Patient Assistance Program Application

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

Thank you for your interest in the NS Support Patient Assistance Program ("PAP"). The PAP is committed to helping uninsured patients in financial need receive free prescription medication. Patients must submit accurate and complete documentation to validate levels of income as requested below. Approved patients will be eligible to receive assistance for one year from the date of the application. Applying is free.

For questions, please contact the NS Support Patient Assistance Program at 833-NSSUPRT (833-677-8778), Monday–Friday, 8 AM to 8 PM ET.

Am I eligible for this free prescription program?

You may qualify for our free prescription program if you meet these requirements:

- You have been prescribed an NS Pharma medication
- Your income isn't more than four times the Federal Poverty Level based on household size
- You don't have health insurance
- You aren't covered by government health insurance, including Medicare, Medicaid, CHIP, TRICARE, Indian Health Service, Department of Defense, or other federal or state assistance programs
- You are a citizen or a permanent resident of the United States or its territories, and reside in the US or its territories
- You are being treated by a US licensed doctor as an outpatient

What information is required on the application form?

Your PAP application must include the following information:

PATIENT INFORMATION

- ❑ Complete the Patient Information (Section 1)
- ❑ Complete the Financial Information (Section 2), including all sources of household income and household size
- ❑ Sign Patient/Parent/Guardian/Legal Representative Authorization (Section 3)
- ❑ Attach proof of income **(required). One of the following must be submitted with this application:**
  - Last year's tax return
  - IRS Form 4506-T if no tax return was filed

  Other acceptable documentation:
  - 1040, 1040A, 1040EZ
  - W-2
  - 1099
  - Pay stubs
  - Social Security Award Letter statement

PHYSICIAN INFORMATION

- ❑ Complete Physician Information (Section 4) and Prescription Information (Section 5). Provide phone, fax, and DEA, Tax ID or State License number
- ❑ Have Patient fully complete the Patient Information sections (Sections 1-3)
- ❑ Sign the Prescription Information section (Section 5)

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1. PATIENT/PARENT/GUARDIAN /LEGAL REPRESENTATIVE INFORMATION

PATIENT NAME (First, MI, Last) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

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

PRIMARY CONTACT NAME _____ RELATIONSHIP TO PATIENT _____

PREFERRED PHONE # _____ EMAIL ADDRESS _____

2. FINANCIAL INFORMATION

List all household sources.

NUMBER OF PEOPLE IN HOUSEHOLD (include self) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8+

HAVE YOU RECEIVED DISABILITY PAYMENTS FROM SOCIAL SECURITY FOR MORE THAN 2 YEARS? ☐ Yes ☐ No

SALARY/WAGES $ _____ ALIMONY/CHILD SUPPORT $ _____ PENSION/RETIREMENT $ _____

DISABILITY $ _____ SOCIAL SECURITY $ _____ UNEMPLOYMENT $ _____

ANNUAL INCOME $ _____ TOTAL YEARLY COMBINED HOUSEHOLD INCOME $ _____

DOCUMENTATION ATTACHED (check all that apply):

☐ Most recent 1040, 1040EZ, and/or 1040 SR Federal tax returns ☐ W-2 form ☐ Other ☐ Copies of 3 most recent pay stubs ☐ Social Security Award Letter or Check

3. PATIENT/PARENT/GUARDIAN/LEGAL REPRESENTATIVE AUTHORIZATION

My (or my parent/guardian/legal representative's) signature below 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.

☐ I attest that I am a citizen or a permanent resident of the United States or its territories, and reside in the US or its territories.

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

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

RELATIONSHIP TO PATIENT _____

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4. PHYSICIAN INFORMATION

NAME (First, Last) _____ AFFILIATION _____

ADDRESS _____ SUITE # _____ CITY _____ STATE _____ ZIP _____

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

OFFICE CONTACT _____ PREFERRED PHONE # _____

FAX _____ EMAIL ADDRESS _____

5. PRESCRIPTION FOR VILTEPSO® (VILTOLARSEN) INJECTION, FOR IV INFUSION

PATIENT NAME (First, MI, Last) _____ DOB (MM/DD/YYYY) _____ WEIGHT _____ kg

PATIENT ALLERGIES _____

CONCURRENT MEDICATION(S) _____

_____

_____

DOSAGE FORM AND STRENGTH: VILTEPSO 250 mg/5 mL (50 mg/mL) in a single-dose vial

PRESCRIBING INSTRUCTIONS: Administer VILTEPSO 80 mg/kg intravenously, once a week, over 60 minutes. Combine with normal saline to a minimum volume of 100 mL.

DAYS SUPPLY ☐ 30 days ☐ Other _____ ☐ Refills _____

SPECIALTY PHARMACY: Sonexus Health Pharmacy Services

SITE OF CARE ☐ Physician Office ☐ Hospital Outpatient Department ☐ Infusion Center/Clinic ☐ Home Infusion

I request that the medication prescription written above be provided for the above-named patient who has demonstrated a medical need. To the best of my knowledge, my patient does not have affordable third-party coverage for this prescription through, for example, an HMO, Private Insurance, State Pharmacy Program, Medicaid, or CHIP. By signing this form, I authorize NS Support as my designated agent on behalf of my patients, to process the prescription and coordinate Product shipment as indicated on the Patient Start Form for VILTEPSO only for the specific patient identified. I also attest that I will not bill, charge, seek credit for or otherwise submit any claim for reimbursement to any third-party payor or the patient for the Product the patient receives at no charge through the Program. I also agree to inform NS Pharma, Inc. of any Serious Adverse Events, whether the event is related to the Product or not. By including my email address above, I agree to receive communication related to the NS Support Patient Assistance Program by email.

PRESCRIBER INFORMATION (REQUIRED) SPECIAL NOTE: Physician must comply with state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in follow-up and delayed processing.

DIAGNOSIS: G71.01 Duchenne Muscular Dystrophy

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION (NO STAMPS ALLOWED): I certify that treatment with VILTEPSO is medically necessary for this patient. I have reviewed the current VILTEPSO Prescribing Information and I will be supervising the patient's treatment. I authorize NS Support to act on my behalf to transmit this prescription to a contracted specialty pharmacy.

PRESCRIBER NAME (Please Print) _____

PRESCRIBER SIGNATURE (Dispense as written)_____ DATE _____

(Prescriber's signature required. Stamped signature not allowed.)

I authorize NS Support as my designated agent on behalf of my patient to forward the above prescription, by fax or other mode of delivery, to the pharmacy chosen by the above-named patient or their parent, guardian, or legal representative.

If you are a prescriber in New York, South Carolina, or Washington, you must attach a prescription on your state's official prescription form with this application.

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Patient 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.
- 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.
- Patients (or their parent, guardian, or legal representative) must notify NS Support of any changes in their total gross income and/or health insurance status.
- Patients who no longer satisfy the eligibility requirements will be immediately withdrawn from the NS Support Patient Assistance Program, including patients participating in the NS Support Patient Assistance Program who become eligible for Medicaid coverage.
- NS Pharma, Inc. has the right to modify, alter, or cancel the NS Support Patient Assistance Program at any time without prior notification.

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