NS Support®
NS PHARMA ACCESS SOLUTIONS

Resource Guide

Helping with patient access to VILTEPSO® (viltolarsen)

Parent of actual patient

Viltepso®
(viltolarsen) injection

Connecting Patients and Your Practice With Tailored Access Support and Customized Resources

At NS Support, we are dedicated to being a committed partner to the families coping with Duchenne muscular dystrophy (DMD). We stand ready to provide optimal access support and resources for your patients, those who care for them, and your practice.

When you prescribe VILTEPSO® (viltolarsen), we are uniquely able to identify and tackle the access and affordability challenges that your patients may encounter. The team consists of a:

Case Manager

A personal connection who provides ongoing support to help manage and expedite access and care coordination for patients and those who care for them.

Director of Patient Access (DPA)

A specialist in patient access, affordability support, and billing and coding. By anticipating challenges and barriers to treatment, your DPA can help streamline coverage approvals and appeals, and work closely with the entire access team to identify appropriate treatment providers and ensure continuation of coverage.

Patient Engagement Lead (PEL)

A Patient Engagement Lead provides a constant care connection throughout your patient's treatment journey. They will help reduce delays in access to treatment and assist in coordinating infusion appointments.

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

Warnings and Precautions: Kidney toxicity was observed in animals who received viltolarsen. Although kidney toxicity was not observed in the clinical studies with VILTEPSO, the clinical experience with VILTEPSO is limited, and kidney toxicity, including potentially fatal glomerulonephritis, has been observed after administration of some antisense oligonucleotides. Kidney function should be monitored in patients taking VILTEPSO. Serum creatinine may not be a reliable measure of kidney function in DMD patients.

Serum cystatin C, urine dipstick, and urine protein-to-creatinine ratio should be measured before starting VILTEPSO. Consider also measuring glomerular filtration rate before starting VILTEPSO. During treatment, monitor urine dipstick every month, and serum cystatin C and urine protein-to-creatinine ratio every three months.

Urine should be free of excreted VILTEPSO for monitoring of urine protein. Obtain urine either prior to VILTEPSO infusion, or at least 48 hours after the most recent infusion. Alternatively, use a laboratory test that does not use the reagent pyrogallol red, which has the potential to generate a false positive result due to cross reaction with any VILTEPSO in the urine. If a persistent increase in serum cystatin C or proteinuria is detected, refer to a pediatric nephrologist for further evaluation.

Adverse Reactions: The most common adverse reactions include upper respiratory tract infection, injection site reaction, cough, and pyrexia.

To report an adverse event, or for general inquiries, please call NS Pharma Medical Information at 1-866-NSPHARM (1-866-677-4276).

Comprehensive Support Right From the Start

We can help patients start and stay on treatment

- Rapid benefits investigation and verification
- Prior authorization assistance*
- Insights about infusion options in a home infusion setting, infusion center, hospital outpatient department (HOPD), or physician office
- Ongoing, highly responsive support and follow-up calls

We have included a quick, easy-to-use guide for completing a Patient Start Form

- After the Patient Start Form is completed, you may then use the Product Order Form if appropriate

We help identify which affordability program is right for your patients

- Co-pay Assistance Program for eligible patients with commercial insurance
- Government-funded insurance options
- Resources for uninsured patients, including Patient Assistance Program

We can provide ongoing support with prior authorization, reauthorization, and continuation of therapy

- Claims submission information, including coding and billing
- Exceptions and appeals information*
- Templates for Letters of Medical Necessity (LMN) through the LMN Builder Tool available at viltepso.com/support

*Prior authorization and exceptions and appeals assistance is limited. NS Support does not provide any information that requires the medical judgment of the prescriber, and only the prescriber can determine whether to pursue a prior authorization, an exception, or an appeal.

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

Viltepso® (viltolarsen) injection

Initiating Therapy for Your Patients

Complete the **Patient Start Form** and submit it to NS Support

A completed Patient Start Form automatically enrolls your patient in NS Support.*
This initiates the benefits investigation process and enrolls eligible patients in the Co-pay Assistance Program for VILTEPSO® (viltolarsen).

Following submission of the form, each patient will be assigned a unique NS Support ID. A completed benefit summary will be faxed to the referring healthcare professional and our team will assist with next steps.

You can fax or mail the completed Patient Start Form to NS Support

Fax: 888-212-0482

Mail: NS Support, PO Box 7613
Overland Park, KS 66207-9941

*NS Support cannot enroll patients in NS Support services without Patient/Parent/Guardian/Legal Representative Authorization, which can be found on the Patient Start Form, or a separate signed Patient Authorization Form for VILTEPSO on file. In addition, an NS Support Patient Start Form must be submitted for each patient for whom treatment with VILTEPSO is requested. Our team can assist with obtaining patient authorization when needed.

Patient insurance benefits investigation is provided as a service by AssistRx under contract for NS Pharma, Inc. AssistRx provides assistance in determining whether treatment can be covered by the payor based on the payor's health plan guidelines and the patient information you provided on the Patient Start Form, following your determination of medical necessity.

Verification of insurance coverage is ultimately the responsibility of the provider. Since reimbursement by payors is subject to many factors, AssistRx and NS Pharma, Inc. do not represent or guarantee that payor reimbursement or any other payment or reimbursement of any kind will be made. Information provided as a result of the benefits investigation is provided for general reference and informational purposes only. AssistRx makes every effort to be accurate in the information provided; however, no representations or warranties are expressed or implied by AssistRx and NS Pharma, Inc. regarding the accuracy or reliability of the information. AssistRx or NS Pharma, Inc. or its agents or employees shall not be liable legally, financially, or otherwise, for damages of any kind as a result of or related to these services. Providers and other users of this information resulting from benefits investigation services accept full responsibility for use of the service.

NS Pharma, Inc. does not assume responsibility for, nor does it guarantee the availability, scope, or quality of the services offered including reimbursement support, prescription fulfillment coordination, and other services under NS Support. Providers, not NS Pharma, Inc., are responsible for the services they provide. NS Support services have no value apart from the product.

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

Sample Form

Item 1
Complete the required patient information.

Item 2
Provide complete insurance information or attach a copy of the front and back of the patient's insurance card(s) or face sheet.

Item 3
Complete to ensure prompt communication with your office.

Item 4 (Optional)
Indicate the preferred site(s) of infusion and facility name(s).

Item 5
Check the box to confirm the patient is exon 53 amenable.

Item 6
Sign to authorize contact with the patient and initiate the benefits investigation process.

Item 7
Ask the patient or parent (or their guardian or legal representative) to read the Patient Authorization information on page 2 of the form and sign. NS Support will contact the patient if the physician is unable to obtain the patient's signature.

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Patient Start Form

NS Support
NS PHARMA ACCESS SOLUTIONS
833-NSSUPRT (833-677-8778)

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.

NS Pharma

Viltepso® (viltolarsen) injection

Supporting You and Your Patients Every Step of the Way

Support for you and your office

A completed Patient Start Form connects your office and patients with personalized support. Following receipt of a completed form, NS Support will:

Verify insurance benefits within 2 business days

- Advise if a prior authorization (PA) is required
- Send a concise benefits summary to your office and your patients and caregivers

Provide limited support for PA and the exceptions and appeals process

- Research the patient's health plan for PA requirements and forms
- Monitor the status of the PA submission
- Your DPA can support the exceptions and appeals process with multiple letters of medical necessity templates
- Notify your office prior to PA expiration
- Proactively support the reauthorization process to help mitigate the potential for treatment interruption

Supply insights about treatment and infusion site-of-care options

- Help patients and caregivers understand the treatment process
- Discuss infusion site-of-care options to help patients and caregivers determine the best setting for treatment:
  - Physician's office, ambulatory infusion center, hospital outpatient departments, or home infusion
- Help confirm patient plan coverage at the site-of-care
- Provide support for referrals, including coordination with home infusion partners

Support streamlined product acquisition options via:

- Buy & Bill through our specialty distribution network
- Product acquisition through our network specialty pharmacy or specialty distribution network

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Support for your patients

Personally assigned and experienced case managers and Patient Engagement Leads are ready to offer your patients and their caregivers individualized, caring support and resources throughout the entire patient journey. They can help by:

- Explaining insurance benefits and out-of-pocket cost support options
- Providing insights about convenient infusion site options
- Discussing alternative and supplemental sources of financial assistance
- Follow-up calls and support throughout the patient journey
- Providing information about national and local advocacy organizations offering support for patients and those who care for them

Identifying Ways to Help Patients Afford Their Treatment

Our goal is simple: we want to help your patients get treatment with VILTEPSO® (viltolarsen) regardless of their insurance or financial situation.

For patients with commercial insurance

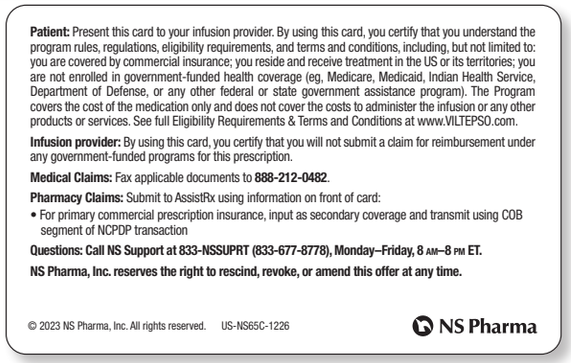
Eligible patients with commercial insurance coverage for treatment with VILTEPSO are automatically enrolled in the NS Support Co-pay Assistance Program.* This program provides:

- Savings on their deductible, co-pay, and insurance costs for VILTEPSO
- Automatic program re-enrollment each calendar year if the patient continues to meet eligibility criteria

Co-pay ID

Identifies a patient enrolled in the NS Support Co-pay Assistance Program

Remind patients and those who care for them to provide their co-pay assistance card to their infusion provider.



Patient: Present this card to your infusion provider. By using this card, you certify that you understand the program rules, regulations, eligibility requirements, and terms and conditions, including, but not limited to: you are covered by commercial insurance; you reside and receive treatment in the US or its territories; you are not enrolled in government-funded health coverage (eg, Medicare, Medicaid, Indian Health Service, Department of Defense, or any other federal or state government assistance program). The Program covers the cost of the medication only and does not cover the costs to administer the infusion or any other products or services. See full Eligibility Requirements & Terms and Conditions at www.VILTEPSO.com.

Infusion provider: By using this card, you certify that you will not submit a claim for reimbursement under any government-funded programs for this prescription.

Medical Claims: Fax applicable documents to **888-212-0482**.

Pharmacy Claims: Submit to AssistRx using information on front of card:

- For primary commercial prescription insurance, input as secondary coverage and transmit using COB segment of NCPDP transaction

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

NS Pharma, Inc. reserves the right to rescind, revoke, or amend this offer at any time.

NS Pharma

*Restrictions apply. $20,000 maximum program benefit per calendar year per eligibility criteria. See full Eligibility Requirements & Terms and Conditions on page 16 for details.

The NS Support Co-pay Assistance Program is for eligible patients who have commercial insurance that covers a portion of the medication and administration costs for VILTEPSO. Other restrictions apply. See full Eligibility Requirements & Terms and Conditions on page 16 for details.

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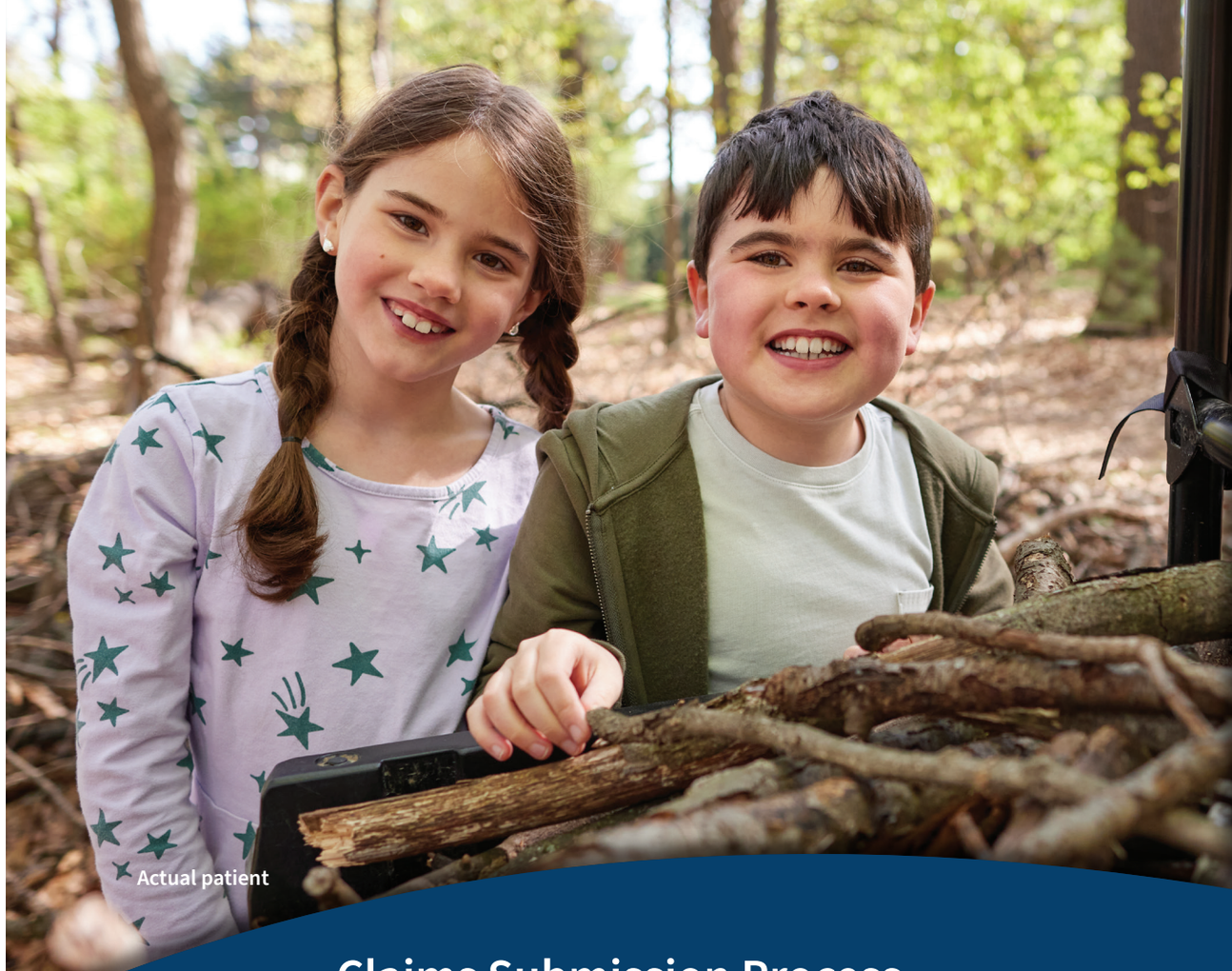

Claims Submission Process

Medical Benefit Claims:

Fax the following documents to 888-212-0482:

- ❑ Completed claim form (Universal UB-04 or CMS-1500 Claim Form)
- ❑ Primary explanation of benefits (EOB) showing the itemized claim from the patient's commercial insurance company with the cost for VILTEPSO listed separately

Pharmacy Benefit Claims:

- Submit the transaction to AssistRx using claims information on the front of the patient's Co-pay Assistance Program Card
- If primary commercial prescription insurance exists, input card information as secondary coverage and transmit using the Coordination of Benefits (COB) segment of the National Council for Prescription Drug Programs (NCPDP) transaction. Applicable discounts will be displayed in the transaction response

If the infusion provider cannot or does not participate in the Program, or if the patient has already paid for treatment, the patient may submit a claim using a Patient Reimbursement Form, available at viltepso.com. Completed forms can be faxed to 888-212-0482, uploaded to the NS Support Patient Engagement Site, or mailed to: NS Support, PO Box 7613, Overland Park, KS 66207-9941.

Viltepso® (viltolarsen) injection

Actual patient

Additional Cost Support Options

NS Pharma has expanded its free goods programs. Please reach out to your Director of Patient Access (DPA) for program specifics.

Patients with Medicaid and other government-funded insurance

NS Support can provide information about government-funded insurance, like Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and government health plan options for VILTEPSO® (viltolarsen), including:

- Medicaid
- Children's Health Insurance Plan (CHIP)
- Medicare
- Dual-eligible Special Needs Plans (D-SNPs)

For patients who are uninsured

The NS Support Patient Assistance Program (PAP) can help uninsured patients in financial need navigate the complex and often confusing access and reimbursement landscape.

- Patients who meet program requirements may be able to receive VILTEPSO at no charge for up to 1 year*
  - Restrictions apply. See full Eligibility Requirements & Terms and Conditions on page 18
- Medicaid denial is required

Our team can also provide information about independent foundations and programs that may offer financial assistance.

*Patients, parents, guardians, or legal representatives may be responsible for additional costs associated with administration of the drug.

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Ongoing Support for Your Patients

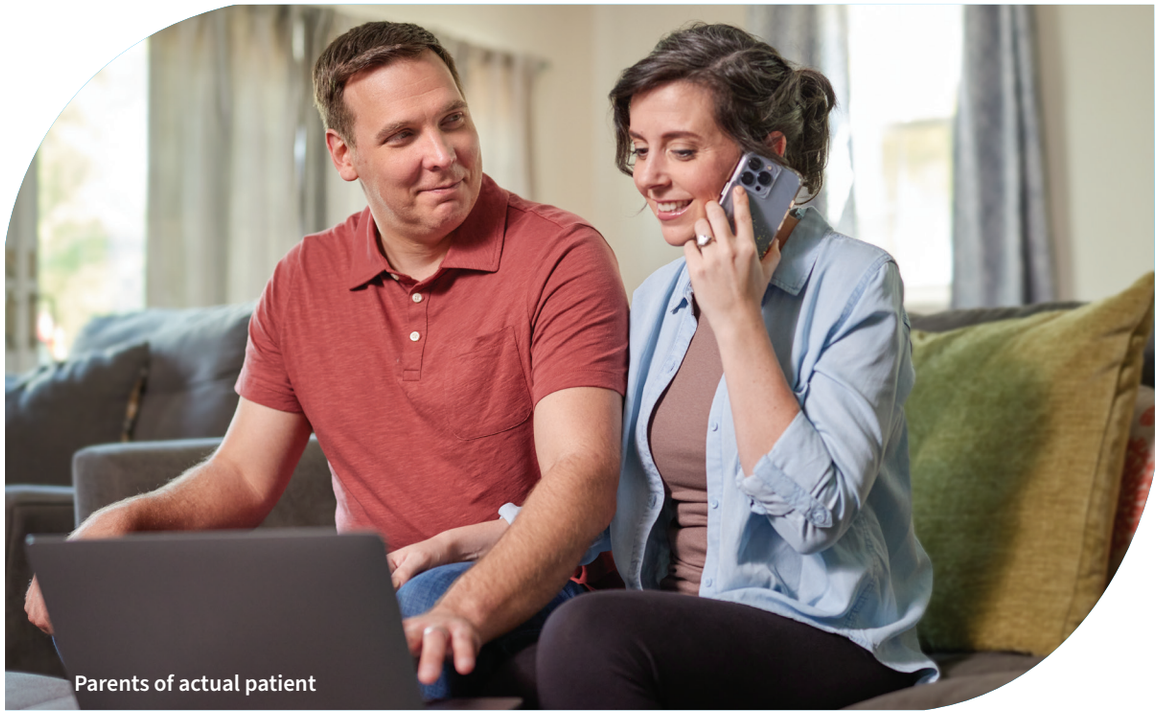
Individualized treatment continuation support

We provide eligible patients with access to medication to help avoid interruption of therapy:

- Treatment continuation during the health plan reauthorization process
- While in transition from commercial insurance to Medicaid and/or Medicare

Insights about treatment and infusion site-of-care options

- Help patients and those who care for them understand the treatment process
- Discuss infusion site-of-care options to help patients and those who care for them determine the best setting for treatment:
  - Physician office
  - Ambulatory infusion center
  - HOPDs
  - Home infusion
- Help confirm patient health plan coverage at the site-of-care
- Provide support for referrals
  - Including coordination with home infusion providers



Parents of actual patient

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Ongoing Support for Your Office Staff

Limited exceptions and appeals assistance

If your patient is denied coverage, NS Support provides helpful information regarding the steps typically required to:

- Request coverage under a health plan's exceptions process
- Use the appeals process if an exception request is denied

Coding and billing information

NS Support provides helpful information, including:

- General coding and billing information to support claims submissions for VILTEPSO® (viltolarsen)*
  - Sample CMS-1500 and UB-04 claims forms
- Answers to coding- and claims-related questions concerning:
  - General and policy-specific procedures
  - Policies for accurate and complete claims documentation, per payor requirements

Ask your NS Pharma Director of Patient Access for additional information.

*Each healthcare provider is ultimately responsible for determining the appropriate codes, coverage, and payment for individual patients. NS Support does not guarantee third-party coverage or payment for VILTEPSO or reimburse for denied claims. Providers should contact their third-party payors for specific information on coding and billing requirements.
You may also contact NS Support for coding and billing information for VILTEPSO. Call 833-NSSUPRT (833-677-8778), Monday–Friday, 8 AM to 8 PM ET.

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Co-pay Assistance Program

Eligibility Requirements

- ❑ 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.

Terms and Conditions

- 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 every calendar year 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.
- The patient 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).
- You will not in any way report or count the value of the product provided under this Program as true out-of-pocket (TrOOP) spending 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 NS Support 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.

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Patient Assistance Program

Eligibility Requirements

- ❑ 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.
- ❑ You were denied coverage by Medicaid.
- ❑ 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 may be required to 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.

Terms and Conditions

- 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.

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Resources to Support Patient Access to Treatment

Please use the forms enclosed in the pocket, also available at viltepso.com.

Patient Start Form

Patient Authorization Form

NS Support Product Order Form

Connect with NS Support today!

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Committed to ongoing access and affordability solutions for patients prescribed VILTEPSO® (viltolarsen) and those who care for them.

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

Warnings and Precautions: Kidney toxicity was observed in animals who received viltolarsen. Although kidney toxicity was not observed in the clinical studies with VILTEPSO, the clinical experience with VILTEPSO is limited, and kidney toxicity, including potentially fatal glomerulonephritis, has been observed after administration of some antisense oligonucleotides. Kidney function should be monitored in patients taking VILTEPSO. Serum creatinine may not be a reliable measure of kidney function in DMD patients.

Serum cystatin C, urine dipstick, and urine protein-to-creatinine ratio should be measured before starting VILTEPSO. Consider also measuring glomerular filtration rate before starting VILTEPSO. During treatment, monitor urine dipstick every month, and serum cystatin C and urine protein-to-creatinine ratio every three months.

Urine should be free of excreted VILTEPSO for monitoring of urine protein. Obtain urine either prior to VILTEPSO infusion, or at least 48 hours after the most recent infusion. Alternatively, use a laboratory test that does not use the reagent pyrogallol red, which has the potential to generate a false positive result due to cross reaction with any VILTEPSO in the urine. If a persistent increase in serum cystatin C or proteinuria is detected, refer to a pediatric nephrologist for further evaluation.

Adverse Reactions: The most common adverse reactions include upper respiratory tract infection, injection site reaction, cough, and pyrexia.

To report an adverse event, or for general inquiries, please call NS Pharma Medical Information at 1-866-NSPHARM (1-866-677-4276).

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

We're here to help. Call us today!

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Patient Start Form

FAX OR MAIL THE COMPLETED FORM TO NS SUPPORT

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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.

NS Pharma

Clear Form Print Form

NS Support
NS PHARMA ACCESS SOLUTIONS

833-NSSUPRT (833-677-8778)

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.

NS Pharma

NS Support
NS PHARMA ACCESS SOLUTIONS

833-NSSUPRT (833-677-8778)

Patient Authorization Form for VILTEPSO® (viltolarsen)

FAX OR MAIL THE COMPLETED FORM TO NS SUPPORT

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

PATIENT/PARENT/GUARDIAN/LEGAL REPRESENTATIVE AUTHORIZATION ON BEHALF OF PATIENT

Permission to share and use Protected Health Information

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 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 below, 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.

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 above, for the patient to participate in the NS Support Program, and to release the patient's Protected Health Information to NS Pharma, Inc., supporting the access program as indicated on this form.

☐ 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.

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

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.

Clear Form Print Form

NS Pharma

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833-NSSUPRT (833-677-8778)

Product Order Form

Use this form to order/reorder VILTEPSO® (viltolarsen)

EMAIL OR FAX THE COMPLETED FORM TO NS SUPPORT

 NS.SupportOrders@assistrx.com  888-212-0482

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

SHIPPING INFORMATION

CONTACT NAME _____ FACILITY NAME _____

PHONE _____ EMAIL _____

SHIPPING ADDRESS _____ SUITE # _____

CITY _____ STATE _____ ZIP _____

PREFERRED DISTRIBUTOR

☐ ASD Healthcare ☐ Besse Medical ☐ Cardinal PR ☐ Cardinal SPD

☐ McKesson Plasma & Biologics ☐ McKesson Specialty Care ☐ Metro Medical ☐ Oncology Supply

YOUR DISTRIBUTOR ACCOUNT # _____ PURCHASE ORDER # _____

NOTE: You will be invoiced for VILTEPSO purchased from the specialty distributor at the contracted rates under your agreement or rates quoted at the point of sale. You are financially responsible for and agree to pay the specialty distributor all invoiced charges for products on this order. Each invoice will be due and payable by you within the payment terms offered by the specialty distributor on the date of order.

ORDER INFORMATION – Please list all NS Support Patient IDs under the same account. Patients must be enrolled in NS Support and have a Patient ID prior to placing an order.

NS SUPPORT PATIENT ID	VIAL QUANTITY

USE OF PRODUCT ACQUISITION INFORMATION

By providing your information and information about your patient on this Order Form, you are placing an order for VILTEPSO to dispense to patients who have been prescribed VILTEPSO. The information you provide will only be used by NS Pharma, Inc., its affiliated companies, agents, and representatives, including providers of alternate sources of funding for prescription drug costs, and other service providers involved in managing and delivering this service for healthcare providers and patients (collectively, "NS Pharma"). You may withdraw your request for this service at any time by calling 833-NSSUPRT (833-677-8778). You agree to be contacted by NS Pharma, Inc. at NS Support by mail, fax, email, or phone for the purposes of managing and delivering this product. Our Privacy Policy, available at https://www.nspharma.com/privacy-policy, governs the use of the information you provide. By providing the information on this Order Form and submitting this Order Form, you indicate that you have read, understand, and agree to these terms and agree to receive program-related communications from NS Support and its service providers. Please call NS Support at 833-NSSUPRT (833-677-8778) if you wish to change your communication preferences. This form is submitted in full compliance with all applicable laws, regulations and rules.

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

Clear Form Print Form

NS Pharma