KEVEYIS® *(dichlorphenamide)* PRESCRIPTION START FORM

FAX completed form to 1-312-276-4846 phone 1-844-538-3947

KEVEYIS® dichlorphenamide 50 mg tablets

PATIENT INFORMATION

FIRST NAME: LAST NAME: MIDDLE INITIAL: SEX: ☐ MALE ☐ FEMALE

DOB (MM/DD/YYYY): EMAIL ADDRESS: HEIGHT: WEIGHT: ☐ LB ☐ KG

ADDRESS: CITY/STATE/ZIP CODE:

HOME PHONE: CELL PHONE:

CAREGIVER NAME (IF APPLICABLE): PHONE NUMBER:

PRESCRIPTION DRUG INSURANCE INFORMATION

PLEASE SEND A COPY (FRONT AND BACK) OF THE PATIENT'S PRESCRIPTION, MEDICAL, AND SECONDARY INSURANCE CARDS.

PRIMARY INSURANCE: RX BIN#: RX PCN#: RX ID#: RX GROUP#:

CARDHOLDER NAME: RELATIONSHIP TO CARDHOLDER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

EMPLOYER: RX ID#:

SECONDARY INSURANCE: RX BIN#: RX PCN#: RX GROUP#:

CARDHOLDER NAME: RELATIONSHIP TO CARDHOLDER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

CLINICAL INFORMATION

PRIMARY DIAGNOSIS: ICD-10 CODE: ☐ G72.3 ☐ G71.19 ☐ OTHER (SPECIFY):

TYPE OF PRIMARY PERIODIC PARALYSIS: ☐ HYPERKALEMIC ☐ HYPOKALEMIC ☐ PARAMYOTONIA CONGENITA ☐ OTHER (SPECIFY):

ALLERGIES: ☐ NO KNOWN DRUG ALLERGIES

COMORBIDITIES:

PRESCRIPTION INFORMATION

PRESCRIPTION: KEVEYIS (dichlorphenamide) 50 mg tablets

DISPENSE: ☐ 30-DAY SUPPLY REFILLS _____

DIRECTIONS FOR USE

PLEASE CHECK ONE OF THE FOLLOWING: ☐ TAKE 1 TABLET BY MOUTH ONCE DAILY ☐ TAKE 1 TABLET BY MOUTH TWICE DAILY

TITRATION/OTHER DOSING INSTRUCTIONS:

Initial dose: 50 mg once or twice daily. Titrate dose lower or higher, based on individual response, at weekly intervals (or sooner in case of adverse reaction). The maximum recommended dose is 200 mg daily.

I certify that I have prescribed KEVEYIS as described above based on my professional judgment of medical necessity. I authorize the release of medical and/or other patient information relating to KEVEYIS therapy to agents of Xeris Pharmaceuticals® and Service Providers (including, but not limited to, pharmacies dispensing KEVEYIS) to use and disclose as necessary for prior authorization processing and fulfillment of the prescription. I authorize CloudTop Health to prepare and submit prior authorization requests, appeal requests, and other administrative tasks on behalf of the prescriber and to receive notices in connection with requests which may include faxes, phone calls, mail, email, or any other form of communication. I authorize the forwarding of this Start Form (and the information included herein) to PANTHERx Rare Pharmacy.

SIGN HERE

PHYSICIAN'S SIGNATURE (CHOOSE ONE)

DISPENSE AS WRITTEN*	DATE	SUBSTITUTION ALLOWED	DATE

ANY SPECIAL INSTRUCTIONS:

***Certain states require "brand medically necessary" or other language to be handwritten by the prescriber if he/she has made this determination in his/her independent clinical judgment.**

State requirements: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information that is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 1-844-538-3947 to obtain instructions as to the proper destruction of the transmitted material.

PRESCRIBER INFORMATION

FIRST NAME: LAST NAME: NPI#: DEA#:

OFFICE ADDRESS: CITY/STATE/ZIP CODE:

SHIP TO: ☐ PATIENT ☐ OFFICE PHONE: FAX:

PA CONTACT NAME: OFFICE EMAIL ADDRESS: OFFICE PHONE:

Your patient will be contacted by PANTHERx Rare Pharmacy to arrange for delivery of KEVEYIS.

KEVEYIS® *(dichlorphenamide)* PRESCRIPTION START FORM

FAX completed form to 1-312-276-4846 phone 1-844-538-3947

KEVEYIS® dichlorphenamide 50 mg tablets

XERIS CARECONNECTION™ PATIENT SUPPORT SERVICES

By signing this Authorization, I understand I am giving Xeris Pharmaceuticals®, its affiliates, and business partners permission to use the personal information provided in this registration form to contact me by the following methods, but not limited to: mail, email, telephone call, or text, about disease and product information, disease or product-related events, support services, market research, and to share other promotional information. By submitting this form, I consent to these uses and agree to the Xeris Pharmaceuticals privacy statement located at xerispharma.com/privacy-policy. I understand I can opt out by clicking on the unsubscribe link in future communications or by sending a letter with my full contact information (eg, name, address, email address, phone number, etc) to Xeris CareConnection Patient Support Services, 1375 West Fulton Street, Suite 1300, Chicago, IL 60607.

AUTHORIZATION AND RELEASE OF HEALTH INFORMATION

By signing this Authorization, I authorize each of my physicians, pharmacies, other healthcare providers, and each of my health insurers, to use and disclose health information related to my taking KEVEYIS® that identifies me personally, including my name, address, and telephone number(s) and information about my insurance, prescriptions, medical condition and health (my "Information") to Xeris Pharmaceuticals® (the manufacturer of KEVEYIS), its Xeris CareConnection™ Patient Support Services, and their respective agents, contractors, and third-party vendors, including providers of alternate sources of funding for prescription drug costs (collectively, "the Program") so that the Program may: (1) help to verify, assist with, and coordinate insurance coverage or otherwise obtain payment for my treatment with KEVEYIS; (2) coordinate my receipt of, and payment for, KEVEYIS; (3) conduct analytics to gain insight into and support the effectiveness of the Program; and (4) provide me with adherence reminders and support for KEVEYIS including email or text.

I understand that once my Information has been disclosed to the Program, state and federal privacy laws may no longer protect the Information and that it may be subject to further disclosure by the Program. I also understand that the Program intends to use and disclose my Information only for the purposes described in this Authorization and that results of the analytics will only be shared outside of the Program after being anonymized. I understand that my pharmacy, health insurance company and healthcare providers may receive payment from Xeris Pharmaceuticals in exchange for disclosing my Information to the Program and/or for providing me with therapy support services. I understand that I do not have to sign this Authorization and that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be affected if I do not sign it. I also understand, however, that if I do not sign this Authorization, the Program cannot provide me with assistance.

This Authorization will remain in effect for five (5) years, unless I cancel my enrollment before then. I understand that I may cancel (revoke) the Authorization at any time by sending a written notice of cancellation to: Xeris CareConnection Patient Support Services, 1375 W Fulton Street, Suite 1300, Chicago, IL 60607. I understand that if I do cancel this Authorization, the cancellation will be effective for each of my healthcare providers and health plans/insurers upon receipt by each such entity, respectively, but will not affect any information already disclosed. I understand that I am entitled to a copy of this Authorization after signing on the previous page.

PATIENT INFORMATION

FIRST NAME: LAST NAME: DOB (MM/DD/YYYY):

CHECK THE BOXES BELOW TO CONFIRM YOU HAVE READ AND AGREE TO THE FOLLOWING SERVICES AND AUTHORIZATIONS:

☐ AUTHORIZATION AND RELEASE OF HEALTH INFORMATION
☐ AUTHORIZATION OF PATIENT SUPPORT SERVICES

PATIENT NAME:_____ AUTHORIZED PARTY NAME:_____ RELATIONSHIP TO PATIENT:_____

SIGN HERE ▶ PATIENT/AUTHORIZED PARTY SIGNATURE:_____ DATE:_____

Your patient will be contacted by PANTHERx Rare Pharmacy to arrange for delivery of KEVEYIS.

QUESTIONNAIRE

PRESCRIBER INFORMATION

FIRST NAME: LAST NAME: NPI#:

ADDRESS: CITY/STATE/ZIP CODE:

PATIENT INFORMATION

FIRST NAME: LAST NAME: DOB:

ADDRESS: CITY/STATE/ZIP CODE:

PRIOR AUTHORIZATION REQUEST

The patient's insurance requires prior authorization for this prescription. If you would like us to submit and follow up on the request, send a copy of the medication form, chart notes, labs and radiology reports along with this form.

CLINICAL INFORMATION

What is the diagnosis?

☐ Hyperkalemic periodic paralysis ☐ Hypokalemic periodic paralysis
☐ Primary periodic paralysis variant ☐ Other: _____

Diagnosis confirmed by: (please attach relevant documentation)

☐ Family History Documented ☐ Clinical Assessment ☐ Other: _____

Has the patient been admitted to a hospital due to their PPP? ☐ YES ☐ NO

Has the provider confirmed the patient does not have a contraindication to KEVEYIS® (e.g. hepatic insufficiency, hypersensitivity to sulfonamides, severe pulmonary obstruction, takes high-dose asprin)? ☐ YES ☐ NO

Have nonpharmacologic interventions been tried (e.g. diet, refraining from vigorous exercise)? ☐ YES ☐ NO

Has acetazolamide been tried and failed? ☐ YES ☐ NO

If yes, indicate reason for failure: ☐ Inadequate response ☐ Intolerance or hypersensitivity ☐ Contraindication

Has generic dichlorphenamide been tried? ☐ YES ☐ NO

If yes, indicate reason for failure: ☐ Inadequate response ☐ Intolerance or hypersensitivity ☐ Contraindication

In the prescriber's opinion, is KEVEYIS the best treatment option for the patient?

☐ Alternatives would not be as effective for treating the patient's condition.
☐ Alternatives would likely have adverse effects.

ALL INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

* Prescriber Signature: Title:

** Please sign to validate.*