

DUVYZAT™ (givinostat) Patient Start Form

Fax or mail the completed form to ITF ARC.
FAX: 855-748-3272 Mail: ITF ARC, PO Box 5490 Louisville, KY 40255

Questions?
Call ITF ARC at 855-448-3272, Monday–Friday, 8 AM–8 PM ET.

Patient Information:

Prescriber Attestation: I have written authorization on file to disclose this information for purposes of investigating access to DUVYZAT.

Please check primary contact Patient Parent/Caregiver

Patient Information

First Name _____ Last Name _____ Date of Birth ___/___/___ Gender: Male Female Other Gender _____

Address _____ City _____ State _____ ZIP _____ Email _____

Phone _____ Home Cell Other Best time to call: Morning Afternoon Evening

Preferred Language: English Spanish Other _____

Parent/Guardian/Caregiver Information

First Name _____ Last Name _____ Relationship to Patient _____

Address _____ City _____ State _____ ZIP _____ Email _____

Phone _____ Home Cell Other Best time to call: Morning Afternoon Evening

Preferred Language: English Spanish Other _____

Insurance Information:

Please attach copies of the front and back of the patient's prescription, medical, and secondary insurance cards.

Patient has no insurance

Medical Insurance Information

Primary _____

ID # _____ Group # _____

Phone _____ Policy Holder _____

Relationship to Patient _____

Secondary _____

ID # _____ Group # _____

Phone _____ Policy Holder _____

Relationship to Patient _____

Prescription Insurance Information

Primary _____

Rx Member ID # _____ Rx BIN _____ Rx PCN _____

Rx Group # _____ Phone _____ Policy Holder _____

Relationship to Patient _____

Secondary _____

Rx Member ID # _____ Rx BIN _____ Rx PCN _____

Rx Group # _____ Phone _____ Policy Holder _____

Relationship to Patient _____

Patient Financial Information (information used solely to assess the patient for determining eligibility for the DUVYZAT Patient Assistance Program if needed):

Please see Patient Authorization below and on pages 3 and 4 to validate this information through a financial assessment screening.

Annual Household Income \$ _____ Household Size (number of people living in the household) _____

Patient Authorization: Authorization to Share My Health Information

By signing below, I acknowledge that I have read and agree to the Patient Authorization set forth on pages 3 and 4 of this Start Form.

Patient/Guardian/Legally Authorized Representative Signature _____ Date (mm/dd/yyyy) ___/___/___

Relationship _____

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Prescriber Information:

Prescriber First Name _____ Prescriber Last Name _____ Prescriber Specialty _____
 Facility Name _____ Facility Address _____ City _____ State _____ ZIP _____
 NPI # _____ State License # _____ Facility Contact Name _____ Role _____
 Phone _____ Fax _____ Email _____

Prescription (Both prescriptions to be filled out by prescriber only):

For prescription fulfillment by pharmacy after benefit investigation

DUVYZAT oral suspension: 8.86 mg/mL
 Height: Feet ___ Inches _____ Weight _____ kg Date ___/___/___
 Directions and dose (check one of the following recommended dosages for patients 6 years of age and older for the treatment of DMD or fill in "Other"):
 10 kg to less than 20 kg: Take 2.5 mL (22.2 mg) orally twice daily with food
 Quantity: 1 bottle of 140 mL
 20 kg to less than 40 kg: Take 3.5 mL (31 mg) orally twice daily with food
 Quantity: 1 bottle of 140 mL
 40 kg to less than 60 kg: Take 5 mL (44.3 mg) orally twice daily with food
 Quantity: 2 bottles of 140 mL
 60 kg or more: Take 6 mL (53.2 mg) orally twice daily with food
 Quantity: 3 bottles of 140 mL
 Other _____
 Refills _____

For prescription fulfillment by pharmacy for temporary supply (Quick Start or Bridge)

DUVYZAT oral suspension: 8.86 mg/mL
 Directions and dose (check one of the following recommended dosages for patients 6 years of age and older for the treatment of DMD or fill in "Other"):
 10 kg to less than 20 kg: Take 2.5 mL (22.2 mg) orally twice daily with food
 Quantity: 1 bottle of 140 mL Refills: up to 1
 20 kg to less than 40 kg: Take 3.5 mL (31 mg) orally twice daily with food
 Quantity: 1 bottle of 140 mL Refills: up to 3
 40 kg to less than 60 kg: Take 5 mL (44.3 mg) orally twice daily with food
 Quantity: 2 bottles of 140 mL Refills: up to 2
 60 kg or more: Take 6 mL (53.2 mg) orally twice daily with food
 Quantity: 3 bottles of 140 mL Refills: up to 2

The dosage of DUVYZAT may be modified if the patient experiences a decrease in platelets, diarrhea, or an increase in triglycerides.

Prescriber Authorization (no stamps)

Prescriber Signature for Prescription _____ Date ___/___/___
 Substitution Permitted _____ Date ___/___/___
 Prescriber Signature for Prescription _____ Date ___/___/___
 Dispense as Written (no stamps) _____ Date ___/___/___

Prescriber Authorization: I certify that I have prescribed DUVYZAT as described above based on my professional judgment of medical necessity. I authorize ITF Therapeutics LLC, its affiliates, agents, and contractors (collectively, ITF) to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. I authorize the release of medical and/or other patient information relating to DUVYZAT therapy to agents of ITF Therapeutics LLC, and service providers (including, but not limited to DUVYZAT-dispensing pharmacies) to use and disclose as necessary for prior authorization processing and fulfillment of the prescription. I authorize ITF's specialty pharmacy partners to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

Certain states require "brand medically necessary" or similar language to be handwritten by the prescriber if he/she has made this determination in his/her independent clinical judgment. The prescriber should comply with state-specific prescription requirements.

Patient Clinical Information:

Previous and Current Therapies: Please attach a list of all therapies the patient is currently taking or has previously taken.

Gene therapy: Yes No
 DUVYZAT (givinostat): Current, please specify _____ Discontinued Not Applicable
 Exon-skipping therapy: Current, please specify _____ Discontinued Not Applicable
 Emflaza (deflazacort): Current, please specify _____ Discontinued Not Applicable
 Agamree (vamorolone): Current, please specify _____ Discontinued Not Applicable
 Corticosteroids: Current, please specify _____ Discontinued Not Applicable
 Other _____
 Any known allergies _____ No Known Allergies

Confirm patient has Duchenne muscular dystrophy (DMD) Provide patient's ICD-10-CM Code: G71.01 Other _____

Ambulatory Non-ambulatory

Baseline platelet count _____ x 10⁹/L Date ___/___/___ Baseline triglycerides _____ mg/dL Date ___/___/___

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Patient Authorization for Services by the ITF ARC Program

- By checking this box, I consent to receive autodialed marketing calls and text messages from and on behalf of ITF at the phone number(s) I have provided. I understand that consent is not a requirement of any product purchase or enrollment. Message frequency may vary. Message and data rates may apply. I may opt out at any time by texting STOP or calling 855-448-3272.

I authorize the disclosure and use of my personal information for the following purposes:

1) Use and Disclosure of Personal Information

I authorize:

- (a)** My healthcare providers, their staff, pharmacies and health insurance plans (“my healthcare providers”) to disclose personal and medical information to ITF Therapeutics LLC and its agents, contractors (together “ITF”) for the purposes set forth in **(b)**
- (b)** ITF to use and disclose information shared by me and my healthcare providers to help me access ITF products and services, which may include:
- Working with my health insurance plan to verify my insurance and understand benefits for ITF products and services;
 - Communicating with my healthcare providers and health plans about benefits, coverage and medical care;
 - Coordinating a prescription for an ITF medicine with a pharmacy;
 - Evaluating my eligibility for ITF programs to potentially assist with financial out-of-pocket costs for ITF products or no-cost medication programs for ITF products;
 - Confirming the financial information I provided in the Patient Financial Information section on page 1, by conducting a non-credit inquiry through third-party credit bureaus for purposes of evaluating my potential eligibility for the ITF patient assistance program;
 - Opting in for marketing purposes including contacting me by mail, electronic mail, telephone (including leaving voicemail message), and text messages to discuss ITF services and my health benefits for DUVYZAT (rates for text messaging may be charged by my mobile carrier);
 - Sharing information or materials for an ITF product that relates or supports treatment of my medical condition;
 - Using my de-identified information to conduct internal data analyses

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(c) That I understand that if I receive free medications from ITF, I will

- Not seek payment or reimbursement from any healthcare provider or health insurance plan for such free medication
- Not sell or give the medication to anyone because it is illegal to do so
- Take care to safeguard any medication I receive
- Not transfer or share the medication with anyone other than myself for whom it is prescribed

2) Use my de-identified data for research and publication purposes; to conduct data analytics, market research, and ITF ARC–related business activities; and/or to contact me about ITF ARC services

This form is complete and accurate to the best of my knowledge. I will update my information promptly if any of the information reflected on this form changes by contacting ITF ARC at 855-448-3272.