NEUROCRINE™ Access Support

CRENESSITY Enrollment Form to PANTHERx Rare

Crenessity™ (crinecerfont)

Sign and date completed form and fax to PANTHERx Rare at 1-855-606-7288. NPI #1750843314. 1120 Stevenson Mill Rd., Ste 400, Coraopolis, PA 15108. For additional assistance call 1-855-CRNSITY (276-7489) 8 AM - 8 PM ET, M-F

1. PATIENT INFORMATION

First Name*: | Last Name*: | DOB*: | Last 4 digits of SSN:

Address: | City: | State: | Zip*:

Phone*: | Mobile Phone? ☐ Yes ☐ No | Preference: ☐ Call ☐ Text

Email: | Primary Language: ☐ English ☐ Spanish ☐ Other:

Sex on file with Insurance^*: ☐ Male ☐ Female | Gender ☐ Male ☐ Female ☐ Non-binary/gender non-conforming ☐ Other gender identity

^Neurocrine recognizes that patients may not identify as male or female. However, many insurers still require this field.

Caregiver/Alt Contact Name: | Caregiver/Alt Contact Phone: | Relationship:

REQUIRED: I have read and agree to the PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION terms **on the next page**.

Patient/Representative Signature: | Date:

Description of Representative's Authority:

I have read and agree to PHARMACY TEXTING, MARKETING/OTHER COMMUNICATIONS, AND SUPPORT PROGRAMS COMMUNICATIONS terms **on the next page**.

Patient/Representative Signature: | Date:

Description of Representative's Authority:

2. PATIENT INSURANCE INFORMATION – Please attach a copy of patient's insurance card, if available.

Primary Payer Type: ☐ Commercial ☐ Medicaid ☐ Medicare ☐ Other_____ ☐ Patient does not have insurance **(fill in section 3 below)**

RX Insurance Name: | Policy Holder Name: | Policy Holder DOB:

Member ID: | BIN #: | PCN #: | Rx Group #: | Provider Call #:

3. PATIENT ASSISTANCE PROGRAM – Eligible patients may qualify to receive their prescription at no cost. Income subject to verification.

US Resident: ☐ Yes ☐ No | Total Monthly Gross Household Income: | Household #:

Additional eligibility will be confirmed by the pharmacy. A Care Coordinator will contact the patient directly to collect any information not provided.

Alternate Funding Programs: Patients are ineligible for the patient assistance program (PAP) if they are participating in programs that: (i) require the patient to apply to the PAP as a condition of insurance coverage for CRENESSITY, or otherwise subjects any insurance coverage contingent upon application to, or denial of eligibility for, the PAP; or (ii) engages in any activity that could make the patient appear to be un- or underinsured.

4. CLINICAL INFORMATION – Please attach medication list, if available.

Primary Diagnosis Code*: ☐ Congenital Adrenal Hyperplasia (E25.0) ☐ Unspecified Adrenogenital Disorder (E25.9) ☐ Other Diagnosis: _____

Weight (kg): | Height: | Current Steroid Dose: | Allergies: | Previous Therapies: | ☐ Additional Clinical Notes

5. PRESCRIPTION – Weight-based dosing guidance **on the next page**.

CRENESSITY PRESCRIPTION*: (Eligible patients subject to insurance benefit coverage determination delays may receive limited supply of product at no cost.)

☐ 100 mg soft gel capsule twice daily, 30-day supply
Sig: _____
Refills #: _____

☐ 50 mg soft gel capsule twice daily, 30-day supply
Sig: _____
Refills #: _____

☐ 50 mg/mL oral solution, 25 mg twice daily, 30-day supply
Sig: _____
Refills #: _____

☐ 50 mg/mL oral solution, 50 mg twice daily, 30-day supply
Sig: _____
Refills #: _____

Other Rx: | **Quantity:** | **Sig:** | **Other Rx Refills #:**

6. PRESCRIBER INFORMATION

Prescriber Name*: | Prescriber NPI*:

Office/Facility: | Phone: | Fax:

Address: | City: | State: | ZIP:

Office/Facility Contact Name: | Phone: | Fax: | Email:

7. PRESCRIBER CERTIFICATION

I understand and agree that, as the prescriber, I will comply with my state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in the prescription not being filled or outreach to me, as the prescriber. I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed CRENESSITY based on my independent professional judgment of medical necessity. I certify that, where required by law, I have obtained my patient's written legal permission to share patient identifiable information with Neurocrine Biosciences Inc., its affiliates, agents, and contractors including PANTHERx RARE Pharmacy (collectively, Neurocrine). I am under no obligation to prescribe CRENESSITY and I have not received, nor will I receive, any benefit or remuneration of any kind from Neurocrine for prescribing CRENESSITY nor will I seek any reimbursement for any free or discounted product provided to the patient under the patient support program, or for dispensing the product if the patient requests shipping to my facility. I authorize Neurocrine to act on my behalf for the limited purposes of transmitting this prescription to the pharmacy. I also authorize the Neurocrine patient support program to perform any steps necessary to secure reimbursement for CRENESSITY, including but not limited to insurance verification and case assessment. I understand that Neurocrine or the patient support program may need additional information and I agree to provide it as needed for the purposes of securing reimbursement or otherwise providing product to the patient. I also acknowledge that Neurocrine will use and share the personal data collected about me (as the prescriber) in accordance with the Privacy Policy at www.neurocrine.com/privacy-policy.

Prescriber Signature*: | Date*:

(Original signature required. If required by applicable law, please attach copies of all applicable prescriptions on official state prescription forms.)

*Indicates required fields.

8. PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

I authorize my/my child's healthcare providers, health insurance carriers, laboratory providers, pharmacy providers and other entities involved in my/my child's healthcare (collectively, Healthcare Entities) to share my/my child's individual health and identifying information, including but not limited to health insurance information, financial information, medical diagnosis and condition, physical examinations, clinical tests, blood tests, X-rays, and other procedures, treatment information including prescription information, and name, date of birth, sex, address, email address, and telephone number to Neurocrine and its agents, representatives, and contractors including but not limited to third parties authorized by Neurocrine (collectively, Neurocrine). Such information may be shared with Neurocrine so that Neurocrine can: (1) provide me/my child with support services (and related information and materials) related to any of Neurocrine's products, including but not limited to, online support, financial assistance services, compliance and persistency and other therapy support services; (2) conduct data analysis, market research and other necessary internal business activities; and (3) provide me/my child with information about Neurocrine's products, services, and programs for educational or other purposes. I understand that pharmacy providers, or others working on their behalf, may receive remuneration from Neurocrine in exchange for the health information and/or for any support services provided.

Once my/my child's health information has been disclosed to Neurocrine, I understand that it may be redisclosed by Neurocrine, and federal privacy laws no longer protect the redisclosed information. However, Neurocrine agrees to protect my/my child's health information by using and disclosing it only for purposes described above or as required by law or regulations. This authorization expires 10 years after the date I signed, or such shorter time as may be required by applicable law, unless otherwise canceled earlier. I understand I have a right to receive a copy of this authorization.

I understand that I may refuse to sign this authorization and that my/my child's treatment (including with a Neurocrine product), insurance enrollment, or eligibility for benefits are not conditioned upon my agreement to sign this authorization. I may cancel this authorization at any time by calling 1-855-CRNSITY (276-7489) or by mailing a letter to PANTHERx Rare, 121 Bayer Road, Pittsburgh, PA 15205 and that doing so will end my consent for my Healthcare Entities to further disclose my/my child's health information to Neurocrine after notification of my cancellation but will not affect previous disclosures pursuant to this authorization. Canceling this authorization will not affect my/my child's ability to receive treatment, insurance enrollment, or eligibility for benefits.

I understand that if I do not sign this authorization, or later cancel it, I/my child will not be able to receive Neurocrine's support program services.

9. PHARMACY TEXTING, MARKETING/OTHER COMMUNICATIONS, AND SUPPORT PROGRAMS COMMUNICATIONS

I authorize Neurocrine and its authorized agents, representatives, contractors and other third parties including PANTHERx RARE Pharmacy (collectively, Neurocrine) to:

1. To contact me by mail, email, fax, telephone, text message, chat, push notifications and other forms of electronic messaging (collectively, Communications Methods) to provide me/my child with CAH support services related to any of Neurocrine's CAH products, including any information or materials related to such services;
2. Use and disclose my/my child's medical and health information in connection with providing CAH support services, including but not limited to, disclosing my/my child's information to vendors, processors, and service providers for business purposes associated with providing CAH support services, sharing such information with my/my child's healthcare provider, insurance provider, or pharmacy, or disclosing my/my child's information where required by applicable laws or regulations; and
3. Contact me by any Communications Methods for marketing purposes related to, or to provide me with information about, Neurocrine's CAH products, services, and programs or other topics of interest, conduct market research, or ask me about my/my child's experience with or thoughts about such topics.

I understand that:

1. Personnel including but not limited to pharmacists, providing CAH support services on behalf of Neurocrine are not employed by my/my child's healthcare professional;
2. Any information I provide Neurocrine may be used by Neurocrine to help develop new products, services, and programs, or as otherwise described in Neurocrine's Privacy Policy at www.neurocrine.com/privacy-policy;
3. Neurocrine will not sell or transfer my/my child's personal data to any unrelated third party for marketing purposes without my express permission;
4. My authorization to receive marketing communications is not required as a condition of purchasing or receiving any goods from Neurocrine, but that if I do not provide authorization or later revoke my authorization, I/my child may not be able to receive CAH support services from Neurocrine; and
5. I may revoke my authorization to receive marketing communications and choose not to receive marketing or other communications from Neurocrine by following the process described in Neurocrine's Privacy Policy.

AGE AND BODY WEIGHT DOSAGE REGIMEN – Adults (18 and older), pediatrics (4–17)

Adult and pediatric patients weighing ≥55 kg (≥121 lb) 100 mg twice daily (200 mg per day)

Pediatric patients weighing 20 kg to <55 kg (44 lb to <121 lb) 50 mg twice daily (100 mg per day)

Pediatric patients weighing 10 kg to <20 kg (22 lb to <44 lb) 25 mg twice daily (50 mg per day)