Patient Enrollment

REL18-201

RELiZORB should only be used in conjunction with an enteral feeding system that has a low-flow/no-flow alarm (pump rate should be set between 24-120 mL/hour). RELiZORB should not be used with formulas that contain insoluble fiber. For more information regarding RELiZORB use, visit www.relizorb.com, or call 1-844-632-9271.

RELiZORB® (iMMOBILIZED LIPASE) CARTRIDGE

Please complete this form and email or fax to RelizorbOrder@asembia.com or 1-844-233-3146. Please note – All fields denoted with an asterisk (*) are required fields.

1. Patient Information

Name* (First, Last): ______ Date of Birth:* ______ Sex: ☐ Male ☐ Female

Address:* ______ City:* ______ State:* ______ Zip:* ______

Please check preferred method of contact:

☐ Work Phone:* ______ ☐ Home Phone:* ______

☐ Mobile Phone:* ______ Email: ______

Permission to contact patient/patient representative?

☐ Yes ☐ No Best time to contact: ______

☐ I authorize Alcresta and ASPN Pharmacies, LLC, to send me text messages about my RELiZORB order to the above stated cell phone number(s). I understand that standard data fees and text messaging rates may apply based on my plan with my mobile phone carrier. The termination of this authorization can be implemented at any time by calling RELiZORB Support Services at 1-844-632-9271.

2. Current Insurance Information

Patient Insurance Plan: ☐ Patient has no insurance ☐ Medicare ☐ Medicaid ☐ Medicare Advantage ☐ Private/Commercial

Pharmacy Plan Name: ______

Pharmacy Plan Phone: ______ ID Number: ______

Rx Bin: ______ Rx PCN: ______

Group ID #: ______ Secondary Insurance Information: ______

Medical Insurance Plan Name: ______

Medical Insurance Plan Phone Number: ______

Policy Holder: ______ Policy Holder Date of Birth: ______

Relationship to Patient: ______

3. Patient Authorization

My signature below certifies that I have read, understand, and agree to the Patient Authorization Statement on page 2.

Patient Name (please print): ______

Patient Signature X ______ **Date:** ______

If signed by a representative, please describe the representative's authority to act on behalf of the patient (Note: office personnel cannot sign on behalf of the patient): ______

I am acting for another person, and I hereby affirm that I have the legal right to do so, that I am the parent or legal guardian of the patient or otherwise have a valid power of attorney to act on behalf of the patient.

Representative Name (please print): ______

Representative Signature X ______ **Date:** ______

PHYSICIAN TO COMPLETE SECTIONS 4 - 6

4. Prescriber Information

Prescriber Name* (First, Last): ______

Specialty: ______ Center Name:* ______

NPI: ______ Tax ID Number: ______

Address: ______ City: ______ State: ______

Zip: ______ Phone: ______ Fax: ______

Primary Office Contact: ______

Direct Contact Number/Extension: ______

Email: ______

5. Prescription for RELiZORB® (IMMOBILIZED LIPASE) CARTRIDGE

In order for us to send RELiZORB to your patient, the prescription information must be complete and accurate.

Patient Name* (First, Last): ______ Date of Birth: ______

Diagnosis Code: ______

Product Name: RELiZORB® (iMMOBILIZED LIPASE) CARTRIDGE

Height: ______ ☐ in ☐ cm Weight: ______ ☐ lb ☐ kg Date: ______

Please attach the following: patient demographics, insurance information, history and physical, and medication list

Current Enteral Formula: ______ Product: ______

Volume (mL/day): ______ Pump Type: ______ Rate (mL/hour): ______

RELiZORB PRESCRIPTION (check all that apply)

Instructions: Use 1 cartridge in-line with enteral feeding tube set, change cartridge with every 500 mL of enteral formula (max of 2 cartridges used/day)

☐ 1 cartridge/day (500 mL) Dispense 30 each/cartridge ☐ 2 cartridge/day (1000 mL) Dispense 60 each/cartridge No. of Refills: ______

☐ Patient has failed to achieve enteral feeding goals with pancreatic enzyme replacement therapy in conjunction with enteral feeding.

Additional Orders/Comments: ______

☐ I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Doctor/Prescriber Signature X ______ **Date:** ______

Prescriber Certification

My signature below certifies that I have read, understand, and agree to the Prescriber Certification Statement on page 2.

Prescriber Signature X ______ **Date:** ______

6. Bridge to Reimbursement Program

Patient is eligible for up to 2 months free of RELiZORB in the event that the claim submitted for the prescription in section 5 above is delayed in being processed and approved. The shipment will be made to the address designated in section 1.

Patient Name: ______

Product Name: RELiZORB® (iMMOBILIZED LIPASE) CARTRIDGE

Instructions: Use 1 cartridge in-line with enteral feeding tube set, change cartridge with every 500 mL of enteral formula (max of 2 cartridges used/day)

☐ 1 cartridge/day (500 mL) Dispense 30 each/cartridge ☐ 2 cartridge/day (1000 mL) Dispense 60 each/cartridge No. of Refills: ______

Prescriber Signature X ______ **Date:** ______

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Redisclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized redisclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. IMPORTANT WARNING: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.

In order to receive RELiZORB Support Services, you must complete this RELiZORB Patient Authorization form. Please note that you do not need to complete this authorization in order to start on RELiZORB. Call 1-844-632-9271 to reach RELiZORB Support Services or visit www.relizorb.com for more information.

Patient Authorization Statement

Authorization to Share Protected Health Information (PHI) in Accordance with HIPAA and Other Applicable Laws

Some information that RELiZORB Support Services needs to obtain from my healthcare provider(s) and health plan(s) about me, such as my name and address, my health insurance benefits, prescription drug coverage and drug and medical information, including medical conditions, treatment and drug history may be "protected health information" under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The collection, use and disclosure of such protected health information is protected under federal and state privacy laws, including HIPAA. In order for RELiZORB Support Services to provide me with the services described below ("RELiZORB Support Services"), the staff may need to ask for and receive from my healthcare provider(s) and health plan(s) the protected health information about me as described above.

I hereby authorize my healthcare providers (such as my doctor and pharmacies and pharmacists) and health plan and/or health insurer to disclose protected health information about me to Alcresta Therapeutics, Inc., the manufacturer of RELiZORB, its employees, and the companies working with it ("Alcresta") to provide RELiZORB Support Services so that it may use this information as necessary to:

1. Verify insurance coverage for RELiZORB.
2. Help to arrange financial assistance to help pay for my RELiZORB treatment by contacting my insurer, other potential funding services, social workers, patient advocacy organizations, or patient assistance programs on my behalf in order to determine if I am eligible for other financial assistance.
3. Coordinate delivery of and access to RELiZORB.
4. Provide educational and support services and materials related to RELiZORB treatment.
5. Collect information related to RELiZORB treatment to assist in the coordination of care.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by RELiZORB Support Services and no longer be protected by federal privacy regulations, including HIPAA.

I understand that my healthcare professionals, health plans, and health insurers may not condition treatment, payment, enrollment in a health plan, or eligibility of benefits on whether or not I sign this authorization. I acknowledge, however, that Alcresta may not be able to provide me with full RELiZORB Support Services described above unless Alcresta is able to receive from my healthcare providers, health plans, and health insurers the protected health information described in this authorization.

I understand that I have a right to receive a copy of this signed authorization upon request. I understand that I may cancel this authorization at any time by contacting Alcresta at 1-844-632-9271 or in writing at relizorb@alcresta.com. My cancellation will not apply to protected health information already disclosed by my healthcare providers and health plans and insurers to RELiZORB Support Services on the basis of this authorization before they learn that I have cancelled it. This authorization will expire when I contact Alcresta to cancel it.

I also authorize Alcresta to contact me by phone, email, and/or mail in order to provide me with information related to RELiZORB or to ask me about my experiences with, or thoughts about, products, services, and programs that Alcresta offers or sponsors. My signature on the form verifies that I understand and agree that any information I provide may be used by Alcresta to help develop new products, services, and programs.

Prescriber Certification .

By signing above, I verify that the information being disclosed in this enrollment form is complete and accurate to the best of my knowledge. I understand that ASPN Pharmacies, LLC (ASPN) reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through this Program. Finally, I authorize ASPN as my designated agent to use and disclose my patient's protected health information as may be necessary for treatment, payment, and healthcare operations, including to verify the accuracy of any information provided, to verify patient eligibility, to provide for payment and reimbursement, and to forward the above prescription information, by fax or other mode of delivery, to a pharmacy for fulfillment. Finally, I allow ASPN to email me regarding prescription status updates and act as my prior authorization agent in dealing with prescription and medical insurance companies.

RELiZORB and the Alcresta capstone are registered trademarks of Alcresta Therapeutics, Inc.

Patents: www.alcresta.com/patents

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