Getting Your Patient Started on ARIKAYCE

Arikares® Support Program Enrollment Form and Patient Information

ARIKAYCE Prescription and *Arikares® Support Program* Enrollment Form

ARIKAYCE (amikacin liposome inhalation suspension) Limited Population

Arikares Support Program

Fax: 1-800-604-6027 or **E-mail:** enrollment@arikares.com

Please complete all fields on pages 1 and 3 to prevent any delays and include scanned copies of both sides of the patient's insurance card (fields marked with an asterisk [*] are mandatory/required).

Questions? Phone: **1-833-ARIKA** Alternate Phone: 1-9

PATIENT INFORMATION

*Patient First Name: _____ *Patient Last Name: _____

*DOB: _____ *Gender: ☐Male ☐Female ☐Non-binary ☐Unknown Last 4 of SSN: _

*Physical Address: _____

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

*Mailing Address: _____ ☐Same as P

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

*Mobile Phone: _____ Home Phone: _____ E-mail: _____

Preferred Contact Method(s): (check all that apply) ☐Phone ☐E-mail ☐Text

Preferred Time to Contact: ☐Morning ☐Afternoon ☐Evening

Preferred Contact Language: ☐English ☐Spanish ☐Other: _____

Authorized Alternate Contact: _____

Alternate Contact Phone: _____ Relationship to Patient: _____

Prescription Insurance Information *(Please Send a Copy of Insurance Card)*

*Prescription Coverage Plan Name: _____

Beneficiary/Cardholder: _____ Relationship to Cardholder: _

*Primary Rx Insurance ID #: _____ *Group #: _____

*BIN: _____ *PCN: _____ *Phone: _____

*Primary Rx Plan Type: ☐Private/Commercial ☐Medicare Part D ☐Medicaid ☐TRICARE ☐

Secondary Rx Plan Name: _____

Beneficiary/Cardholder: _____ Relationship to Cardholder: _

Secondary Rx Insurance ID #: _____ Group #: _____

BIN: _____ PCN: _____ Phone: _____

Secondary Rx Plan Type: ☐Private/Commercial ☐Medicare Part D ☐Medicaid ☐TRICARE

Patient Does Not Have Insurance ☐

Patient Authorization Signature

Protected Health Information Disclosure Authorization and Consent–I have read and understand the Prote Information Disclosure Authorization and Consent on page 2. By signing below, I authorize the disclosure of my Patient Support Team as described in the Protected Health Information Disclosure Authorization and Consent

***Patient Signature:** _____ ***Date:** _____

Patient Support Program Enrollment Consent–I have read and understand the Patient Support Prog Consent on page 2. By signing below, I agree to enroll in the Insmed Patient Support Program and cor processing of my Health Information as described in the Patient Support Program Enrollment Consent

***Patient Signature:** _____ ***Date:** _____

Please see Indication and Important Safety Information for ARIKAYCE, including Boxed Warning, on page 4. Please see accompanying full Prescribing Information.

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Patient Authorization may be submitted onli ENROLL.ARIKARES.

What to expect when starting ARIKAYCE

Understanding the *Arikares® Support Program*

Living with this condition is not easy, and neither is starting a new treatment. The *Arikares Support Program* is here to provide you with important information and ongoing support throughout your ARIKAYCE (amikacin liposome inhalation suspension) journey.

Step 1: Being prescribed ARIKAYCE
- You can choose to enroll in the *Arikares Support Program*

Step 2: Welcome to the program
- Your *Arikares Coordinator* contacts you to welcome you to the program
- You receive a Welcome Pack in the mail
- Your voluntary *Arikares Trainer*, a nurse or respiratory therapist, discusses the Welcome Pack with you

Step 3: Receiving ARIKAYCE
- ARIKAYCE arrives at your home, along with a device to help you take it, and a Getting started box

Step 4: Voluntary device training
- You may choose to receive in-home or virtual training from your *Arikares Trainer* to help you take your medication

Step 5: Ongoing support
- Your *Arikares Coordinator* will be in touch throughout your treatment journey to provide focused education and support along the way

If you have any questions, please contact the *Arikares Support Program*
1-833-ARIKARE (1-833-274-5273) or 1-973-437-2376
Monday through Friday from 8 AM to 8 PM Eastern Time
For more information about ARIKAYCE go to ARIKAYCE.com

Arikares Coordinator Name: _____

Arikares Coordinator Tel: _____

Arikares Trainer Name: _____

ARIKAYCE (amikacin liposome inhalation suspension) Limited Population

Arikares Support Program

Please see Important Safety Information for ARIKAYCE, including Boxed Warning. Please see accompanying full Prescribing Information.

ARIKAYCE® (amikacin liposome inhalation suspension) Limited Population

Arikares® Support Program

Please see the accompanying full Prescribing Information for ARIKAYCE for information about Limited Population. Please see Indication and Important Safety Information for ARIKAYCE enclosed, including Boxed Warning.

The *Arikares Support Program* is designed to help your patients **get started on ARIKAYCE (amikacin liposome inhalation suspension)**, **become familiar with taking it**, and **receive support** during their treatment journey.

ARIKAYCE® (amikacin liposome inhalation suspension) Limited Population | Arikares® Support Program

PROGRAM ENROLLMENT

- Complete the *Arikares* Enrollment Form **enclosed** or **download an interactive form** by visiting ArikaresEnrollmentForm.com
  - Submit all pages via fax (1-800-604-6027) or e-mail (enrollment@arikares.com)
- Patient signature on the *Arikares* enrollment form is required to receive full benefits of the program

PAYER ACCESS EDUCATION

- *Patient Access Lead* is available to provide the most recent publicly available payer-specific information regarding
  - Payer approval process
  - Prior authorization and reauthorization
  - Appeal process

SHIPMENT COORDINATION

- *Arikares Coordinator* and specialty pharmacy work with the patient to coordinate the shipment of medication
- Specialty pharmacy reviews financial support options with patient

DEVICE TRAINING

- *Arikares Trainer* can provide one in-office or virtual train-the-trainer to healthcare provider and staff
- *Trainer* conducts voluntary in-home or virtual device training for patient and caregiver(s)

ONGOING PATIENT SUPPORT

- *Arikares Coordinator* provides office with patient updates and answers patients' device-related questions

Insmed Therapeutic Specialist

Arikares Team

Please see the accompanying full Prescribing Information for ARIKAYCE for information about Limited Population. Please see Indication and Important Safety Information for ARIKAYCE enclosed, including Boxed Warning.

QUESTIONS?

Call the *Arikares Support Program* at 1-833-ARIKARE (1-833-274-5273) or 1-973-437-2376.

The *Arikares Support Program* Enrollment Form

The *Arikares Support Program* Enrollment Form is the first step in prescribing ARIKAYCE and enrolling patients in *Arikares*. To begin, you need to gather all the relevant information from each of your patients.

To avoid delays, please **complete all the mandatory fields** in the Enrollment Form (fields marked with an asterisk [*] are required).

Below you can find an annotated example highlighting what's required from the patient and physician sections.

Remember to include copies of each patient's insurance card(s) when submitting the Enrollment Form and Prescription (Rx).

Patient information

- Ensure patient demographic information is filled out completely

Prescription insurance information

- Provide policy and phone numbers
- Include separate prescription plan (if applicable)

Patient signature and date

- Ensure patients sign both signature areas on their Enrollment Form prior to leaving the office. Patient signatures are required to receive full benefits of the program
- ***Patients must read and understand page 2 of the Enrollment Form prior to signing***

ARIKAYCE Prescription and *Arikares® Support Program* Enrollment Form

ARIKAYCE (amikacin liposome inhalation suspension) Limited Population | Arikares Support Program

Fax: 1-800-604-6027 or **E-mail:** enrollment@arikares.com

Please complete all fields on pages 1 and 3 to prevent any delays and include scanned copies of both sides of the patient's insurance card (fields marked with an asterisk [*] are mandatory/required).

Questions? Phone: **1-833-ARIKARE** (1-833-274-5273) Alternate Phone: 1-973-437-2376

PATIENT INFORMATION

*Patient First Name: _____ *Patient Last Name: _____ *MI: ____

*DOB: _____ *Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Unknown Last 4 of SSN: _____

*Physical Address: _____

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

*Mailing Address: _____ ☐ Same as Physical Address

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

*Mobile Phone: _____ Home Phone: _____ E-mail: _____

Preferred Contact Method(s): (check all that apply) ☐ Phone ☐ E-mail ☐ Text

Preferred Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

Preferred Contact Language: ☐ English ☐ Spanish ☐ Other: _____

Authorized Alternate Contact: _____

Alternate Contact Phone: _____ Relationship to Patient: _____

Prescription Insurance Information *(Please Send a Copy of Insurance Card)*

*Prescription Coverage Plan Name: _____

Beneficiary/Cardholder: _____ Relationship to Cardholder: _____

*Primary Rx Insurance ID #: _____ *Group #: _____

*BIN: _____ *PCN: _____ *Phone: _____

*Primary Rx Plan Type: ☐ Private/Commercial ☐ Medicare Part D ☐ Medicaid ☐ TRICARE ☐ Other

Secondary Rx Plan Name: _____

Beneficiary/Cardholder: _____ Relationship to Cardholder: _____

Secondary Rx Insurance ID #: _____ Group #: _____

BIN: _____ PCN: _____ Phone: _____

Secondary Rx Plan Type: ☐ Private/Commercial ☐ Medicare Part D ☐ Medicaid ☐ TRICARE ☐ Other

Patient Does Not Have Insurance ☐

Patient Authorization Signature

Protected Health Information Disclosure Authorization and Consent—I have read and understand the Protected Health Information Disclosure Authorization and Consent on page 2. By signing below, I authorize the disclosure of my PHI to the Insmed Patient Support Team as described in the Protected Health Information Disclosure Authorization and Consent on page 2.

***Patient Signature:** _____ ***Date:** _____

Patient Support Program Enrollment Consent—I have read and understand the Patient Support Program Enrollment Consent on page 2. By signing below, I agree to enroll in the Insmed Patient Support Program and consent to processing of my Health Information as described in the Patient Support Program Enrollment Consent on page 2.

***Patient Signature:** _____ ***Date:** _____

Please see Indication and Important Safety Information for ARIKAYCE, including Boxed Warning, on page 4. Please see accompanying full Prescribing Information.

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Patient Authorization may also be submitted online at ENROLL.ARIKARES.COM

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Mandatory/required fields are highlighted here in yellow for reference only.

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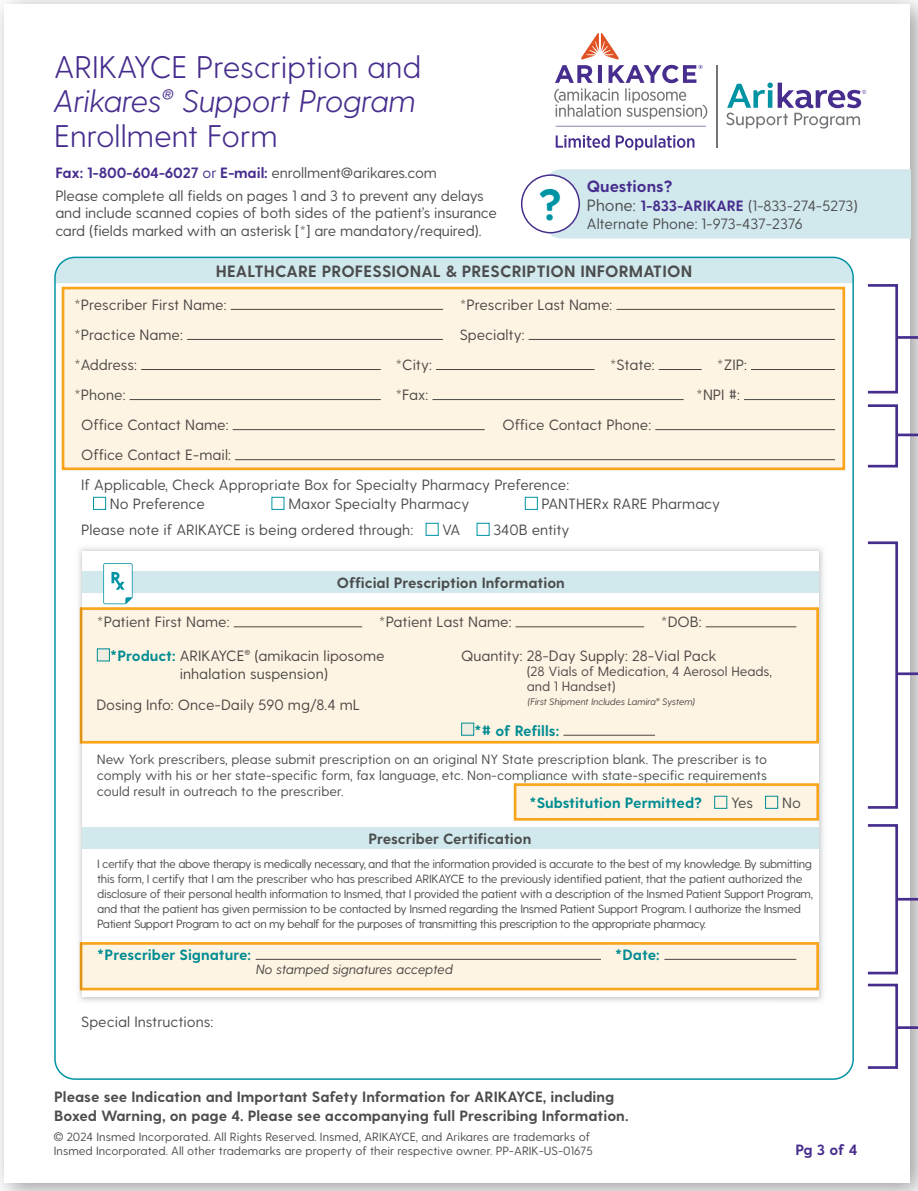
ARIKAYCE® (amikacin liposome inhalation suspension) Limited Population | Arikares® Support Program



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ARIKAYCE® (amikacin liposome inhalation suspension) Limited Population | Arikares® Support Program

Fax: 1-800-604-6027 or **E-mail:** enrollment@arikares.com

Please complete all fields on pages 1 and 3 to prevent any delays and include scanned copies of both sides of the patient's insurance card (fields marked with an asterisk [*] are mandatory/required).

Questions?
Phone: **1-833-ARIKARE** (1-833-274-5273)
Alternate Phone: 1-973-437-2376

HEALTHCARE PROFESSIONAL & PRESCRIPTION INFORMATION

*Prescriber First Name: _____ *Prescriber Last Name: _____

*Practice Name: _____ Specialty: _____

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

*Phone: _____ *Fax: _____ *NPI #: _____

Office Contact Name: _____ Office Contact Phone: _____

Office Contact E-mail: _____

If Applicable, Check Appropriate Box for Specialty Pharmacy Preference:
☐ No Preference ☐ Maxor Specialty Pharmacy ☐ PANTHERx RARE Pharmacy

Please note if ARIKAYCE is being ordered through: ☐ VA ☐ 340B entity

Official Prescription Information

*Patient First Name: _____ *Patient Last Name: _____ *DOB: _____

☐ ***Product:** ARIKAYCE® (amikacin liposome inhalation suspension)

Quantity: 28-Day Supply: 28-Vial Pack (28 Vials of Medication, 4 Aerosol Heads, and 1 Handset)
(First Shipment Includes Lamira® System)

Dosing Info: Once-Daily 590 mg/8.4 mL

☐ ***# of Refills:** _____

New York prescribers, please submit prescription on an original NY State prescription blank. The prescriber is to comply with his or her state-specific form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

***Substitution Permitted?** ☐ Yes ☐ No

Prescriber Certification

I certify that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. By submitting this form, I certify that I am the prescriber who has prescribed ARIKAYCE to the previously identified patient, that the patient authorized the disclosure of their personal health information to Insmed, that I provided the patient with a description of the Insmed Patient Support Program, and that the patient has given permission to be contacted by Insmed regarding the Insmed Patient Support Program. I authorize the Insmed Patient Support Program to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

***Prescriber Signature:** _____ ***Date:** _____
No stamped signatures accepted

Special Instructions:

Please see Indication and Important Safety Information for ARIKAYCE, including Boxed Warning, on page 4. Please see accompanying full Prescribing Information.

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Prescribing physician contact information

- Please list accurate fax numbers for future communications

Office contact

- Staff member in your office who will communicate with an *Arikares Coordinator* regarding patient enrollment, their insurance coverage, and their progress

Prescription information

- **Complete entire section, including number of refills**

Prescriber signature and date

- Required; no stamped signatures accepted

Special instructions

- Include any applicable special instructions (optional)

Mandatory/required fields are highlighted here in **yellow** for reference only.

ARIKAYCE®
(amikacin liposome inhalation suspension)
Limited Population

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