KEVEYIS® (dichlorphenamide) Prescription Start Form

Fax completed form to 1-312-276-4846

Phone: 1-844-538-3947

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

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

☐ AUTHORIZATION AND RELEASE OF HEALTH INFORMATION OUTLINED ON THE NEXT PAGE
☐ AUTHORIZATION OF PATIENT SUPPORT SERVICES OUTLINED ON THE NEXT PAGE

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

▶ PATIENT/AUTHORIZED PARTY SIGNATURE: _____ DATE: _____

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 the forwarding of this Start Form (and the information included herein) to PANTHERx Rare Pharmacy.

PHYSICIAN'S SIGNATURE (CHOOSE ONE)

SIGN HERE

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:

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:

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

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 one (1) year, 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.

XERIS CARECONNECTION PATIENT SUPPORT SERVICES

Get the support you need to start and stay on treatment

Dedicated Patient Access Manager (PAM)

- Help you along your journey and answer any questions or concerns you may have while taking KEVEYIS®

Specialized ongoing support

- Connect you to a clinical pharmacist who specializes in rare disease and checks in with you regularly

Education

- Ongoing personalized PPP management and treatment education

Advocacy

- Connect you with patient advocacy organizations that offer resources and support for those living with PPP

Caregiver assistance

- Help with switching doctors when you have a life event

Financial assistance

- Help you understand insurance benefits and navigate any changes

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 https://www.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 W Fulton Street, Suite 1300, Chicago, IL 60607.

BE SURE TO CHECK THE XERIS CARECONNECTION BOX ON THE PREVIOUS PAGE TO GET ALL OF THESE BENEFITS.