KEVEYIS®
dichlorphenamide 50 mg tablets

KEVEYIS Start Form

Fax completed form to: 1-844-538-1030

24 Summit Park Dr, Pittsburgh, PA 15275 | Phone: 1-844-538-3947

STRONGBRIDGE™ CareConnection

Patient Information

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

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

ADDRESS: CITY/STATE/ZIP:

HOME PHONE: CELL PHONE:

CAREGIVER NAME (IF APPLICABLE): PHONE:

Prescription Drug Insurance Information

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

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

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

EMPLOYER:

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

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

☐ PATIENT DOES NOT HAVE INSURANCE

I HAVE READ AND AGREE TO THE PATIENT SERVICES AUTHORIZATION AND RELEASE OF HEALTH INFORMATION ON THE NEXT PAGE (SIGNATURE AND DATE REQUIRED TO PARTICIPATE)

PATIENT NAME:_____ RELATIONSHIP TO PATIENT (IF OTHER THAN PATIENT SIGNING): _____

PATIENT/AUTHORIZED PARTY SIGNATURE:_____ **DATE:**_____

Clinical Information

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

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

ALLERGIES: ☐NO KNOWN DRUG ALLERGIES

COMORBIDITIES:

Prescriber Information

FIRST NAME: LAST: NPI#: DEA#:

PHONE: FAX: SHIP TO: ☐PATIENT ☐OFFICE ☐ALTERNATIVE (SPECIFY):

OFFICE CONTACT NAME: OFFICE EMAIL: OFFICE PHONE:

Prescription Information

PRESCRIPTION: **KEVEYIS® (DICHLORPHENAMIDE) 50 MG TABLETS**

DISPENSE: ☐ 30-DAY SUPPLY
☐ REFILLS (MAXIMUM OF 11 REFILLS):_____

Bridge Program*

PRESCRIPTION: **KEVEYIS® (DICHLORPHENAMIDE) 50 MG TABLETS**

DISPENSE: ☐15-DAY SUPPLY ☐ 3 ADDITIONAL REFILLS

Directions For Use

PLEASE CHOOSE ONE OF THE FOLLOWING

☐ TAKE 1 TABLET BY MOUTH TWICE A DAY

☐ OTHER DOSING INSTRUCTIONS:_____

Initiate dosing at 50 mg twice daily. The initial dose may be increased or decreased based on individual response, at weekly intervals (or sooner in case of adverse reaction). The maximum recommended total daily dose is 200 mg.

*New York prescribers must also submit an electronic prescription.

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 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:**_____

KEVEYIS®
dichlorphenamide 50 mg tablets

STRONGBRIDGE™
CareConnection

Patient Services Authorization & 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 Strongbridge Biopharma plc (the manufacturer of KEVEYIS), its Strongbridge CareConnection Patient Support Program, 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; (4) contact me to provide information about Primary Periodic Paralysis, as well as treatment options, support and materials, program and market research opportunities; (5) provide me with information about KEVEYIS, disease awareness and management programs and educational materials; and (6) 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 Strongbridge Biopharma plc 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: 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 on the previous page.

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