KEVEYIS®
dichlorphenamide 50 mg tablets

STRONGBRIDGE™
CareConnection

KEVEYIS Start Form

Phone: **1-844-538-3947** Fax: **1-844-538-1030**

STEP 1 Complete all fields on this form to prevent delays in processing.
STEP 2 If able, obtain patient signature for HIPAA authorization.
STEP 3 Fax form, along with copies of both sides of patients insurance and prescription benefit cards.

Patient Information

FIRST NAME: LAST NAME: MI: SEX: ☐ MALE ☐ FEMALE

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

ADDRESS: CITY/STATE/ZIP:

PRIMARY PHONE NUMBER: ☐ CELL ALTERNATIVE PHONE NUMBER ☐ CELL

BEST TIME TO REACH ME ☐ AM ☐ AFTERNOON ☐ EVENING

CAREGIVER NAME (IF APPLICABLE) PHONE NUMBER: ☐ CELL

Prescription Drug Insurance Information

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

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

SECONDARY INSURANCE: PCN # BIN#: ID#: GROUP#:

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

☐ PATIENT DOES NOT HAVE INSURANCE ☐ SEND COPY FRONT/BACK OF PRESCRIPTION, MEDICAL AND SECONDARY INSURANCE CARD

To the Patient: This authorization will allow healthcare providers, including your physician(s), pharmacies, and your health insurance plan(s), to use and share your medical information with Strongbridge CareConnection for the purposes described below. Please review this form carefully before signing. (If you are an authorized representative who will sign on behalf of the patient, please indicate below your relationship to the patient and your authority to sign on the patient's behalf.)

Patient Authorization to Use and Disclose Medical Information

By signing this Authorization, I authorize each of my physicians, pharmacists, 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 information about my insurance, prescriptions, medical condition and health (my "Information") to Strongbridge Biopharma plc (the manufacturer of KEVEYIS), its Strongbridge CareConnection Patient Support Program, and their respective agents and contractors (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) provide me with information about KEVEYIS, disease awareness and management programs and educational materials; and (4) provide me with adherence reminders and support for KEVEYIS.

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. I understand that my pharmacy, health insurance company and healthcare providers may receive remuneration (payment) from Strongbridge Biopharma plc in exchange for disclosing my Information to Strongbridge 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 one (1) year after the date I sign it, as shown below, 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: Strongbridge CareConnection Patient Support Program, 900 Northbrook Drive, Suite 200, Trevose PA 19053. 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 below.

PATIENT NAME: **PATIENT SIGNATURE:** **DATE:**

RELATIONSHIP AND AUTHORITY TO SIGN ON BEHALF OF THE PATIENT (IF SIGNED BY SOMEONE OTHER THAN PATIENT):

CONTACT INFORMATION (IF OTHER THAN PATIENT):

KEVEYIS®
dichlorphenamide 50 mg tablets

STRONGBRIDGE™
CareConnection

PATIENT FIRST NAME: **LAST:** **DOB:**

Clinical Information

PRIMARY DIAGNOSIS: PRIMARY ICD-10 CODE:

ALLERGIES: ☐ NO KNOWN DRUG ALLERGIES

COMORBIDITIES:

Prescriber Information

PRESCRIBER FIRST NAME: LAST: OFFICE CONTACT:

SHIP TO: ☐ PATIENT ☐ OFFICE ☐ ALTERNATIVE

ALTERNATIVE SHIPPING ADDRESS: CITY/STATE/ZIP:

OFFICE/CLINIC ADDRESS: CITY/STATE/ZIP

PHONE NUMBER: FAX NUMBER: NPI#: DEA#:

Prescription Information	Bridge Program*
PRESCRIPTION: **KEVEYIS ® (DICHLORPHENAMIDE) 50 MG TABLETS** DISPENSE: ☐ 30-DAY SUPPLY REFILLS:	PRESCRIPTION: **KEVEYIS ® (DICHLORPHENAMIDE) 50 MG TABLETS** DISPENSE: ☐ 15-DAY SUPPLY ☐ 3 ADDITIONAL REFILLS
DIRECTION FOR USE (PLEASE CHOOSE ONE OF THE FOLLOWING): ☐ TAKE 1 TABLET BY MOUTH TWICE A DAY ☐ OTHER DOSING INSTRUCTIONS:	

*New York prescribers must also submit an electronic prescription.

I certify that I have prescribed KEVEYIS (dichlorphenamide) 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 Strongbridge Biopharma and Service Providers (including, but not limited to KEVEYIS-dispensing pharmacies) to use and disclose as necessary for prior authorization processing and fulfillment of the prescription.

PRESCRIBER'S SIGNATURE: **DATE:**