NS Support™

NS PHARMA **ACCESS SOLUTIONS**

Helping to provide affordable access to VILTEPSO™ (viltolarsen) injection

Options to make treatment more affordable

Viltepso™

(viltolarsen) injection

NS Support™
NS PHARMA ACCESS SOLUTIONS

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

NS Support Co-pay Assistance Program

Eligible patients with commercial insurance coverage for treatment with VILTEPSO™ (viltolarsen) **may be automatically enrolled** once NS Support receives their completed Patient Start Form for VILTEPSO.*

For your patients:

- Savings on their co-pay costs for VILTEPSO
- Pay as little as $0 per infusion (program covers the cost of the medication and does not cover the costs to administer the infusion)
- Applicable out-of-pocket costs are covered—up to $20,000 per calendar year
- Automatic re-enrollment for the next calendar year, available ONLY to eligible patients with commercial insurance

For your office:

- Electronic or paper processes to submit requests for co-pay assistance
- Support with information and answers to questions about the program by calling 833-NSSUPRT (833-677-8778)

*Restrictions apply. See full Eligibility Requirements & Terms and Conditions inside.

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

Viltepso™
(viltolarsen) injection

Once patients enroll in NS Support,
a personally assigned Case Manager can help them and their families identify potential options to make treatment more affordable.

INDICATION

VILTEPSO is an antisense oligonucleotide 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

- **Warnings and Precautions:** In clinical studies, no patients experienced kidney toxicity during treatment with VILTEPSO. However, kidney toxicity from drugs like VILTEPSO may be possible. Serum cystatin C, urine dipstick, and urine protein-to-creatinine ratio should be measured before starting and during treatment with VILTEPSO. Consider measuring GFR before starting VILTEPSO.
- **Adverse Reactions:** The most common adverse reactions include upper respiratory tract infection, injection site reaction, cough, and pyrexia.

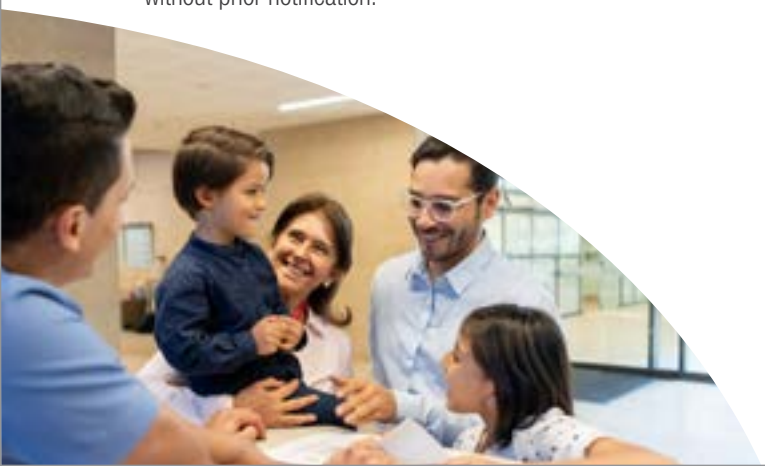
NS Support™
NS PHARMA ACCESS SOLUTIONS

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

Co-Pay Assistance Program

Eligibility Requirements & Terms and Conditions

- You must be a citizen or a permanent resident of the US or its territories and reside in the US or its territories where co-pay assistance is not prohibited.
- You must not be enrolled in government health insurance (eg, Medicare, Medicaid, Indian Health Service, Veterans Administration, Department of Defense, or any other federal or state government assistance programs). If you move or switch from commercial insurance to any government-funded insurance, you will no longer be eligible.
- You are being treated as an outpatient by a licensed healthcare provider in the US and have been prescribed VILTEPSO™ (viltolarsen) by a licensed healthcare provider.
- You currently have private, commercial health insurance with prescription coverage for VILTEPSO medication, and your insurance does not cover the entire cost of VILTEPSO.
- You are under age 65.
- There is no income requirement.
- The Program covers only the cost of VILTEPSO and not the cost of any infusion services or healthcare provider visits, which are the sole responsibility of the patient.
- You will be automatically re-enrolled on December 31 in subsequent calendar years after the initial enrollment period ends as long as you continue to meet the eligibility requirements for participation in the Program.
- You are responsible for reporting receipt of co-pay assistance to any insurer, health plan, or other third party who pays for or reimburses any part of the medication or treatment cost using the NS Support Co-pay Assistance Program, as may be required.
- You must not seek reimbursement, in whole or in part, from government health insurance (eg, Medicare, Medicaid, Indian Health Service, Veterans Administration, Department of Defense, or any other federal or state government assistance programs), a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Account (HRA).
- You will not in any way report or count the value of the product provided under this Program as true out-of-pocket spending (TrOOP) under a Medicare Part D prescription drug benefit.
- Claims must be submitted in a timely manner. An EOB from your private, commercial health insurance must be submitted within 365 days of the date of service on the EOB for you to receive a co-pay assistance benefit. No EOB may be submitted more than 90 days after the expiration date of the Co-pay Assistance Program, and the date of service on the EOB must be prior to the program expiration date. The EOB must reflect your out-of-pocket cost for VILTEPSO and submission of the claim by your physician for the cost of the medication.
- The NS Support Co-pay Assistance Program is not health insurance.
- NS Pharma, Inc. has the right to modify, alter, or cancel the NS Support Co-pay Assistance Program at any time without prior notification.



Viltepso™
(viltolarsen) injection

NS Support™
NS PHARMA ACCESS SOLUTIONS

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

Medicaid Waiver Programs
for children with Duchenne muscular dystrophy (DMD)

How Medicaid waivers work

Through the use of Medicaid waivers, a child with DMD and their family may qualify for Medicaid assistance that is not based on income alone. Medicaid waivers may provide these children with additional services and wrap-around Medicaid coverage to help pay for uncovered services.

Because Medicaid waiver programs are state based, they each have their own rules and benefits. Waiver services in one state will not be transferred to other states in the event you move your residence. In addition, many states have people already on waiver waiting lists that are more than 3 years long before services are granted.

Types of Medicaid waivers

1915(c) waivers, more commonly known as Home- and Community-Based Services (HCBS) waivers

- Permit children with medical, developmental, and intellectual disabilities, including those with DMD, who are not low income to access Medicaid
- Provide services beyond regular Medicaid so that children with DMD can be treated in home- or community-based settings, rather than in long-term care facilities, such as nursing homes
- All states have some type of HCBS waiver program, and most states have more than one HCBS program

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)/Katie Beckett waivers

- Provide full or additional coverage, including the cost of medications, for children younger than 19 who live at home with physical or mental disabilities, mental illness, or other complex medical needs
- Financial eligibility for a child with DMD is based only on the child's income and assets, and not on the income of his parents
- States that offer TEFRA/Katie Beckett waivers must serve all eligible children who apply, and there is no waiting list
- However, TEFRA/Katie Beckett programs are voluntary, meaning states can choose whether or not to offer them

Section 1115 waivers

- Present an opportunity for states to create unique programs to meet the needs of children with disabilities or replace their Medicaid program entirely:
  - Expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible
  - Provide services not typically covered by Medicaid
  - Use innovative service delivery systems that improve care, increase efficiency, and reduce costs as long as these systems do not increase federal Medicaid expenditures

To learn more about Medicaid waivers available in your state, visit: **medicaidwaiver.org** and click on "Disability Benefits."

Kidswaivers.org is another helpful resource for learning more about Medicaid waivers for children.

Viltepso™
(viltolarsen) injection

Patient Assistance Program (PAP) for VILTEPSO

- May help patients in financial need who are uninsured
- Patients who meet program requirements may be able to receive VILTEPSO at no charge for up to one year (program covers the cost of the medication and does not cover the costs to administer the infusion)

Restrictions apply. See full Eligibility Requirements & Terms and Conditions below.

Eligibility Requirements & Terms and Conditions

- You must be a citizen or a permanent resident of the US or its territories and reside in the US or its territories.
- You must not be covered, in whole or in part, by government health insurance (eg, Medicare, Medicaid, CHIP, TRICARE, Indian Health Service, Department of Defense, or other federal or state assistance programs).
- You are being treated as an outpatient by a licensed healthcare professional in the US and have been prescribed VILTEPSO™ (viltolarsen) by a licensed healthcare professional.
- You must be uninsured.
- Your income must not exceed 4 times the Federal Poverty Level based on household size (Federal Poverty Level Guidelines available at https://aspe.hhs.gov/poverty-guidelines).
- You must submit accurate and complete documentation (eg, most recent federal tax return, W-2, pay stubs, Social Security Award Letter or check) as requested by NS Pharma, Inc. each year to validate levels of income.
- You and your prescriber may not bill, charge, seek credit for or otherwise submit any claim for reimbursement for VILTEPSO provided through the Patient Assistance Program to any third-party payor.
- NS Pharma, Inc. and NS Support have the right to verify your eligibility, including the right to audit any information provided on the Patient Start Form, and the right to contact you to confirm receipt of medications.
- NS Pharma, Inc. and NS Support in their sole discretion can determine your eligibility to participate in the NS Support Patient Assistance Program.
- Approved patients will be eligible to receive assistance for one year from the date of enrollment for each enrollment form submitted.
- The Patient Assistance Program covers only the cost of VILTEPSO and not the cost of any infusion services or healthcare provider visits, which are the sole responsibility of the patient.
- The program requires that you (or your parent, guardian, or legal representative) re-enroll every year by completing an NS Support Patient Assistance Program Form for VILTEPSO and provide proof of income.
- A notice regarding re-enrollment will be sent to you (or your parent, guardian, or legal representative) 45 days in advance of the expiration of your participation in the program.

NS Support™
NS PHARMA ACCESS SOLUTIONS

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

NS Pharma

Viltepso™
(viltolarsen) injection

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