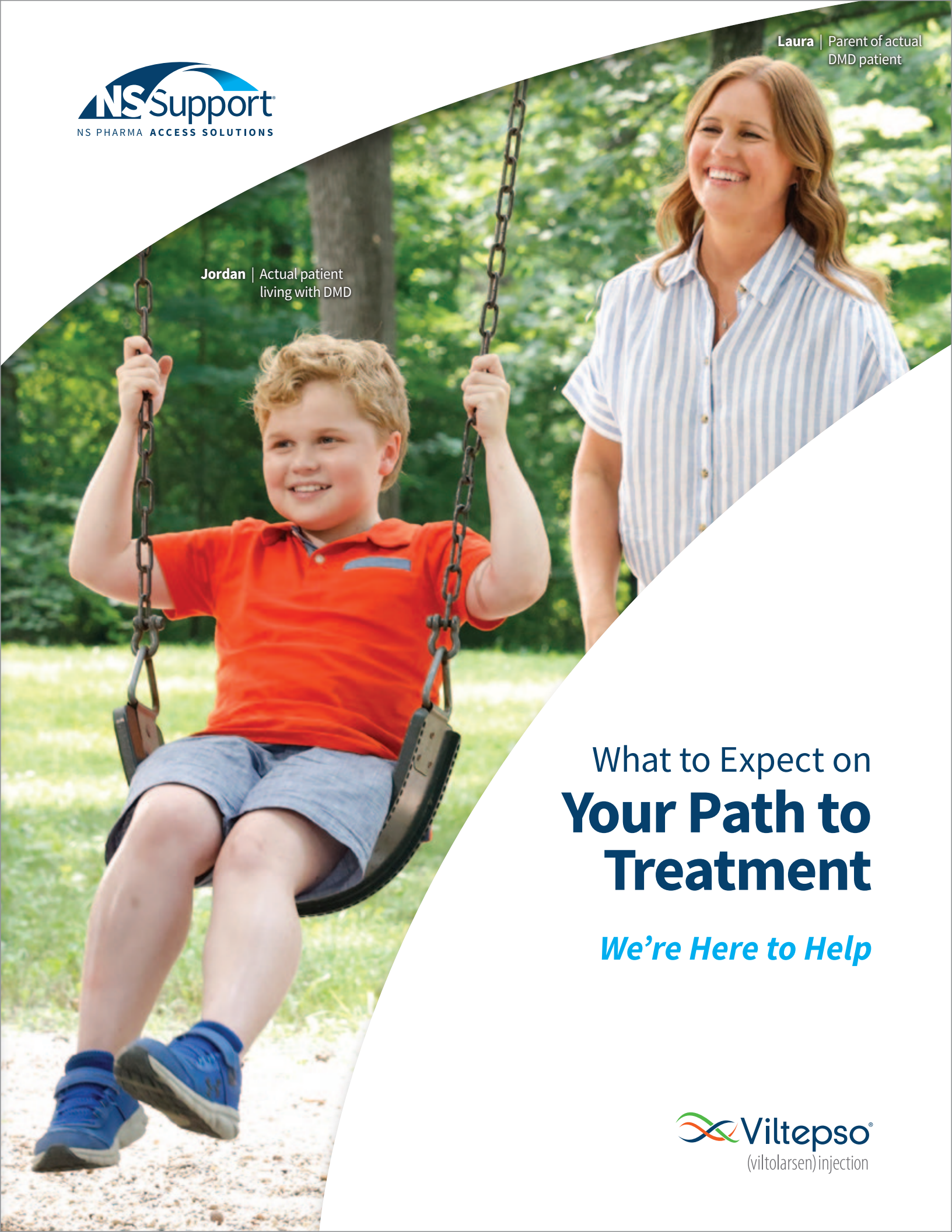
NS Support
NS PHARMA ACCESS SOLUTIONS



What to Expect on

Your Path to Treatment

We're Here to Help

Viltepso®
(viltolarsen) injection

Your Journey...
Our Commitment

Starting treatment can be a challenge. That's why there is a dedicated care team at NS Support to provide you with personalized assistance... ***all along the way.***

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833-NSSUPRT (833-677-8778)
Monday–Friday, 8 AM–8 PM ET

Jordan | Actual patient living with DMD

INDICATION

VILTEPSO is indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 53 skipping. This indication is approved under accelerated approval based on an increase in dystrophin production in skeletal muscle observed in patients treated with VILTEPSO. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.

IMPORTANT SAFETY INFORMATION

In clinical studies, no patients experienced kidney toxicity during treatment with VILTEPSO. However, kidney toxicity from drugs like VILTEPSO may be possible. Your doctor may monitor the health of your kidneys before starting and during treatment with VILTEPSO.

Common side effects include upper respiratory tract infection, injection site reaction, cough, and fever.

For more information about VILTEPSO, visit **www.VILTEPSO.com** and see full **Prescribing Information**.

Viltepso®
(viltolarsen) injection

Your **Care Team** & How They Help

Your Doctor and staff are the leaders of your care team, working with you to determine the most appropriate treatment plan. Once you and your doctor decide to begin treatment with VILTEPSO® (viltolarsen), our team at NS Support will be there to provide ongoing information and customized resources to assist in your care.

START

Your doctor submits a Patient Start Form on your behalf to NS Support

Your ***health plan*** will likely need some information and may take time to approve your treatment. Our team will work with your plan to make sure it has all the details it needs quickly. If, for some reason, your plan doesn't approve your coverage right away, your doctor and care team will file an appeal on your behalf.

You'll also get a call from your ***NS Support Patient Engagement Lead (PEL)*** — a dedicated resource who works directly with you and your care team to provide personalized access support, coordinate care, and help reduce delays throughout the treatment journey.

Treatment is approved

Once treatment is approved, we can help you and your doctor choose an ***infusion provider*** who is right for you. Depending on your coverage, you may have a number of options — including treatment right in your home. The infusion provider can also help coordinate your schedule and provide helpful appointment reminders.

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Infusion is scheduled

Expect a call from an ***NS Support Case Manager***, who will welcome you, go over your health plan coverage, help you understand possible cost support options, and explain how we can help. We can also put you in touch with your Patient Engagement Lead.

Your care team will check in and help avoid process delays by scheduling follow-up calls, answering questions, and streamlining ongoing health plan reauthorizations to keep things on track.

Our goal at NS Support is to assist patients, their caregivers, and healthcare providers through the entire process and make the path to treatment as smooth as possible.

Patient support **with a personal touch**

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Helpful Healthcare **Terms to Know**

Appeal: The action you and your doctor can take if you disagree with a coverage or payment decision made by your health plan.

Benefits: The treatments or services covered by your health plan. In Medicaid or the Children's Health Insurance Program (CHIP), covered benefits are defined in state program rules.

Benefits Summary: A document provided to you and your doctor by your health plan explaining your coverage for medication, treatment, and services.

Claim: A request for payment that you or your doctor submit to your health plan when you get treatments and services that are covered by the plan.

Coverage Determination: A decision your health plan makes on whether they will cover some, or all, of the cost of a treatment or service.

Denial: A health plan's refusal to pay for treatments or services. Depending on the type of denial, you may be able to appeal the decision.

Exception Request: A formal request by you or your doctor to consider health plan coverage when your health plan does not cover a treatment or service.

Formulary: A published list of drugs covered by a prescription drug plan or a health plan that offers prescription drug benefits.

Health Plan: An individual or group plan that provides, or pays the cost of, medical care and/or prescription drugs.

Infusion Provider: The service provider who may be designated by your health plan to provide infusion therapy at a hospital, infusion center, or in your home.

Payer (Insurance Company): The entity that pays your health insurance claims, such as a commercial health plan, third-party health plan administrator, and government programs such as Medicare and Medicaid.

Prior Authorization: The mandatory approval from your health plan that may be needed before you can get coverage for a treatment or service prescribed by your doctor.

Reauthorization: A subsequent review and approval, if required by your health plan, to continue a treatment or service after an initial coverage determination and prior authorization.

See complete list of terms.

For more information about VILTEPSO, visit **www.VILTEPSO.com** and see full **Prescribing Information**.

Viltepso® (viltolarsen) injection

Your **Info & Notes**

Doctor _____ Phone _____

NS Support Case Manager _____ Phone _____

NS Support Patient Engagement Lead _____ Phone _____

Infusion Provider _____ Phone _____

Infusion Nurse _____ Phone _____

Notes

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Speak to your healthcare professional for more information about VILTEPSO, or visit VILTEPSO.com.

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NS Support **Terms to Know**

Advocacy Group: An organization you can join that provides patient- and caregiver-focused education, representation, and support services.

Appeal: The action you and your doctor can take if you disagree with a coverage or payment decision made by your health plan.

Benefits: The treatments or services covered by your health plan. In Medicaid or the Children's Health Insurance Program (CHIP), covered benefits are defined in state program rules.

Benefits Investigation: The process taken to determine your health plan coverage for a particular treatment or service.

Benefits Summary: A document provided to you and your doctor by your health plan explaining your coverage for medication, treatment, and services.

Bridge: A program that covers patients experiencing issues during the reauthorization process. Patients must meet eligibility requirements.

Claim: A request for payment that you or your doctor submit to your health plan when you get treatments and services that are covered by the plan.

Clinicals: The documented medical information derived from medical examinations and tests that your doctor uses to describe your condition, develop a treatment plan, and obtain authorization for the treatment plan.

Coinsurance: A percentage of the cost of your medications and healthcare services that you must pay out-of-pocket before your health plan provides coverage for the remainder of the costs.

Coordination of Benefits: A process to determine which health plan pays first for the same medical claim when you are covered by two or more health plans.

Copay: A set amount that you must pay out-of-pocket for the cost of medications and healthcare services before your health plan provides coverage for the remainder of the costs.

Coverage: The specific terms and conditions, including costs, that define what your health plan will provide for your treatment by a doctor or healthcare service.

Coverage Determination: A decision your health plan makes on whether they will cover some, or all, of the cost of a treatment or service.

Criteria: The patient demographic information or clinical data used to support requirements for a coverage determination, prior authorization or reauthorization.

Deductible: The initial out-of-pocket cost you must pay before your health plan begins to pay for treatments or healthcare services.

Denial: A health plan's refusal to pay for treatments or services. Depending on the type of denial, you may be able to appeal the decision.

DocuSign®: An online service that enables you to read and sign documents electronically.

Exception Request: A formal request by you or your doctor to consider health plan coverage when your health plan does not cover a treatment or service.

Excluded Services: Health care services that your health plan does not typically pay for or cover.

External Appeal: A formal effort to overturn your health plan's denial of an exception request by an outside, independent decision-maker, regardless of the type of insurance or state an individual lives in.

Formulary: A published list of drugs covered by a prescription drug plan or a health plan that offers prescription drug benefits.

Health Plan: An individual or group plan that provides, or pays the cost of, medical care and/or prescription drugs.

Infusion Provider: The service provider who may be designated by your health plan to provide infusion therapy at a hospital, infusion center, or in your home.

Medicaid: A joint federal and state health insurance program that helps with medical costs for some people with physical or mental disabilities and/or limited income and resources. Eligibility and benefits vary from state to state.

NS Support **Terms to Know** (cont'd)

Medicaid Waiver: An exception allowing the state Medicaid service to put aside the rules that usually apply to the Medicaid program, some of which pertain to children, such as the Katie Beckett and 1915c waivers. This type of waiver may also help provide you with additional services for long-term care.

Medical Benefit: Typically covers most medical procedures and services performed by a doctor as well as the medications given by a healthcare professional, such as an infusion or injection.

Not Medically Necessary: A health plan's classification for treatments or services your doctor may want to provide to you that is considered unwarranted, or more costly than equivalent treatments or services.

Orders: The documents your doctor uses to describe your treatment process.

Out-of-Pocket Program (or Copay Assistance Program): A specific program, usually sponsored by a pharmaceutical manufacturer, designed to cover deductibles, copays, or coinsurance for your medication, if you are commercially insured.

Patient Assistance Program (PAP): A program, typically sponsored by a pharmaceutical manufacturer, that provides financial assistance to supplement or cover all of your prescription drug costs. Patients must meet eligibility requirements.

Patient Start Form: The required document you and your doctor fill out and fax to NS Support in order to receive a prescription medication as well as to enroll in NS Support.

Payer (Insurance Company): The entity that pays your health insurance claims, such as a commercial health plan, third-party health plan administrator, and government programs such as Medicare and Medicaid.

Peer-to-Peer: A type of consultation your doctor may have with other healthcare providers to help determine your best treatment options, plans, and/or strategies. This may also occur when your doctor is seeking support or approval for a coverage determination from your health plan or when health plan coverage has been denied.

Pharmacy Benefit: Also called a Prescription Benefit, it is the coverage your health plan offers for prescription medications, usually medications you are able to give yourself at home.

Pre-Certification: The process your doctor may be required to follow in collecting information about your medical condition to validate the need for a treatment or service.

Pre-Determination: A payer's review of your doctor's recommended services to make sure it is considered medically necessary.

Primary Insurance: The health insurance that typically pays first on your claim for treatments and services.

Prior Authorization: The mandatory approval from your health plan that may be needed before you can get coverage for a treatment or service prescribed by your doctor.

Provider: Any individual or group of individuals that supplies you with a health care service, such as a physician, hospital, group medical practice, nursing home, or pharmacy.

Reauthorization: A subsequent review and approval, if required by your health plan, to continue a treatment or service after an initial coverage determination and prior authorization.

Secondary Insurance: Health insurance that covers costs after the primary insurance. It usually pays for all or some of the costs not covered by the primary insurance but may not cover services that primary insurance didn't cover.

Specialty Pharmacy: A licensed pharmacy that typically provides medications for patients with conditions requiring complex therapies. It may also provide counseling services for your condition and treatment, and other ancillary support services for you and your doctor.

NS Pharma