

# CRENESSITY Enrollment Form to PANTHERx Rare



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

Primary Language:   English   Spanish   Other:	1. PATIENT INFORMATION	N				
Phone:   Mobile Phone?   Yes   No   Preference:   Coll   Text	First Name*:	Last Name*:	DOB*:	Last 4 digits of SSN:		
Email:   Primary Language:   English   Spanish   Other: Sex on file with insurance**:   Made   Female   Gender   Male   Female   Non-binary/gender non-conforming   Other gender identity   **Meurocinine recognizes that patients may not identify as male or female. However, many insures still require this field. **Carcegiver / Alt Contact Name:   Carcegiver / Alt Contact Phone:   Relationship:   **REQUIRED: Howe read and agree to the PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION terms on the next page.   **Politerity/Representatives Signature**   Date:	Address:	City:	Stc	ıte: Zip*:		
Sex on file with insurance**: Mote   Femole   Gender   Male   Femole   Mon-binary/gender non-conforming   Other gender identity **Neurocinia recognizes that patients may not identify as male or femole. However, many insures still require this field. **Caregiver/Alt Alt Contact Name:   Caregiver/Alt Contact Name:   Relationship:   Relationship:    **REQUIRED: Indiversed and agree to the PATIENT AUTHORIZATION TO SHARE HEALTH INTORNATION terms on the next page.    **Patient/Representative Signature.   Date:   Date:    **Description of Representative's Authority:   Date:   Date:   Date:    **Description of Representative's Authority:   Date:   Date:	Phone*:	Mobile Phone?	☐ Yes ☐ No	Preference: Call Text		
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Requirer   Ait Contact Name:   Caregiver   Ait Contact Phone:   Redutionship:	Sex on file with Insurance^*: Male Female Gender Male Female Non-binary/gender non-conforming Other gender identity					
Posterior   Post	^Neurocrine recognizes that patients may not identify as male or female. However, many insurers still require this field.					
Date:  Description of Representative's Authority:  Intower read and agree to PHARMACY TEXTINS, MARKETINS/OTHER COMMUNICATIONS, AND SUPPORT PROGRAMS COMMUNICATIONS terms on the next page.  Potient/Representative Signature.  Description of Representative's Authority:  2	Caregiver/Alt Contact Nam	e: Caregiver/	Alt Contact Phone:	Relationship:		
Description of Representative's Authority:	REQUIRED: I have read and ag	gree to the PATIENT AUTHORIZATION TO SH	ARE HEALTH INFORMATION terms	on the next page.		
Date	Patient/Representative Sign	ature:		Date:		
Description of Representative's Authority:  2. PATIENT INSURANCE INFORMATION - Piesse attach a copy of potient's insurance card, if available.  Primary Payer Type:   Commercial   Medicaid   Medicaid   Other   Potient does not have insurance (fill in section 3 below)  RX Insurance Name:   Policy Holder Name:   Policy Holder DDs:    RX Insurance Name:   Policy Holder Name:   Policy Holder DDs:    RX Insurance Name:   Policy Holder Name:   Policy Holder DDs:    RX Insurance Name:   Policy Holder Name:   Policy Holder DDs:    RX Insurance Name:   Policy Holder Name:   Policy Holder Name:   Policy Holder DDs:    RX Insurance Name:   Policy Holder Name:   Policy Holder Name:   Policy Holder DDs:    RX PATIENT ASSISTANCE PROGRAM - Eligible patients may qualify to receive their prescription at no cost incomo 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.  Atternate runding Programs: Patients are ineligible for the patient acesistance program (PAP) if they are participating agroagms 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 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 as a condition of insurance coverage for CRENESSITY or or developed to be un- or underinsured.  4. CLINICAL INFORMATION - Please attach medication list if available  Primary Plagnasis Code*:   Congenital Aderend Hyperplasia (£25.0)   Unspecified Adrenagenital Disorder (£25.9)   Other Diagnosis:    Weight (Kg)	Description of Representative	ve's Authority:				
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Primary Payer Type:   Commercial   Medicald   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.   PATENT 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.    Attender Jung Programs Proteins are ineligible for the poteint acessistance 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 CRINESSITY, or otherwise subjects any insurance coverage contingent upon application to, or denial of eligibility for the PAP as of (i) regards in any activity that could make the potient appear to be un- or underinsured.  4.   CLINICAL INFORMATION - Pieces attach medication list, if available.  Weight (kg):   Leight:   Current Steroid Dose:   Allergies:   Previous Therapies:   Additional Clinical Notes    1.   PRESCRIPTION - Weight-based dosing guidance on the next page.  CREMESSITY PRESCRIPTION*: (Eligible patients subject to insurance benefit coverage determination delays may receive limited supply of product at no cost.)    1.   Other Rx:   Quantity:   Sig:     Sig:   Other Rx Refills #:    2.   PRESCRIBER INFORMATION    Prescriber Name*:   Quantity:   Sig:   Other Rx Refills #:    3.   PRESCRIBER CRETIFICATION    1.   PRESCRIBER CRETIFICATION    1.   PRESCRIBER CRETIFICATION    1.   Prescriber Name:   Phone:   Fax:   Email:    3.   PRESCRIBER CRETIFICATION    1.   Prescriber Name:   Phone:   Fax:   Email:    3.   PRESCRIBER CRETIFICATION    3.   PRESCRIBER CRETIFICATION    3.   PRESCRIBER CRETIFICATION    4.   Prescriber Name:   Phone:   Fax:   Email:    3.   Prescriber Name:	Description of Representati	ve's Authority:				
Rx Group #: Policy Holder DOB:	2. PATIENT INSURANCE IN	NFORMATION - Please attach a copy of po	atient's insurance card, if availab	le.		
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Weight (kg):   Height:   Current Steroid Dose:   Allergies:   Previous Therapies:   Additional Clinical Notes	4. CLINICAL INFORMATIO	N - Please attach medication list, if availat	ole.			
CRENESSITY 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:   50 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, 25 mg 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, 25 mg 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, 25 mg twice daily, 30-day supply   Sig:   Refills #:   50 mg /mL oral solution, 50 mg twice daily, 30-day supply   Sig:   Refills #:   50 mg /mL oral solution, 50 mg twice daily, 30-day supply   Sig:   Refills #:   50 mg /mL oral solution, 50 mg twice daily, 30-day supply   Sig:   Refills #:   50 mg /mL oral solution, 50 mg twice daily, 30-day supply   Sig:   Refills #:   50 mg /mL oral solution, 50 mg twice daily, 30-day supply   Sig:   Refills #:   50 mg /mL oral solution, 50 mg twice daily, 30-day supply   Sig:   Refills #:   50 mg /mL oral solution,	Primary Diagnosis Code*:	🗌 Congenital Adrenal Hyperplasia (E25	i.0) Unspecified Adrenogenit	:al Disorder (E25.9) 🗌 Other Diagnosis:		
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100 mg soft gel capsule twice daily, 30-day supply   Sig:	5. PRESCRIPTION - Weigh	nt-based dosing guidance <u>on the nex</u>	t page.			
twice daily, 30-day supply Sig:						
Sig:					mg	
Refills #: Other Rx Refills #:					_	
Prescriber Name*:  Office/Facility:  Address:  City:  Phone:  Fax:  Phone:  Fax:  Office/Facility Contact Name:  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-complicance with state-specific requirements could result in the prescriber 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 on the 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 benefit or remuneration of any kind from Neurocrine product if the patient requests shipping to my facility. I authorize Neurocrine to act on my benefit or remuneration of any kind from Neurocrine product if the patient requests shipping to my facility. I authorize Neurocrine to act on my benefit or remuneration of any kind from Neurocrine 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 Name*:  Office/Facility:  Address:  City:  State:  ZIP:  Office/Facility Contact Name:  Phone:  Fax:  State:  ZIP:  Office/Facility Contact Name:  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 pre	Other Rx:	Quantity:	Sig:	Other Rx Refills #:		
Office/Facility:  Address:  City:  State:  ZIP:  Office/Facility Contact Name:  Phone:  Fax:  Email:  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 non ysteps 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.c	6. PRESCRIBER INFORMATION					
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Date"	form, fax language, etc. Non-cor that the patient and prescriber in CRENESSITY based on my indepepermission to share patient ider (collectively, Neurocrine). I am u Neurocrine for prescribing CRENI or for dispensing the product if the prescription to the pharmacy. I including but not limited to insurinformation and I agree to provi	mpliance with state-specific requirements or nformation contained in this enrollment form endent professional judgment of medical ner htifiable information with Neurocrine Bioscien ander no obligation to prescribe CRENESSITY or ESSITY nor will I seek any reimbursement for a he patient requests shipping to my facility. I also authorize the Neurocrine patient support rance verification and case assessment. I unde it as needed for the purposes of securing	ould result in the prescription not to a is complete and accurate to the cessity. I certify that, where require acces Inc., its affiliates, agents, and a and I have not received, nor will I re any free or discounted product pro authorize Neurocrine to act on my t program to perform any steps no derstand that Neurocrine or the pure reimbursement or otherwise provi	being filled or outreach to me, as the prescriber. I very best of my knowledge and that I have prescribed and by law, I have obtained my patient's written legal contractors including PANTHERX RARE Pharmacy exceive, any benefit or remuneration of any kind from by bounded to the patient under the patient support proposes of transmitting this excessary to secure reimbursement for CRENESSITY, attent support program may need additional iding product to the patient. I also acknowledge that	n ogram, s	



## Patient Authorization and Consent



#### 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 I-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)

