XERMELO® (telotristat ethyl) tablets, 250 mg

TerSera SupportSource

TerSera Support Source Enrollment Form for XERMELO

Phone: 1-844-XERMELO (937-6356)
Fax: 1-855-215-5318

Please complete pages 1 and 2 of this document and fax to TerSera SupportSource via the number above. ***Required fields.***

1 Prescriber Information

*Name (First, Last) _____ Site Name _____

*Street Address _____ *City _____ *State _____ *ZIP Code _____

*Telephone _____ *Fax _____ Office Contact Name _____

*State License# _____ *National Provider ID# _____

2 Patient Information

*Name (First, Middle Initial, Last) _____ ☐ Male ☐ Female

*Date of Birth (MM/DD/YYYY) _____ *Email Address _____

*Street Address _____ *City _____ *State _____ *ZIP Code _____

Home Telephone _____ *Mobile Telephone _____

Legal Representative/Caregiver Name (First, Last) _____ Relationship to Patient _____ Caregiver Telephone _____

3 Insurance Information

Please submit copies of both sides of patient's insurance card(s) ☐ **Check if patient does not have insurance**

*Primary Insurance _____ *Insurance Telephone _____

*Policy ID# _____ Group# _____ Policy Holder Name (First, Last) and Relationship to Patient _____

Pharmacy Plan Name _____ Pharmacy Plan Telephone _____

Policy ID# _____ Group# _____ Rx BIN# _____ Rx PCN# _____

Secondary Insurance _____ Insurance Telephone _____

Policy ID# _____ Group# _____ Policy Holder Name (First, Last) and Relationship to Patient _____

4 XERMELO® Prescription

Prescriber Signature

Prescription Instructions

Prescription: XERMELO® (telotristat ethyl) tablets 250 mg TID, 28-day supply ☐ ICD-10 E34.0 ☐ Other _____

*Number of Refills ☐ 3 Months ☐ 6 Months ☐ 12 Months

Special Instructions: _____

I appoint TerSera, its affiliates and their representatives (collectively "TerSera") to convey on my behalf the prescription described herein to a pharmacy, if applicable.

I certify that I am disclosing this information to TerSera Therapeutics LLC ("TerSera") to help enable treatment for this patient and the patient is aware of, has consented to, and has directed my disclosure of their information to TerSera so that TerSera may contact the patient to further enable services for those purposes and that such consent and direction applies to disclosures made through the duration of the patient's therapy.

***Prescriber Signature** (stamps not acceptable) _____ ***Date** _____

Preferred Pharmacy:

☐ Biologics ☐ In-Office/Clinic dispensing pharmacy or hospital/health system dispensing pharmacy

Pharmacy Name _____ Pharmacy Telephone _____

A patient signature is required on page 2 in Section 5: Patient Authorization to share personal health information, TerSera SupportSource Enrollment and consent for marketing communications.

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Patient Name _____ Date of Birth _____

5. Patient Authorization to Share Personal Health Information

I authorize my health plans and health care providers ("Health Care Entities") to disclose my personal health information ("PHI") to TerSera Therapeutics LLC ("TerSera Therapeutics"), its affiliates, their representatives, agents, and contractors (collectively, "TerSera") regarding my participating in the TerSera SupportSource Program ("Program") and use of XERMELO. My PHI shall include information about me, my medical condition, treatment, medications, family history, coverage, and payment, and other information relevant to the Program.

My PHI may be used by TerSera to communicate with my Health Care Entities, anyone else I may designate, or me regarding the Program or any TerSera Therapeutics medications or therapies. It may be used regarding any prior authorizations ("PAs"), appeals and denials; insurance and other coverage and benefits investigations and verification; co-payment, coinsurance, free medications, or patient or other assistance regarding my use or prescribed need for XERMELO. It may be used by TerSera to administer, evaluate, and improve the Program and for general business and administrative purposes. I also authorize my PHI to be used for TerSera NurseSupport and other education in connection with the Program or my use of XERMELO.

I understand that certain persons or entities may receive remuneration for using or disclosing my PHI regarding Program and other TerSera Therapeutics activities. Once my PHI has been disclosed under this Authorization, it may no longer be subject to protections and safeguards under the HIPAA Privacy Rule or other privacy laws.

I may refuse to sign this Authorization. My refusing to sign this Authorization shall not impact my right to treatment, payment, enrollment in a health plan, or eligibility for benefits. However, if I revoke or decline to sign this Authorization, I will no longer be eligible to receive Program services. I understand that I may revoke this Authorization at any time by sending written notice of such to TerSera Therapeutics LLC, c/o TerSera SupportSource, 520 Lake Cook Road, Suite 500, Deerfield, IL 60015. Any revocation shall become effective upon receipt of such by any Health Care Entity, except to the extent that action already has been taken in reliance on this Authorization. I understand that I am entitled to receive a copy of this signed Authorization, which shall expire as of five (5) years from the date I have executed this Authorization, unless otherwise specified by State or other applicable law or revoked by me earlier in writing. MARYLAND HEALTHCARE PROVIDERS, under Md. Code HG § 4-303(b)(4) this authorization expires ONE YEAR from the date of signature.

Patient Signature _____ Date _____

Legal Representative Signature _____ Date _____

TerSera Support Source Enrollment (must check box below to be enrolled in support services)

☐ By checking this box, I authorize TerSera Therapeutics LLC, its affiliates, their representatives, agents, and contractors (collectively, "TerSera") to enroll me in the following programs, if I am eligible, to support the use of my XERMELO prescription. This may include the following programs: TerSera NurseSupport, copay assistance, and Patient Assistance Program ("PAP"). Terms and conditions apply and can be found at TerSeraSupportSource.com. If I am enrolled in PAP, I hereby provide "written instructions" authorizing TerSera Therapeutics LLC and its vendor, under the Fair Credit Reporting Act, to obtain information from my credit profile or other information from EXPERIAN, solely for the purpose of determining financial qualifications for programs administered by TerSera Therapeutics LLC. I understand that I must affirmatively agree to these terms to proceed in this financial screening process. I understand that this information, including my health information, is required to fulfill my request. If my application is approved and my income or health coverage changes, I will call TerSera SupportSource at 855-686-8725. I understand that TerSera will process my personal information in accordance with its Privacy Statement available at https://tersera.com/privacy-policy.

Consent for Marketing Communications

☐ By checking this box, I consent to allow TerSera Therapeutics LLC (or its agents) ("TerSera") to send marketing and other text messages ("Texts") to any cell phone number(s) I have provided or may provide regarding the TerSera SupportSource Program ("Program"). Texts may be by automatic telephone dialing system ("ATDS") on a recurring basis regarding TerSera programs, products, goods, or services. Signing this Consent is not a condition of participating in the Program or obtaining or purchasing any programs, products, goods, or services from TerSera. I understand that my cell phone service provider may charge me fees for Texts sent to me. Message and data rates may apply; message frequency may vary; text HELP for help. Except as required by law, TerSera shall have no liability for the cost of any such Texts. TerSera Privacy Policy and Terms of Service shall apply. See Privacy Policy at TerSera.com/Privacy-Policy; Terms of Use at TerSera.com/Terms-of-Use. I may withdraw my consent to receive Texts by replying "STOP," "QUIT," "OPT OUT," "END," "CANCEL," "UNSUBSCRIBE," or "PLEASE OPT ME OUT" via return Text, or by contacting TerSera in writing at TerSera SupportSource, 520 Lake Cook Road, Suite 500, Deerfield, IL 60015.

XER-P-0466 (05/2024)

TerSera® therapeutics