATIENT FINANCIAL INFORMATION – Only required if applying for the Patient Assistance Program

Gross annual household income: _____ Number of household members (including applicant): _____

4 PRESCRIBER INFORMATION

Name: _____ Practice name: _____ NPI: _____

Phone: (____) ____ - ____ Fax: (____) ____ - ____ Practice contact name: _____

Practice contact email: _____

5 PRESCRIPTION SECTION – If necessary, attach a separate prescription to meet your state's requirements

ICD-10 Code: _____ Date of diagnosis: ____/____/____

Has a tumor biopsy been completed? ☐ Yes ☐ No If no, specify reason: _____

Tumor location: ☐ Midline ☐ Non-midline Confirmed H3 K27M mutation? ☐ Yes ☐ No

Is the patient currently taking MODEYSO?: ☐ No ☐ Yes If yes, what was the last fill date? ____/____/____

Current and prior treatment (check all that apply): ☐ Radiotherapy ☐ Surgery ☐ Chemotherapy ☐ Other: _____

Height: _____ (inches) Weight: _____ (kg) Date collected: ____/____/____

PRESCRIPTION

MODEYSO is supplied as 125 mg capsules. **(Check one):**

Patient Weight	Instructions for Use
☐ 10 kg to less than 12.5 kg	Take 1 capsule (125 mg) once per week
☐ 12.5 kg to less than 27.5 kg	Take 2 capsules (250 mg) once per week
☐ 27.5 kg to less than 42.5 kg	Take 3 capsules (375 mg) once per week
☐ 42.5 kg to less than 52.5 kg	Take 4 capsules (500 mg) once per week
☐ 52.5 kg and above	Take 5 capsules (625 mg) once per week
☐ Other:	Other:

Dispense quantity needed for 28-day supply with _____ refills.

TEMPORARY SUPPLY PRESCRIPTION

Complete this section only for QuickStart or Bridge prescription

MODEYSO is supplied as 125 mg capsules. **(Check one):**

Patient Weight	Instructions for Use
☐ 10 kg to less than 12.5 kg	Take 1 capsule (125 mg) once per week
☐ 12.5 kg to less than 27.5 kg	Take 2 capsules (250 mg) once per week
☐ 27.5 kg to less than 42.5 kg	Take 3 capsules (375 mg) once per week
☐ 42.5 kg to less than 52.5 kg	Take 4 capsules (500 mg) once per week
☐ 52.5 kg and above	Take 5 capsules (625 mg) once per week
☐ Other:	Other:

Dispense quantity needed for 28-day supply with 0 refills.

PRESCRIPTION CERTIFICATION

By signing, 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, all necessary consents, authorizations and permissions to release, in accordance with applicable federal and state privacy laws and regulations, medical and other patient information to Jazz Pharmaceuticals, Inc. and its affiliates and vendors to use and disclose the information for the purposes outlined in the patient consent, including for the purpose of seeking information related to coverage for the therapy(ies) and/or assisting in initiating or continuing therapy and to provide financial assistance to the patient. I understand that I am under no obligation to prescribe any Jazz Pharmaceuticals, Inc. product and that I have not received, nor will I receive, and benefit from Jazz Pharmaceuticals, Inc. for doing so. I understand that neither I nor the patient may seek reimbursement from any government program or third-party insurer for any free product received under the program.

➔ Prescriber signature: _____ Date: ____/____/____

^aPatients must enroll in JazzCares with a signed consent. There is no guarantee of approval for these programs. Jazz reserves the right to terminate or modify these programs at any time with or without notice. Other terms and conditions apply.

PATIENT CONSENT AND REQUEST FOR TRANSMISSION OF PERSONAL INFORMATION TO JAZZ

Patient name: _____ Date of birth: ____ / ____ / ____

Email: _____ Phone number: (____) ____ - ____

Patient representative name (If applicable): _____ Relationship to patient: _____

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 the following information ("Personal Information") to Jazz, including its affiliates and vendors, (collectively "Jazz") for any patient support programs and activities, including the JazzCares program:

- Information about me, including my name, demographic and contact information, date of birth, and financial information;
- Information concerning my health and treatment with Jazz products, including relevant diagnoses and prescriptions; and
- Information about my health insurance, including benefits, deductibles and out-of-pocket costs.

I authorize Jazz to use and further disclose the Personal 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, including utilizing a third-party financial screening tool to evaluate my financial eligibility for certain JazzCares program;
- (ii) verifying, investigating, coordinating, and resolving insurance coverage or reimbursement inquiries and payment for Jazz products;
- (iii) coordinating my receipt of and payment for Jazz products;
- (iv) contacting me by phone, email or text message 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 research, focus groups, surveys or interviews);
- (v) contacting and providing my Personal 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 Personal Information and 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; and
- (viii) for other related Jazz business purposes.

I authorize Jazz to contact me using the contact information provided to Jazz through a variety of means including email, postal mail, phone, fax, or SMS/text (if I consent by checking the box below) for the purposes described above unless I opt out of these communications by contacting Jazz 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 may report back to my prescriber(s) and their staff, my health insurer(s) or the Pharmacy, any Personal Information about me that Jazz may create or receive. I understand that my health insurer(s), Pharmacy, and third party vendor(s) may receive remuneration (payment) in exchange for providing me with support services for the purposes described above.

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

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. I also understand that I can revoke this form at any time in the future, but if I do so, I may 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 Personal Information that have already occurred in reliance on this form.

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 applicable state law. I can also revoke it earlier by calling 1-844-302-2737 or sending my request to: Jazz Pharmaceuticals, 13410 Eastpoint Centre Dr, Louisville, KY 40223.

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.

Further information concerning Jazz Pharmaceuticals' privacy practices can be found at <https://www.jazzpharma.com/privacy-statement/>. If you are a resident of California, a description of the personal information collected by Jazz Pharmaceuticals and your rights under the California Consumer Privacy Act can also be found on this website: <https://www.jazzpharma.com/privacy-statement/supplemental-notice-for-california-consumers/>. I verify the information provided is true and correct. If I am the caregiver for the patient, I confirm I am authorized to sign on behalf of the patient.

Income Validation Consent

I understand and authorize Jazz and its affiliates and vendors to use a third-party financial services company to run an income validation to determine eligibility for patient assistance programs. If discrepancies are found during this validation, JazzCares may request additional supporting income documentation.

- ☐ If you prefer not to consent to an income validation, please check the box. By opting out of the income validation, you will need to provide proof of income documentation to determine your eligibility for the patient assistance program.

Consent to Telephone Communications (TCPA Consent)

- ☐ By checking this box, I consent to Jazz calling and texting me at the phone numbers(s) provided with promotional communications relating to Jazz products and services and/or my condition or treatment (standard text messaging rates may apply). I can reply STOP to opt out at any time.

Consent to Share Health Information

Signature of patient or patient representative: _____ Date: ____ / ____ / ____

Patient representative name: _____ Patient representative phone number: (____) ____ - ____

JazzCares Program Consent

Signature of patient or patient representative: _____ Date: ____ / ____ / ____

Patient representative name: _____ Patient representative phone number: (____) ____ - ____

Questions? Call 1-844-302-2737 or visit jazzcares.com