Bafiertam® (monomethyl fumarate) delayed-release capsules 95mg

Patient Enrollment Form Instructions

INSTRUCTIONS FOR HEALTHCARE PROVIDERS

Once you and your patient decide BAFIERTAM is an appropriate treatment.

Patients will receive a phone call from Banner Patient Support or their Specialty Pharmacy to arrange delivery of the prescription and answer questions about starting BAFIERTAM.

1. Have your patient read the Patient Authorization section on page 2 and sign on page 3 of the BAFIERTAM Patient Enrollment Form or provide consent online at www.Bafiertam.com/eConsent

2. Fill out all sections of page 3 of the Patient Enrollment Form, being sure to:
   - Copy both sides of the patient's primary and secondary medical insurance cards, and pharmacy benefit card, and submit them with the form
   - Indicate ICD-10 code, list recent MS therapies (if any), and select dosing option
   - Select the Quick Start Program to provide the first month's therapy at no charge to eligible patients while coverage is being secured
   - Sign and date page 3

3. Once complete, submit page 3 and copies of insurance cards by fax to Banner Patient Support at 1-866-539-0270

INSTRUCTIONS FOR PATIENTS

GETTING STARTED WITH BAFIERTAM

1. Read the Patient Authorization on page 2.

2. Fill out the Patient Information section on page 3 of the Start Form, and don't forget to:
   - Provide your contact information and signature as indicated. If you prefer to provide your consent online, visit www.Bafiertam.com/eConsent
   - Check the boxes to receive important updates and information to your mobile device and take full advantage of Banner Patient Support services

WHAT TO EXPECT NEXT

You'll receive a phone call and/or message from your Care Manager at Banner Patient Support to help you get started. If you don't hear from us, give us a call at 1-855-3BANNER (1-855-322-6637)

For questions and help call Banner Patient Support
1-855-3BANNER (1-855-322-6637)
Monday through Friday (8:30AM to 8:00 PM ET)

PATIENT AUTHORIZATION

Patient consent to allow Banner to work together with my insurance provider, pharmacy, and others to provide support on my behalf.

I authorize my healthcare providers, pharmacies and health insurers, and their service providers ("Providers") to disclose information relating to my insurance benefits, medical condition, treatment and prescription details ("Personal Information") to Banner Life Sciences LLC, its affiliates and service providers ("Banner Parties"), including Banner Life Sciences reimbursement support personnel and their service providers, so they can provide the following support services (the "Services"):

- Help coordinate insurance coverage for, access to, and receipt of my medication.
- Communicate with me about my medication and possible patient assistance and access programs, including Banner copay programs, and, if I am enrolled, administer my participation in those programs.
- Conduct quality assurance and other internal business activities and ask for feedback related to the Services or my treatment and carry out the Banner Parties' legal responsibilities.
- Consent for Calls and Texts (optional): We'll check in with you via autodialed calls and text messages to support your therapy, at the telephone number(s) that I provide. My carrier's message and data rates may apply.
- Consent for Patient Services and Marketing (optional): provide me with information, including promotional and product materials, regarding offers, services, programs, educational training, and ongoing support on the use of Banner Life Sciences' products that may be of interest to me.

In delivering the Services, Banner Parties may share my Personal Information with each other, with my Providers, or with government agencies or other financial assistance programs that might help me pay for my medication. They may combine information collected from me with information collected from other sources and use that information to administer the Services. My pharmacies or other healthcare providers may receive payment from Banner Parties for providing certain Services, based on my enrollment or participation. Once I authorize disclosure of my Personal Information, it may no longer be protected by federal health privacy law and applicable state laws.

I understand I do not have to sign this Authorization to get my medication or insurance coverage, that I have a right to a copy, and can cancel this Authorization at any time by calling 1-855-322-6637 or writing to: Banner Patient Support, 50 Bearfoot Rd., Northborough, MA 01532.

This Authorization will expire 5 years after I sign it, or earlier if required by state law, unless I cancel it sooner. If I cancel it, I may no longer qualify for Services from Banner Parties, but it will not impact my Provider's treatment or my insurance benefits. I also understand that if a Provider is disclosing my Personal Information to Banner Parties on an authorized, ongoing basis, my cancellation will be effective with respect to that Provider as soon as they receive notice of my cancellation. Cancellation will not affect prior uses or disclosures.

Please provide your patient authorization signature in the patient information section on page 3.

If you prefer to authorize your consent online, visit www.Bafiertam.com/eConsent.

Patient consent is required to initiate Banner Patient Services.

For questions and help call Banner Patient Support

1-855-3BANNER (1-855-322-6637)

Monday through Friday (8:30AM to 8:00 PM ET)

Bafiertam® (monomethyl fumarate) delayed-release capsules 95mg

Patient Enrollment Form

Please complete form and fax toll-free
FAX: 1-866-539-0270

PATIENT INFORMATION

FIRST NAME | MIDDLE INITIAL | LAST NAME | DATE OF BIRTH | GENDER

HOME ADDRESS | CITY | STATE | ZIP

HOME PHONE | MOBILE ☐ OK TO TEXT | WORK | BEST TIME TO CALL

EMAIL ADDRESS | PREFERRED LANGUAGE IF NOT ENGLISH

ALTERNATIVE CONTACT NAME | RELATIONSHIP TO PATIENT | TELEPHONE ☐ OK TO TEXT

PATIENT AUTHORIZATION

I have read and agree to the Patient Authorization (page 2).

SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE | DATE

☐ **I would like to receive text messages and calls.** I have read and agree to receive text messages and calls as explained on page 2 in Consent for Calls and Texts (optional)

☐ **I would like to receive information about other Banner products.** I have read and agree to receive promotional materials as explained on page 2 in Consent for Patient Services and Marketing (optional)

INSURANCE INFORMATION (PLEASE PROVIDE COPIES OF FRONT AND BACK OF ALL MEDICAL AND PRESCRIPTION INSURANCE CARDS)

PHARMACY BENEFITS | SUBSCRIBER ID # | GROUP # | TELEPHONE

PRIMARY MEDICAL INSURANCE | SUBSCRIBER ID # | GROUP # | TELEPHONE

HEALTHCARE PROVIDER (HCP) INFORMATION

HCP FIRST NAME	HCP MIDDLE INITIAL	HCP LAST NAME	SPECIALTY	NPI #	STATE LICENSE #
Abington Neurological Assoc		215-957-9250	215-957-9254		1154432227

OFFICE/CLINIC NAME	TELEPHONE	FAX	GROUP NPI # (IF APPLICABLE)
1151 Old York Rd, Ste 200	Abington	PA	19001

ADDRESS | CITY | STATE | ZIP

OFFICE CONTACT NAME | CONTACT TELEPHONE | CONTACT EMAIL ADDRESS

PREFERRED METHOD OF COMMUNICATION: ☐ NO PREFERENCE ☐ OFFICE PHONE ☐ FAX ☐ EMAIL PREFERRED CONTACT TIME: _____

DIAGNOSIS AND PRESCRIPTION

DOSING

☐ **Titration Dose for Bafiertam 95mg caps:**

95 mg PO BID x 7 days then increase to 190mg
(95 mg x 2 capsules) PO BID
Qty: #120 capsules **Refills:** No refills

☐ **Maintenance Dose for Bafiertam 95mg caps:**

190 mg (95 mg x 2 capsules) PO BID
Qty: ☐ 90-day supply #360 capsules **Refills:** 3
☐ 30-day supply #120 capsules **Refills:** 11

☐ **Quick Start Program:** Eligible patients can receive one month's supply at no cost

ICD-10 CODE

☐ MULTIPLE SCLEROSIS G35

☐ OTHER ICD-10 CODE: _____

CURRENT/MOST RECENT MS THERAPY

☐ NO PRIOR MS THERAPY

MEDICATION: _____ DATES OF THERAPY: _____

MEDICATION: _____ DATES OF THERAPY: _____

PHYSICIAN SIGNATURE REQUIRED FOR PRESCRIPTION

I authorize Banner Life Sciences LLC, and its affiliates, agents and service providers ("Banner") as my designated agent and on behalf of my patient to provide any information on this form to the insurer of the above named patient, forward the above prescription by fax or by any means as allowed by applicable law to a pharmacy that can provide the prescribed medication for the above named patient and otherwise provide any information on this form for use as authorized by the above named patient. If my patient has not signed the Patient Authorization section of this form, I certify that I have my patient's authorization, including under HIPAA and other applicable privacy laws, for the release of my patient's identification and insurance information to Banner for benefits verification and coordination of benefits. If required by applicable law, please attach copies of all prescriptions on official state prescription forms.

HCP Prescriber Signature

PRESCRIBER SIGNATURE (dispense as written). Signature stamps not acceptable.

DATE

PRESCRIBER SIGNATURE (substitution permitted). Signature stamps not acceptable.

DATE

Prescriber signature required for consent and to validate prescriptions. Prescriber attests that this is their signature. NO STAMPS. By signing, prescriber certifies that the above is medically necessary.

INDICATION AND IMPORTANT SAFETY INFORMATION

What is BAFIERTAM?

- BAFIERTAM is a prescription medicine used to treat relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.
- It is not known if BAFIERTAM is safe and effective in children.

Do not take BAFIERTAM if you:

- have had an allergic reaction (such as welts, hives, swelling of the face, lips, mouth or tongue, or difficulty breathing) to monomethyl fumarate, dimethyl fumarate, diroximel fumarate, or any of the ingredients in BAFIERTAM.
- are taking dimethyl fumarate or diroximel fumarate.

Before taking and while you take BAFIERTAM, tell your doctor about all of your medical conditions, including if you:

- have liver problems
- have or have had low white blood cell counts or an infection
- are pregnant or plan to become pregnant. It is not known if BAFIERTAM will harm your unborn baby
- are breastfeeding or plan to breastfeed. It is not known if BAFIERTAM passes into your breast milk. Talk to your healthcare provider about the best way to feed your baby while using BAFIERTAM.

Tell your doctor about all the medicines you take including prescription and over-the-counter medicines, vitamins, and herbal supplements.

How should I take BAFIERTAM?

- Take BAFIERTAM exactly as your doctor tells you to take it.
- You will be given 1 strength of BAFIERTAM when starting your treatment.
- The recommended starting dose is one 95 mg capsule taken by mouth 2 times a day for 7 days.
- The recommended dose after 7 days is two 95 mg capsules taken by mouth 2 times a day.
- BAFIERTAM can be taken with or without food.
- Swallow BAFIERTAM capsules whole and intact. Do not crush, chew, or mix the contents with food.
- If you take too much BAFIERTAM, call your doctor or go to the nearest hospital emergency room right away.

Continue to page 5.

Banner Patient Support
TEL: 1-855-3BANNER
TEL: 1-855-322-6637
FAX: 1-866-539-0270

What are the possible side effects of BAFIERTAM?

BAFIERTAM may cause serious side effects including:

- **allergic reaction** (such as welts, hives, swelling of the face, lips, mouth or tongue, or difficulty breathing). Stop taking BAFIERTAM and get emergency medical help right away if you get any of these symptoms.
- **PML (progressive multifocal leukoencephalopathy)** a rare brain infection that usually leads to death or severe disability over a period of weeks or months.
  – Tell your doctor right away if you get any of these symptoms of PML:
  - weakness on one side of the body that gets worse
  - clumsiness in your arms or legs
  - vision problems
  - changes in thinking and memory
  - confusion
  - personality changes
- **herpes zoster infections (shingles)**, including central nervous system infections
- **other serious infections**
- **decreases in your white blood cell count** Your doctor should do a blood test to check your white blood cell count before you start treatment with BAFIERTAM and while you are on therapy. You should have blood tests after 6 months of treatment and every 6 to 12 months after that.
- **liver problems. BAFIERTAM may cause serious liver problems that may lead to liver failure, a liver transplant, or death.** Your doctor should do blood tests to check your liver function before you start taking BAFIERTAM and during treatment if needed.
  – Tell your doctor right away if you get any of these symptoms of a liver problem during treatment:
  - severe tiredness
  - loss of appetite
  - pain on the right side of your stomach or have dark or brown (tea color) urine
  - have dark or brown (tea color) urine
  - yellowing of your skin or the white part of your eyes

The most common side effects of BAFIERTAM include:

- flushing, redness, itching, or rash
- nausea, vomiting, diarrhea, stomach pain, or indigestion
- Flushing and stomach problems are the most common reactions, especially at the start of treatment, and may decrease over time. Call your doctor if you have any of these symptoms and they bother you or do not go away. Ask your doctor if taking aspirin before taking BAFIERTAM may reduce flushing.

These are not all the possible side effects of BAFIERTAM. Call your doctor for medical advice about side effects.
You may report side effects to FDA at 1-800-FDA-1088

For more information go to dailymed.nlm.nih.gov.

BANNER™ LIFE SCIENCES