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(fosdenopterin) for injection

The ForgingBridges Access and Support Program—for prescribers, for patients, for you

Provided by Origin Biosciences, with a commitment to help bring NULIBRY to those who need it

Make sure your patients are enrolled to receive all the support* they need for NULIBRY

Instructions for Prescribers

Discuss the ForgingBridges program with your patient's parents or caregivers

They are automatically enrolled in the Program to be evaluated for affordability options based on individual needs

Fill out personal and practice information

- Include NPI number
- Primary facility contact information
- NICU/PICU information if applicable

Indicate prescription information and sign

- Indicate ICD-10 codes and other relative information

Sign, where applicable, for all program opportunities

Fax completed form to ForgingBridges: 1-833-551-2223

- Include all completed and signed pages (6)
- Patient's pharmacy information
- Medical coverage information

Instructions for Parents/Caregivers

Discuss the ForgingBridges application with your healthcare provider

ForgingBridges offers programs that provide a high level of support during every step of the treatment journey

Read and sign to give consent for access to ForgingBridges services

- Insurance benefits verification and appeals support
- Prior authorization assistance
- Patient affordability programs, which can help qualified patients get NULIBRY

Provide insurance information

- Include primary and secondary insurance information
- Include medical and pharmacy information
- Preferred method of contact

Please call 1-888-55BRIDGE (1-888-552-7434) with any questions

*Subject to eligibility.

NULIBRY.com

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NULIBRY Enrollment Form

In order to obtain your prescription for NULIBRY, you must enroll in the ForgingBridges | NULIBRY Patient Support Program. Print and fax completed enrollment forms to 833-551-2223. All pages must be received to process enrollment.

Phone: 1-888-55BRIDGE (1-888-552-7434)
Fax: 833-551-2223
Web: NULIBRY.com/forgingbridges

SUPPORT OFFERED

In addition to dispensing your medication, the ForgingBridges | NULIBRY Access and Support program is your source to help you feel supported on your child's path with NULIBRY.

This form will enroll your child in the ForgingBridges | NULIBRY Patient Support Program.

Origin Biosciences, Inc. has designed this support program to help you learn more about your child's disease and treatment, and to help your child get started on their NULIBRY treatment journey.

Please complete the form and let us know which support programs you would like to be enrolled in:

- ☐ **By checking this box, the patient will be evaluated for all ForgingBridges | NULIBRY Programs listed below. Otherwise, please check the programs you are interested in being evaluated for.**
- ☐ **Insurance Support and Financial Assistance**
  Includes benefits verification, prior authorization, appeals support, and potential financial assistance options.
- ☐ **ForgingBridges | NULIBRY Copay Assistance Program**
  Helps patients manage out-of-pocket copay coinsurance costs for those with commercial insurance or private prescription drug coverage.
- ☐ **Nurse and Educational Support**
  ForgingBridges clinical staff will provide educational information on your disease and information on NULIBRY. You will also opt into occasional reminder phone calls and emails.

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

Please read the consent details on page 5 that explain how your information will be used. If you have any questions, please feel free to reach out to our program staff at the number listed above. After you read the information on page 5, please sign below.

Please legibly complete all required fields.

SIGN HERE _____ Parent/Caregiver or Legal Representative _____ Print Name _____ Date

PATIENT CONSENT TO ENROLL IN FORGINGBRIDGES PATIENT ASSISTANCE PROGRAM

Please read the consent details on page 6 that explain the consent and agreement to share financial information if needed. If you have any questions, please feel free to reach out to our program staff at the number listed above. After you read the information on page 6, please sign below.

SIGN HERE _____ Parent/Caregiver or Legal Representative _____ Print Name _____ Date

AGREE TO RECEIVE RELEVANT ORIGIN MARKETING COMMUNICATIONS (OPTIONAL)

Origin Biosciences, Inc. would like to send you additional information about our product and financial assistance programs.

To learn more about how your information is used or if you decide that you no longer want to receive information about Origin Biosciences, Inc. products and services, please contact ForgingBridges | NULIBRY at NULIBRY@mckesson.com.

☐ **Check here if you are interested in sharing your story and/or experience with others. By checking this box, I understand that a representative from Origin Biosciences, Inc. may contact me to discuss my experience with NULIBRY.**

SIGN HERE _____ Parent/Caregiver or Legal Representative _____ Print Name _____ Date

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PATIENT INFORMATION

Name: _____ DOB: _____
(First, MI, Last) (mm/dd/yyyy)

Street: _____

City: _____ State: _____ ZIP: _____

Gender: ☐ Male ☐ Female Today's Date: _____ Current Weight: _____

PARENT/CAREGIVER INFORMATION (PARTY RESPONSIBLE FOR PATIENT)

Parent/Caregiver Name: _____
(First, MI, Last)

Primary Phone: _____ Primary Email: _____

I consent to allow ForgingBridges to leave me a voicemail about treatment information.: ☐ Yes ☐ No

Primary Email: _____

Street: _____

City: _____ State: _____ ZIP: _____

DOB: _____ Gender: ☐ Male ☐ Female Preferred Language (If Not English): _____
(mm/dd/yyyy)

Additional Contact Permitted to Receive Patient Information

Name: _____

Email: _____

Relationship to Patient: _____

Phone: _____

PRIMARY INSURANCE INFORMATION

Please attach copies (front and back) of all available insurance and prescriptions cards. **No Insurance?** ☐

Primary Medical Insurance Name: _____

_____

Insurance Phone: _____

Policy ID #: _____

Group #: _____
(First, MI, Last)

Primary Rx Insurance Name (If Different): _____

_____

Rx Insurance Phone: _____

Policy ID #: _____

Group #: _____

Policy Holder Name: _____ Social Security #: _____

Relationship to Patient: _____ Rx BIN #: _____ Rx PCN #: _____

Street: _____

City: _____ State: _____ ZIP: _____

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SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Please attach copies (front and back) of all available insurance and prescriptions cards.

Secondary Medical Insurance Name: _____

Insurance Phone: _____

Policy ID #: _____

Group #: _____

Secondary Rx Insurance Name (If Different): _____

Rx Insurance Phone: _____

Policy ID #: _____

Group #: _____

Policy Holder Name: _____ Social Security #: _____
(First, MI, Last)

Relationship to Patient: _____ Rx BIN #: _____ Rx PCN #: _____

Street: _____

City: _____ State: _____ ZIP: _____

PRESCRIBER INFORMATION (PRESCRIBER TO FILL OUT)

Prescriber Name: _____ Group Tax ID (NPI #): _____

Prescriber Facility Name: _____

Specialty: _____ Primary Facility Contact Email: _____

Street: _____ Primary Contact Phone: _____

City: _____ State: _____ ZIP: _____ Primary Facility Contact Fax: _____

Hospital Admission Date (if different from DOB): _____

Complete below if the patient is hospitalized at a different location than the prescriber.

Hospital Name: _____

Hospital Contact Name: _____ Hospital Contact Email: _____

Street: _____

City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____

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NICU/PICU INFORMATION

NICU ☐ PICU ☐

NICU/PICU Contact Name: _____

NICU/PICU Contact Email: _____

Phone: _____ Fax: _____

Best Time to Contact: _____

DIAGNOSIS AND ICD-9/ICD-10 CODE

Diagnosis: _____

ICD-9/ICD-10: _____

TREATMENT AND PRESCRIPTION INFORMATION

Fill out this section to write your patient's prescription. Please submit a separate prescription if required by state law.

Prescription for NULIBRY Date: _____

Name of Manufacturer: Origin Biosciences

An infusion pump and supplies are required for adequate administration of NULIBRY. Please see the full Prescribing Information for details, specifically the Instructions for Use section.

It is the provider's responsibility to source the necessary supplies for the administration of NULIBRY if insurance does not cover these items.

Patient Name: _____ DOB: _____
(mm/dd/yyyy)

NULIBRY for injection 9.5 mg fosdenopterin hydrobromide per vial:

SIG: _____

Quantity: _____ Refills: _____

NULIBRY for injection 9.5 mg fosdenopterin hydrobromide per vial:
QuickStart Prescription
(Provides up to 2 months of free treatment to patients if their insurance coverage is delayed by more than 5 days.)

SIG: _____

Quantity: _____ Refills: _____

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HEALTHCARE PROVIDER CONSENT

I certify that (1) the prescribed medicine is medically necessary for this patient and the treatment decision was based solely on my independent medical judgement, (2) services provided by Origin Biosciences, Inc. ("Origin") on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use any Origin product or service, (3) the patient provided me with an authorization to release their personal health information to Origin (together with its affiliates, including but not limited to its third party business partners, vendors, and other agents) for purposes of enrollment in the Program and receipt of patient support services, and;

If my patient is eligible for free product, I understand that receiving free product is not contingent on any purchase obligations. I also understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; nor should it be sold, traded, or distributed for sale. I will notify Biologics immediately if NULIBRY is no longer medically necessary for this patient's treatment or if my patient's insurance status changes. (1) I certify that I have obtained my patient's necessary legal authorization to forward the above service request form and furnish any information on this form to the insurer of the above named patient and (2) I authorize Origin to forward the above prescription, by fax or other mode of delivery, to Biologics specialty pharmacy. I agree to comply with my state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. I understand that noncompliance with state-specific requirements could result in outreach to me as the prescriber.

SIGN HERE _____ Prescriber Signature Required – No Stamps

_____ Print Name

_____ Date

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

By signing on above, I authorize my healthcare providers, insurers and pharmacies ("Healthcare team") to disclose information often referred to as protected healthcare information ("Health Information") to Origin Biosciences, Inc. and its affiliates and agents (the "Parties"). Health Information includes information such as: (1) name, address, telephone, and other personal and contact information, (2) health insurance coverage related information, and (3) treatment-related information.

I authorize the Parties to use my Information for the following purposes:

- Enrolling me in the ForgingBridges Patient Assistance Program (the "Program")
- Providing me with educational information, nursing educational calls (if selected), and other treatment-related educational support
- Verifying, investigating, assisting, and helping with coordinating my health insurance coverage for NULIBRY
- Assessing my initial and continued eligibility for various financial assistance programs
- Coordinating prescription fulfillment
- Contacting me regarding the Program
- Assisting with analyses related to the use of NULIBRY

The Parties agree to use and disclose my Information only as allowed by me in this Authorization or as otherwise allowed by law. I understand that my pharmacy may get payments from Origin Biosciences, Inc. for my information and providing Program services. Once my Health Information and Financial Information (together "Information") has been disclosed to the Parties, I understand that federal privacy laws may no longer protect it from further disclosure.

I understand that I may refuse to sign this Authorization, that I may refuse to disclose all or some of my Information, and that a refusal to sign will not affect my ability to obtain medical care, insurance coverage, or access to health benefits. However, if I do not sign this Authorization, I understand I will not be able to participate in the Program. This Authorization expires ten years from the date signed below, or as otherwise required by state and local law, unless and until I cancel the Authorization before then. I may cancel this Authorization at any time by writing to ForgingBridges | NULIBRY at 11800 Weston Parkway, Cary, NC 27513, or by sending an email to NULIBRY@mckesson.com. I understand that canceling this Authorization will end my participation in the Program and will not affect any use or disclosure of the Information made before my request is received.

I understand that I have a right to receive a copy of this Authorization when it is signed.

PATIENT CONSENT TO ENROLL IN FORGINGBRIDGES PATIENT ASSISTANCE PROGRAM

By signing this enrollment form for ForgingBridges Patient Assistance Program (the "Program"), I authorize Origin Biosciences, Inc. and its affiliates and agents to provide me with services for which I am eligible under the Program.

I would like to be considered for free drug via the Program which requires a financial assistance assessment to determine eligibility. I also understand that I may be asked to provide certain financial information to the Parties depending on the services I am interested in receiving ("Financial Information").

I understand that this enrollment form also is a "written instruction" authorizing Origin Biosciences, Inc. and its vendor, under the Fair Credit Reporting Act ("FCRA"), to obtain information from my profile or other information from a credit reporting company, Experian Health, for the purpose of determining financial qualifications for programs administered by Origin Biosciences, Inc. I understand that I am affirmatively agreeing to these terms in order to be evaluated for free drug via the Patient Assistance Program. The accuracy of the Financial Information I provide is essential to the lawful operation of the Patient Assistance Program. I promise that any information, including financial and insurance information that I provide, is true and complete.

In addition to the consent provided above, if I enroll in QuickStart Free Drug Program I understand and agree that no free product received via the QuickStart Free Drug Program may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale. I understand that this program is not meant to encourage me or my physician to use or prescribe NULIBRY. I also understand that the program only provides drug and that I will need to find alternative means to support other medical costs associated with the use of this medication. Origin Biosciences, Inc. reserves the right to review patient profiles, grant requests based on patient need, and to change program guidelines or terminate the program at any time without notification.

MARKETING COMMUNICATIONS

We will not sell or transfer your Personal Data to any unrelated third party for marketing purposes without your express permission. We may share such Personal Data with regulatory authorities, if required, or contact you to conduct market research.

I authorize Origin Biosciences, Inc. and companies working with Origin Biosciences, Inc. to contact me by mail, email, and/or telephone to provide me with the information I requested and other related information and services or programs that Origin Biosciences, Inc. offers or sponsors, or other topics of interest. I understand that I am not required to provide this consent as a condition of purchasing any property, goods, or services from Origin Biosciences, Inc. I also understand that I may participate in the ForgingBridges | NULIBRY Program if I do not sign this optional marketing authorization.