PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Revcovi (elapegademase-lvlr) injection

PRESCRIPTION & ENROLLMENT FORM

Note: This form is intended for prescriber use only.
If faxed, the fax must come from prescriber's office or hospital (should not be faxed by patient).

Phone: 877-534-9627 (24/7) Fax: 866-889-1510

PATIENT INFORMATION (Include the front and back copy of the patient's insurance card)

First name _____ Last name _____
Date of birth _____ / _____ / _____ ☐ Male ☐ Female
Street address _____
City _____ State _____ Zip _____
Parent/guardian (if applicable) _____ ☐ Principle contact
Home phone _____ Work phone _____
Cell phone _____ Evening phone _____
E-mail address _____
Insurance company name _____
Insurance company phone # _____
Insured name _____
Insured employer _____
Relationship to patient _____
Identification # _____ Policy/group # _____
Prescription card ☐ No ☐ Yes If yes, carrier _____
Policy # _____ Group # _____
Eligible for Medicare? ☐ No ☐ Yes Eligible for Medicaid? ☐ No ☐ Yes
Emergency contact _____ Phone _____

PRESCRIBER INFORMATION

Date _____ Time _____
First name _____ Last name _____
Prescriber specialty _____
Street address _____
City _____ State _____ Zip _____
Phone _____ Fax _____
License # _____ DEA # _____
Prescriber Medicaid UPIN # _____ NPI# _____

CLINICAL INFORMATION

ICD-10 code: _____
Secondary ICD-10: _____ Other _____
☐ NKDA ☐ Known drug allergies _____
Current weight _____ kg Date measured _____
Current Med Profile: _____

TREATMENT INFORMATION

☐ New Patient ☐ Transitioning from Adagen ☐ Return to Revcovi ☐ Continue on Revcovi

PRESCRIBING INFORMATION

For more information visit www.revcovi.com or product website.
Revcovi (elapegademase-lvlr) injection NDC# 57665-002-01 Qty_____Refills_____
Dosage:
Inject _____ mg intramuscular (IM) _____ times per week.
Other instructions _____
Dispensed in carton with one-1.5-mL (1.6mg/mL) single-dose vial/Discard Unused Portion
Rationale for Revcovi therapy
☐ Initial Rx for ADA-SCID ☐ Continuation on ERT
☐ Restart after Gene Therapy ☐ Restart after HSCT

PRESCRIBER SIGNATURE

By signing below, I certify that the prescribed therapy is medically necessary.

Prescriber printed name _____
Prescriber signature _____ Date _____
(No stamps) (Dispense as written)
Prescriber signature _____ Date _____
(No stamps) (Substitutions permitted)

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

A Registry study is being conducted to gain a better understanding of Revcovi in the treatment of ADA-SCID. For further information for you and your patient, please contact Leadiant's VP, Medical Affairs, Drug Safey and Pharmacovigilance, Joseph M. Wiley, MD, FAAP at joseph.wiley@leadiant.com or call 301-670-2182.

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. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. Drug names are the property of their respective owners.

PATIENT AUTHORIZATION

I authorize Walgreen Co., and its affiliates, representatives, agents, and contractors (collectively "Walgreens") to share my protected health information ("PHI") with affiliates, representatives, agents, and contractors of Leadiant Biosciences, Inc. ("Leadiant Representatives"). Leadiant Representatives will use my PHI to provide me with support services related to patient assistance programs.

No PHI will be disclosed to Leadiant Biosciences, Inc. ("Leadiant") pursuant to this Authorization. PHI will only be disclosed to Leadiant Representatives as needed to perform services on behalf of Leadiant. I understand these services may include, but are not limited to, financial assistance, treatment services, and information and materials realted to such services.

Protected Health Information that may be shared with Leadiant Representatives includes, but is not limited to, information about my medical condition, prescription, treatment, care management, health insurance, demographic information and contact information. The purpose of sharing my PHI is: (1) providing, coordinating, managing, and contacting me about my prescriptions (including medication refill and adherence reminders), treatment, patient support, and other services related to my Leadiant therapies; (2) establishing my benefits eligibility, including for any financial or reimbursement support services offered by or on behalf of Leadiant; (3) communicating with me and my healthcare providers, health plans, and other payors about my medical care; and (4) providing me with information about current or future products or services offered by Walgreens.

I understand that once my PHI has been shared with Leadiant Representatives, it might be re-disclosed by Leadiant Representatives and privacy laws may no longer protect it. I also understand that Walgreens will receive a fee from Leadiant in exchange for (1) providing me with certain materials and information described above, and (2) using or disclosing certain PHI pursuant to this Authorization. I understand that I may revoke this Authorization at any time, in writing, by sending written notification to Walgreen Co. Privacy Office, 200 Wilmot Road, Mail Stop 9000, Deerfield, Illinois 60015. I understand that my revocation is not effective to the extent that action has already been taken based on this Authorization.

I understand that signing this Authorization is voluntary. If I do not sign this form, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to additional patient support, financial, or related services offered by Leadiant. This Authorization will expire ten (10) years after the date on which I sign it, or in accordance with applicable state law. I understand that I have the right to receive a copy of this Authorization.

_____ _____

Patient or Authorized Representative Signature | If Authorized Rep, state basis for authority

_____ _____

Patient Printed Name | Date

allianceRx

Walgreens + PRIME

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