NS Support
NS PHARMA ACCESS SOLUTIONS

833-NSSUPRT (833-677-8778)

Patient Start Form

FAX OR MAIL THE COMPLETED FORM TO NS SUPPORT

888-212-0482 PO Box 7613, Overland Park, KS 66207-9941

PLEASE COMPLETE ALL SECTIONS. By providing full information and signatures, you can help avoid processing delays.

1. PATIENT/PARENT/GUARDIAN/LEGAL REPRESENTATIVE INFORMATION

PATIENT FIRST NAME _____ PATIENT LAST NAME _____ DOB (MM/DD/YYYY) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PRIMARY CONTACT NAME _____ RELATIONSHIP TO PATIENT _____

PREFERRED PHONE _____ ☐ Home ☐ Cell ☐ Other PREFERRED LANGUAGE ☐ English ☐ Spanish

EMAIL _____

2. INSURANCE INFORMATION

Complete all information requested below.

PRIMARY _____ ID # _____ GROUP # _____ PHONE _____

POLICYHOLDER _____ RELATIONSHIP TO PATIENT _____

If you have secondary insurance, such as Medicaid, include it here.

SECONDARY _____ ID # _____ GROUP # _____ PHONE _____

POLICYHOLDER _____ RELATIONSHIP TO PATIENT _____

☐ **Check if you are including a copy of the front and back of the patient's insurance card(s) or face sheet.**

3. PHYSICIAN INFORMATION

PHYSICIAN FIRST NAME _____ PHYSICIAN LAST NAME _____

FACILITY NAME _____

ADDRESS _____ SUITE # _____ CITY _____ STATE _____ ZIP _____

NPI # _____ TAX ID # (Optional) _____ OFFICE CONTACT _____

PHONE _____ FAX _____ EMAIL _____

4. PREFERRED SITE OF CARE (OPTIONAL)

Check all that apply.

☐ Hospital Clinic ☐ Home Infusion ☐ Physician's Office ☐ Other ☐ Needs Site of Care Identification PREFERRED PROVIDER(s) (If Available) _____

5. EXON CONFIRMATION

☐ Exon 53 Amenable

6. 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 G71.01 Duchenne muscular dystrophy; and (3) I have obtained and provided 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, contractors, and assignees, including but not limited to commercial and field-based teams (together, "NS Pharma"), for purposes of benefits verification and coordination of dispensing the therapy. I also certify that I may be contacted by NS Pharma by fax, email, phone calls, and detailed voice messages.

PHYSICIAN NAME (Please Print) _____

PHYSICIAN SIGNATURE _____ DATE _____

7. PATIENT/PARENT/GUARDIAN/LEGAL REPRESENTATIVE AUTHORIZATION

NS Support will contact the patient if the physician is unable to obtain the patient's signature.

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/Parent/Guardian/Legal Representative Authorization.

☐ Promotional/educational communications consent: Yes, NS Pharma may send me promotional and/or educational patient communications related to my treatment and condition. Examples of these communications may include but are not limited to product information, newsletters, announcements, healthcare reminders, and tips. I understand that I (or my parent/guardian/legal representative) may opt out of receiving these communications at any time by following the instructions on the communications.

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

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

RELATIONSHIP TO PATIENT _____

Questions? Call NS Support at 833-NSSUPRT (833-677-8778), Monday–Friday, 8 AM–8 PM ET.

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Patient Authorization Form

Patient/Parent/Guardian/Legal Representative Copy

Provider Instructions – NS Support will contact the patient if the physician is unable to obtain the patient's signature.

1. **Instruct the patient or parent/guardian/legal representative to read this page and sign the authorization in Section 7 on page 1 of the Patient Start Form.**
2. **Give the patient or parent/guardian/legal representative a copy of page 1 of the 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

Permission to share and use your Protected Health Information

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 Patient Engagement Leads, 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 by mail, email, phone calls, detailed voice messages, interactive voice recordings that may include use of auto-dialers or artificial or prerecorded voice messages, and SMS text messages (data rates may apply) as explained in the Telephone Consumer Protection Act (TCPA) consent 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 remuneration in exchange for data, product support services, reimbursement services, etc. This authorization expires 5 years from the date of execution, 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 7613, Overland Park, KS 66207-9941. 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.

Cancelling 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.

Communications consent

By checking the box in Section 7 on page 1 of the Patient Start Form, I authorize NS Pharma to send promotional and/or educational patient communications related to my condition, treatment, or related products or services that might be of interest; to contact me (or my parent/guardian/legal representative) occasionally to obtain feedback for market research purposes about my treatment, condition, or experience with the product, NS Pharma, and/or NS Support; and to contact me (or my parent/guardian/legal representative) about other products and services offered by NS Pharma.

Questions? Call NS Support at 833-NSSUPRT (833-677-8778), Monday–Friday, 8 AM–8 PM ET.

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