Lembaz™ Family Support

Lembaz™ (adrabetadex) Injection 900 mg/4.5 mL, for Intrathecal Use Enrollment Form

Phone: **844-237-3600** | Fax: **855-595-2575** | **LembazRx.com/HCP** | **LembazFamilySupport@berentx.com** | M-F, 8 AM-8 PM ET

1 | Patient and Insurance Information

First Name: _____ **MI:** _____

Last Name: _____

Date of Birth: _____ (MM) /_____ (DD) /_____ (YYYY) **Gender at Birth:** ◯ M ◯ F

Primary Language: ◯ English ◯ Spanish ◯ Other _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Preferred Phone: (_____)_____ ◯ Mobile ◯ Home

Alternate Phone: (_____)_____ ◯ Mobile ◯ Home

Email: _____

Authorized Patient Representative (Parent/Guardian/Legal Representative 1):

_____ **Relationship to Patient:** _____

Phone: (_____)_____ ◯ Mobile ◯ Home

Email: _____

Authorized Patient Representative (Parent/Guardian/Legal Representative 2):

_____ **Relationship to Patient:** _____

Phone: (_____)_____ ◯ Mobile ◯ Home

Email: _____

Communications Preference: ◯ Phone ◯ Email ◯ Virtual ◯ In-Person

Okay to leave voicemail? ◯ Yes ◯ No

Patient's Health Insurance: ◯ No insurance. ◯ Copy of all health insurance card(s) and/or prescription card(s) attached. (When submitting this form, provide a scanned copy of the front and back of the patient's insurance cards, as applicable.)

Patient Demographics: ◯ Copy of patient's demographics attached.

2 | Expanded Access Program (EAP) Information, If Applicable

Relevant Clinical Notes/Attachments Included: ◯ Yes ◯ No **EAP Participation:** ◯ Yes ◯ No (If no, proceed to section 3) | ◯ Different Known Location ◯ Unknown Location ◯ Need Help With New Site of Care Location Search (If no, proceed to section 3) **EAP/WEP ID:** _____

EAP Site Name: _____ **Total Completed EAP Injections:** _____ **Date of Last Injection at EAP Site:** _____ (MM) /_____ (DD) /_____ (YYYY)

3 | Prescriber and Site of Care (SOC) Information

Prescriber Name: _____ **Title:** _____

NPI: _____ **Facility Name:** _____

Tax ID: _____ **Office Contact Name:** _____

Facility Address: _____

City: _____ **State:** _____ **ZIP:** _____

Facility Phone: (_____)_____ **Facility Fax:** _____

Email: _____

Communications Preference: ◯ Fax ◯ Phone ◯ Email

Intrathecal Injection SOC: ◯ Same Facility ◯ Other Facility ◯ No preference

Other SOC Facility Name: _____

SOC Contact Name: _____ **SOC NPI:** _____

SOC Address: _____ **City:** _____

State: _____ **ZIP:** _____ **SOC Phone:** (_____)_____

SOC Fax: _____ **Email:** _____

Communications Preference: ◯ Fax ◯ Phone ◯ Email

4 | Prescription and Prescriber Attestation Information

Drug Name: ◯ Lembaz™ (adrabetadex) injection, for intrathecal use. NDC 87230-101-01: one single-dose vial 900 mg/4.5 mL (200 mg/mL) ◯ New to Lembaz™

Primary Diagnosis Code: ◯ E75.24 Niemann-Pick Disease ◯ E75.242 Niemann-Pick Disease type C ◯ E75.249 Niemann-Pick Disease, unspecified

Has an Audiology Test Been Completed? ◯ Yes ◯ No **Date of Audiology Test:** _____ (MM) /_____ (DD) /_____ (YYYY)

Confirmed by Genetic Testing: ◯ Yes (Copy of results attached, if available) ◯ No **Patient Weight:** _____ ◯ kg ◯ lb

Previous Therapies: ◯ Adrabetadex EAP ◯ Levacetylleucine ◯ Arimoclomol ◯ Miglustat ◯ Other _____

Current Therapies: ◯ Levacetylleucine ◯ Arimoclomol ◯ Miglustat ◯ Other _____

Dose/Strength: _____ **Directions:** Inject intrathecally every 2 weeks ◯ Other: _____

Quantity (1 month=2 vials): _____ **Refills:** _____ ◯ Dispense as Written

SIGN HERE

Prescriber Signature: _____ **Date:** _____ (MM) /_____ (DD) /_____ (YYYY)

Prescriber certification: My signature certifies that the patient named on this form is my patient, that the information provided by me in the form is, to the best of my knowledge, complete and accurate, and that therapy with Lembaz™ is medically necessary for my patient. I certify that I have obtained from my patient written authorization, in accordance with all applicable state and federal laws, to release the patient's individually identifiable health information included on this form to Lembaz™ Family Support and that such authorization permits Lembaz™ Family Support to contact the patient and/or otherwise share the patient's individually identifiable information to (i) verify my patient's insurance coverage (including by sharing the information with the patient's insurance plan); (ii) determine my patient's eligibility for Lembaz™ Family Support benefits; and (iii) coordinate Lembaz™ Family Support programs for the benefit of my patient. For Specialty Pharmacy prescriptions, I authorize Lembaz™ Family Support to transmit the above prescription to the appropriate Specialty Pharmacy for my patient. I understand I am under no obligation to prescribe any Beren product, and I certify that I have not received, nor will I receive, any benefit from Beren for doing so. I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. I will not seek reimbursement for any medication dispensed under the Lembaz™ Family Support program from any third-party payer, patient, or other person or entity. Any medication I receive on behalf of my patient from Lembaz Family Support will be appropriately secured and stored until it is dispensed at no charge to the above-named patient only, and will not be resold nor offered for sale, trade, or barter and will not be returned for credit. I agree to comply with and abide by all applicable state practitioner dispensing laws for authorized prescribers. I attest I am not on the HHS/OIG list of excluded individuals. I understand that Beren reserves the right to rescind, revoke, or amend the program and to discontinue support at any time without notice.

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Please see the full Prescribing Information, including Boxed WARNING.

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