Anzupgo® Let's GO™

Patient Assistance Program Enrollment Form

INSTRUCTIONS FOR HEALTHCARE PROFESSIONALS

Complete all required fields with an asterisk

Have your patient complete and sign the Patient Information section (*page 1*) after reading the Patient Authorization in Section 6 (*page 3*)

Sign the Prescriber Certification in Section 5 (*page 2*)

Fax this completed form (*pages 1-3*) to 855-299-8746 or email it to info@AnzupgoLetsGo.com

***Required**

SECTION 1: Patient Information (*to be completed by patient*)

Note: Patients enrolling in the ANZUPGO® Patient Assistance Program (PAP) must be at least 18 years of age.

Patient name*: _____ (FIRST) _____ (MI) _____ (LAST) Date of birth*: ____/____/____ (MM/DD/YYYY) Gender*: ☐ M ☐ F ☐ Prefer not to say

Address*: _____ City*: _____ State*: _____ ZIP*: _____

Primary phone*: _____ Alternate phone: _____ OK to leave a detailed message? ☐ Yes ☐ No

Preferred contact method: ☐ Text ☐ Call ☐ Email Preferred time of day to contact: ☐ Morning ☐ Afternoon ☐ Evening

Email: _____ Primary language: _____

Legal representative name (*if applicable*): _____ (FIRST) _____ (LAST)

Legal representative phone number: _____ Legal representative email: _____

☐ **ANZUPGO® PAP** – I agree this is written authorization for LEO Pharma and its vendors under the Fair Credit Reporting Act (FCRA), to obtain information from my credit profile or other information, solely for the purpose of determining financial qualifications for PAP administered by LEO Pharma. I understand that I must affirmatively agree to these terms to proceed with the financial screening process, which is a condition of participation in PAP.* *NOTE : Please also be prepared to provide household size and proof of income which is required for PAP eligibility evaluation.*

☐ ***(Optional)* I am 18 years of age or older and want to receive helpful tips and resources** about LEO Pharma Inc. and its products and services, including research opportunities, promotional materials about products, disease education, or other savings programs. By checking the box, I agree to be contacted by LEO Pharma Inc. and its service providers to receive marketing communications, including by email, SMS, call, or text message. I understand that I may opt out at any time by calling 1-855-ANZUPGO (269-8746) or by contacting us following the instructions in How to Contact Us in the LEO Pharma Privacy Policy at Leo-pharma.us/privacy-policy. Consent is not a condition of receipt of goods or services. Message frequency may vary. Text HELP for info. Text STOP to cancel. Message and data rates may apply.

For details about how we collect and use personal information, including individual privacy rights, please see LEO Pharma privacy policy, located at Leo-pharma.us/privacy-policy.

Patient Authorization: I certify that I have read the Patient Authorization in Section 6 (*page 3*), and I authorize the disclosure of my information to LEO Pharma as described.

SIGN HERE* _____ ____/____/____ (MM/DD/YYYY)

Patient/legal representative signature

Relationship to patient (*if applicable*)

Program Terms and Conditions: By signing below, I agree to the ANZUPGO PAP Terms and Conditions located at Anzupgo.com/terms-and-conditions.

SIGN HERE* _____ ____/____/____ (MM/DD/YYYY)

Patient/legal representative signature

Relationship to patient (*if applicable*)

Click or scan the QR code for Program Terms and Conditions.

Anzupgo.com/terms-and-conditions

For more information about the ANZUPGO Let's GO Support Program, call 1-855-ANZUPGO (269-8746), Monday-Friday, 8 AM-8 PM ET.

SECTION 2: Insurance Information

NOTE: You may attach a copy of both sides of the patient's insurance card(s) instead of, or in addition to, the below:

Coverage: ☐ Medicare ☐ Medicaid ☐ Commercial/Private ☐ Other ☐ Uninsured

Primary prescription insurance*: _____ Group number*: _____

Phone number*: _____ Policy ID*: _____ PCN*: _____ BIN*: _____

Policyholder name*: _____ Policyholder date of birth*: ____/____/____ (MM/DD/YYYY)

Policyholder relationship to patient*: _____

Secondary prescription insurance? ☐ Yes ☐ No

If the patient is insured and the insurance requires a prior authorization (PA), you must submit a copy of the PA and/or appeal outcome for the medication.

Anzupgo® Let's GO™

Patient name*: First: _____ MI: ☐ Last: _____

Patient date of birth*: ___/___/___ (MM/DD/YYYY)

*Required

SECTION 3: Clinical Information

☐ Diagnosis: Chronic Hand Eczema ☐ Tried and failed topical corticosteroids (TCS) or TCS inadvisable for patient

NOTE: Please complete the following information within this box. The coding information provided is for informational purposes only, is subject to change, and may not apply to all patients or all health plans. The healthcare professional is responsible for selecting the appropriate ICD-10-CM code(s).

ICD-10-CM code(s) (*See below for example codes*)*: _____

Atopic dermatitis:	**Allergic contact dermatitis:**	**Irritant contact dermatitis:**	**Protein contact dermatitis:**	**Acute, recurrent vesicular (dyshidrosis):**	**Hand dermatitis:**
L20.89, L20.9	L23.0-L23.9	L24.0-L24.B3	L25.0-L25.9	L30.1	L30.8

Clinical notes attached? ☐ Yes ☐ No Date of diagnosis: ___/___/___ (MM/DD/YYYY)

Current therapies: _____

Medication allergies: _____ ☐ No known allergies

☐ Check here if patient has initiated ANZUPGO® therapy with samples Date samples started: ___/___/___ (MM/DD/YYYY)

SECTION 4: Prescriber Information

Prescriber name*: _____ NPI number*: _____ State license number: _____

Office name*: _____ Office phone*: _____ Office fax: _____

Address*: _____ City*: _____ State*: _____ ZIP*: _____

Office contact name: _____ Office contact email: _____

SECTION 5: ANZUPGO® (delgocitinib) Prescription Information

Limited distribution network pharmacies

Click or scan the QR code for the most current and complete list.

https://www.anzupgohcp.com/full-list-participating-pharmacies

Has the Rx already been sent to an ANZUPGO® limited distribution network pharmacy? ☐ Yes ☐ No

Limited distribution network pharmacy name: _____

NOTE: Complete ANZUPGO® limited distribution network pharmacy prescription AND ANZUPGO® PAP prescription and sign the Prescriber Certification below.

	Medication and Prescription Type	Dosage Form and Strength	Quantity	Refills	Dosage Instructions
PHARMACY	☐ **ANZUPGO® limited distribution network pharmacy prescription**	30 g tube Cream, 2%	1	____ (specify)	Apply a thin layer of ANZUPGO, twice daily, to the affected areas only on the hands and wrists.
PAP	☐ **ANZUPGO® PAP prescription†**	30 g tube Cream, 2%	1	____ (specify)†	Apply a thin layer of ANZUPGO, twice daily, to the affected areas only on the hands and wrists.

†I approve the dispense of a limited supply of ANZUPGO® for my patient if they experience a qualified lapse in insurance coverage, in accordance with the Terms, Conditions, and Eligibility Rules found at Anzupgo.com/terms-and-conditions.

ATTENTION PRESCRIBERS: Please follow your state's prescribing guidelines for electronic prescribing (if applicable).

Prescriber certification

By signing and dating below, I certify this therapy is medically necessary and this information is complete and accurate to the best of my knowledge. I certify that I am the prescriber who has prescribed ANZUPGO® to the identified patient above for an FDA-approved indication. For the purposes of transmitting this prescription, I authorize LEO Pharma, its affiliates, business partners, agents and service providers, including patient support program service providers (collectively, "LEO Pharma") to forward for these limited purposes this prescription electronically, by facsimile, or by mail to the appropriate dispensing pharmacies. I authorize for my commercially insured patients one or more months of temporary shipments of ANZUPGO® during a benefits determination delay or during the appeal process after an initial coverage delay for ANZUPGO® for the above identified patient. I agree to assist in efforts to secure access to ANZUPGO® for my commercially insured patient. I will not attempt to seek reimbursement for any free product provided under the ANZUPGO® Let's GO™ Support Program and no medication may be returned for credit. I certify that any medication received will be used only for the patient named on this form and will not be offered for sale, trade, or barter. I acknowledge that this program is exclusively for the purposes of patient care and not for remuneration of any sort. I further understand that any free product provided is not contingent on any purchase obligations. I understand that LEO Pharma may revise, change, or terminate the Program at any time without notice. I certify that I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to LEO Pharma and its affiliates, business partners, and agents for purposes relating to LEO Pharma patient support programs, including assisting the patient with benefits verification, prior authorization/appeals assistance, financial assistance resources and information, such as copay support or free drug programs, for which the patient may be eligible, and other support for ANZUPGO®.

PRESCRIBER SIGNATURE*

SIGN HERE* _____ Date*: ___/___/___ (MM/DD/YYYY)

Prescriber signature (No Stamps)* – DISPENSE AS WRITTEN/BRAND MEDICALLY NECESSARY/DO NOT SUBSTITUTE/ NO SUBSTITUTION/DAW/MAY NOT SUBSTITUTE

OR

SIGN HERE* _____ Date*: ___/___/___ (MM/DD/YYYY)

Prescriber signature (No Stamps)* – MAY SUBSTITUTE/PRODUCT SELECTION PERMITTED/SUBSTITUTION PERMISSIBLE

SECTION 6: Patient Authorization

Please read the following carefully, then sign and date where indicated in Section 1 on page 1.

I hereby authorize my healthcare providers, pharmacies, and health insurers, and their service providers (collectively, "Authorized Parties") to use, release, share, or disclose information relating to my insurance benefits, medical condition, treatment, and prescription details related to my therapy ("Personal Information") to LEO Pharma, its affiliates, business partners, agents, and service providers, including patient support program service providers (collectively, "LEO Pharma"), in order to receive or be eligible to receive the following LEO Pharma services (the "Services"):

- Assistance coordinating insurance coverage for, access to, or receipt of my prescription medication from LEO Pharma
- Communications through phone, text, or email about possible access, savings and support services, including, for example, LEO Pharma patient support programs, and, if I am enrolled, assistance administering my participation in those programs
- Communications through phone, text, or email about my prescription medication from LEO Pharma and treatment, including, for example, reminders, health and lifestyle tips, product, and program-related information. Communications may be customized based on Personal Information obtained from my Authorized Parties
- Participation in quality assurance activities such as surveys and feedback related to the Services or my treatment

In delivering the Services, LEO Pharma may release or disclose my Personal Information (including the personal health information set forth therein) to my Authorized Parties and certain financial assistance programs that may assist with my prescription medication payments. I understand and acknowledge LEO Pharma and Authorized Parties may combine my records and information with information and data collected from other sources and use that aggregated information to administer the Services listed above. I understand and acknowledge LEO Pharma may be required to share my records and information with law enforcement authorities or other government officials, or when required by law, statute, regulation, or a judicial or administrative order.

Once I authorize the release of my records and information, I understand and acknowledge it may be re-disclosed by the recipient, and it may no longer be protected by federal or state health privacy laws or other applicable data protection laws or regulations.

I understand that this Authorization is voluntary and that I do not have to sign it in order to get treatment or payment of eligibility in or enrollment benefits from my insurers.

I understand that I can revoke this Authorization at any time by calling 1-855-ANZUPGO (269-8746) or by emailing info@AnzupgoLetsGo.com or writing to:

ANZUPGO® Let's GO™
PO Box 1587
Jeffersonville, IN 47131

OR

LEO Pharma Support Services
7 Giralda Farms
Madison, NJ 07940

This Authorization will expire 5 years after I sign it, or earlier if required by law, unless I revoke it sooner. If the Authorization expires or is revoked, I understand and acknowledge that I may no longer qualify for Services from LEO Pharma, but it will not impact my treatment or my insurance benefits from Authorized Parties. I also understand and acknowledge that if an Authorized Party is disclosing my records and personal health information to LEO Pharma on an authorized, ongoing basis, my revocation of this Authorization will be effective with respect to that Authorized Party as soon as that Authorized Party receives notice of my revocation and such revocation will not affect prior uses or disclosures of my records and personal health information. I understand that I will be able to keep a copy of this Authorization and may, at any time, request a copy of this Authorization. My information may be de-identified and aggregated by LEO Pharma. I understand that my information will be used by LEO Pharma in accordance with the LEO Pharma privacy policy, located at Leo-pharma.us/privacy-policy.

Please see full Prescribing Information and Medication Guide.