NS Support™
NS PHARMA ACCESS SOLUTIONS

Patient Start Form

Mail or fax the completed form to:
NS Support Program, PO Box 29203, Phoenix, AZ 85038-9203, Phone: 833-NSSUPRT (833-677-8778), Fax: 888-212-0482

1. PATIENT/PARENT/GUARDIAN /LEGAL REPRESENTATIVE INFORMATION

PATIENT NAME (First, MI, Last) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DOB (MM/DD/YYYY) _____ GENDER ☐ Male ☐ Female

PRIMARY CONTACT NAME _____ RELATIONSHIP TO PATIENT _____

PREFERRED PHONE # _____ EMAIL _____

BEST TIME TO CALL ☐ AM ☐ PM ____OK TO LEAVE MESSAGE? ☐ Yes ☐ No LANGUAGE, OTHER THAN ENGLISH _____

2. INSURANCE INFORMATION ☐ Check if you are attaching a copy of the patient's insurance cards (front and back copy)

PRIMARY _____ ID # _____ GROUP # _____ PHONE _____

POLICYHOLDER _____ RELATIONSHIP TO PATIENT _____

SECONDARY _____ ID # _____ GROUP # _____ PHONE _____

POLICYHOLDER _____ RELATIONSHIP TO PATIENT _____

3. PATIENT/PARENT/GUARDIAN/LEGAL REPRESENTATIVE AUTHORIZATION

By signing below, I certify and acknowledge that I have read, understand, and agree to the Patient/Parent/Guardian/Legal Representative Authorization on page 2 of this form, for the patient to participate in the NS Support Program, and to release the patient's Protected Health Information to NS Pharma, Inc. (as defined on page 2 of this form), supporting the access program as indicated on the Patient/Legal Guardian Authorization.

PARENT/GUARDIAN/LEGAL REPRESENTATIVE/PATIENT (IF OVER 18) SIGNATURE _____ DATE _____

PARENT/GUARDIAN/LEGAL REPRESENTATIVE/PATIENT (IF OVER 18) PRINT NAME _____

RELATIONSHIP TO PATIENT _____

4. PHYSICIAN INFORMATION

NAME (First, Last) _____ AFFILIATION _____

ADDRESS _____ SUITE # _____ CITY _____ STATE _____ ZIP _____

NPI # _____ STATE LICENSE # _____ TAX ID # _____ DEA ID # _____

OFFICE CONTACT _____ PHONE _____

FAX _____ EMAIL _____

5. SITE OF CARE (IF KNOWN) ☐ Hospital Clinic ☐ Home Infusion ☐ Physician's Office ☐ Other ☐ Needs Site of Care

SITE NAME _____

ADDRESS _____ SUITE # _____ CITY _____ STATE _____ ZIP _____

SITE CONTACT _____ PHONE _____

FAX _____ EMAIL _____

6. EXON CONFIRMATION

☐ Exon 53 Amenable Exon deletion(s): _____

7. PHYSICIAN DECLARATION (a physician's signature is required in order for NS Support to perform a benefits verification)

By signing below, I certify that (1) the therapy is medically necessary and in the best interest of the patient identified above; (2) the patient is appropriately indicated for the therapy; and (3) I have obtained and provide any consent required under federal and state law for the release and use of the patient's information on this form to NS Pharma, Inc. and its agents, including its commercial and field-based teams, for purposes of benefits verification and coordination of dispensing the therapy.

PHYSICIAN NAME (Please Print) _____

PHYSICIAN SIGNATURE _____ DATE _____

Patient/Parent/Guardian/Legal Representative Copy

Provider Instructions

1. **Instruct the patient or parent/guardian/legal representative to read this page and sign the authorization in Section 3 on page 1 of the Patient Start Form.**
2. **Give the patient or parent/guardian/legal representative a copy of page 1 of the NS Support Patient Start Form, and a copy of the Parent/Guardian/Legal Representative Authorization on this page.**

PARENT/GUARDIAN/LEGAL REPRESENTATIVE AUTHORIZATION ON BEHALF OF PATIENT

My (or my parent/guardian/legal representative's) signature on page 1 of the Patient Start Form ("the Form") authorizes each of my physicians and pharmacists (including any specialty pharmacies and other healthcare providers) and each of my health insurers to use and disclose my Protected Health Information ("PHI"), including but not limited to medical records, information related to my medical condition and treatment, financial information, lab values, insurance coverage information, my name, address, and telephone number, to NS Pharma, Inc., and its agents, contractors, and assignees (together, "NS Pharma") to enroll me in and contact me (or my parent/guardian/legal representative) about NS Support, provide case management through telephone or electronic communications to assist with adherence to my medication regimen, and work with third parties to provide community resources and referrals. Third-party vendors, such as specialty pharmacies, may receive financial renumeration in exchange for data, product support services, reimbursement services, etc. This authorization expires 5 years from the date of execution, or 1 year after the date of my last prescription, whichever is later, unless a shorter period is required by state law. I (or my parent/guardian/legal representative) understand that I (or my parent/guardian/legal representative) may refuse to sign this authorization and that my treatment, payment, enrollment, or eligibility for benefits, including my access to therapy, is not conditioned on signing this authorization. I (or my parent/guardian/legal representative) understand that revoking this authorization will not affect the ability to use and disclose PHI received prior to receipt of notification that I (or my parent/guardian/legal representative) wish to discontinue my participation in the program. I (or my parent/guardian/legal representative) understand that I (or my parent/guardian/legal representative) may revoke this authorization at any time verbally at 833-NSSUPRT (833-677-8778) or in writing to NS Support at PO Box 29203, Phoenix, AZ 85038-9203. Once authorization has been revoked or expired, I (or my parent/guardian/legal representative) understand that my future PHI will not be disclosed. I (or my parent/guardian/legal representative) understand that my PHI will not be used or disclosed for any other purposes, unless permitted by law, than for the purposes stated above. Information disclosed pursuant to this authorization or provided to a third-party may no longer be protected by federal privacy laws. I (or my parent/guardian/legal representative) understand that I (or my parent/guardian/legal representative) have a right to receive a copy of this authorization.

A copy of this authorization will be as valid as the original. Cancelling this authorization will not affect the ability of NS Pharma to use and disclose Protected Health Information that it has received prior to receipt of the cancellation of my (or my parent/guardian/legal representative's) authorization. My (or my parent/guardian/legal representative's) authorization will also end if NS Support is discontinued. Furthermore, I (or my parent/guardian/legal representative) understand that I (or my parent/guardian/legal representative) have the right to see or copy the Protected Health Information the patient's Healthcare Providers or Insurers have given to NS Pharma.

NS Pharma