KEVEYIS®
dichlorphenamide 50 mg tablets

KEVEYIS Prescription Start Form

Fax completed form to: 1-844-538-1030

24 Summit Park Dr, Pittsburgh, PA 15275 | Phone: 1-844-538-3947

Your patient will be contacted by PANTHERx Rare Pharmacy to arrange for delivery of KEVEYIS.

Patient Information

FIRST NAME: LAST NAME: MIDDLE INITIAL: SEX: ☐ MALE ☐ FEMALE

DOB (MM/DD/YYYY): / / EMAIL: HEIGHT: WEIGHT: ☐ LB ☐ KG

ADDRESS: CITY/STATE/ZIP:

HOME PHONE: CELL PHONE:

CAREGIVER NAME (IF APPLICABLE): PHONE:

Prescription Drug Insurance Information

PLEASE SEND A COPY (FRONT AND BACK) OF THE PATIENT'S PRESCRIPTION, MEDICAL, AND SECONDARY INSURANCE CARDS.

PRIMARY INSURANCE: RX BIN#: RX PCN#: RX ID#: RX GROUP#:

CARDHOLDER NAME: RELATIONSHIP TO CARDHOLDER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

EMPLOYER:

SECONDARY INSURANCE: RX BIN#: RX PCN#: RX ID#: RX GROUP#:

CARDHOLDER NAME: RELATIONSHIP TO CARDHOLDER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

☐ PATIENT DOES NOT HAVE INSURANCE

I HAVE READ AND AGREE TO:

☐ **THE PATIENT SERVICES AUTHORIZATION AND RELEASE OF HEALTH INFORMATION OUTLINED ON THE NEXT PAGE**

☐ **THE STRONGBRIDGE CARECONNECTION PATIENT SUPPORT SERVICES OUTLINED ON THE NEXT PAGE**

PATIENT NAME: _____ AUTHORIZED PARTY NAME: _____ RELATIONSHIP TO PATIENT: _____

PATIENT/AUTHORIZED PARTY SIGNATURE: _____ **DATE:** _____

Prescription Information

PRESCRIPTION: **KEVEYIS® (DICHLORPHENAMIDE) 50 MG TABLETS**

DISPENSE: ☐ 30-DAY SUPPLY
☐ REFILLS (MAXIMUM OF 11 REFILLS): _____

Bridge Program*

PRESCRIPTION: **KEVEYIS® (DICHLORPHENAMIDE) 50 MG TABLETS**

DISPENSE: ☐ 15-DAY SUPPLY ☐ 3 ADDITIONAL REFILLS

Directions For Use

PLEASE CHECK ONE OF THE FOLLOWING: ☐ TAKE 1 TABLET BY MOUTH ONCE DAILY ☐ TAKE 1 TABLET BY MOUTH TWICE DAILY

TITRATION/OTHER DOSING INSTRUCTIONS: _____

Initial dose: 50 mg once or twice daily. Titrate dose lower or higher, based on individual response, at weekly intervals (or sooner in case of adverse reaction). The maximum recommended dose is 200 mg daily.

I certify that I have prescribed KEVEYIS as described above based on my professional judgment of medical necessity. I authorize the release of medical and/or other patient information relating to KEVEYIS therapy to agents of Strongbridge Biopharma and Service Providers (including, but not limited to KEVEYIS-dispensing pharmacies) to use and disclose as necessary for prior authorization processing and fulfillment of the prescription.

PRESCRIBER'S SIGNATURE: _____ **DATE:** _____

*New York prescribers must also submit an electronic prescription.

Prescriber Information

FIRST NAME: LAST NAME: NPI#: DEA#:

OFFICE ADDRESS: CITY/STATE/ZIP:

SHIP TO: ☐ PATIENT ☐ OFFICE PHONE: FAX:

OFFICE CONTACT NAME: OFFICE EMAIL: OFFICE PHONE:

Clinical Information

PRIMARY DIAGNOSIS: ICD-10 CODE: ☐ G72.3 ☐ G71.19 ☐ OTHER (SPECIFY):

TYPE OF PRIMARY PERIODIC PARALYSIS: ☐ HYPERKALEMIC ☐ HYPOKALEMIC ☐ PARAMYOTONIA CONGENITA ☐ OTHER (SPECIFY):

ALLERGIES: ☐ NO KNOWN DRUG ALLERGIES

COMORBIDITIES:

KEVEYIS®
dichlorphenamide 50 mg tablets

Patient Services Authorization & Release of Health Information

By signing this Authorization, I authorize each of my physicians, pharmacies, other healthcare providers, and each of my health insurers, to use and disclose health information related to my taking KEVEYIS that identifies me personally, including my name, address, and telephone number(s) and information about my insurance, prescriptions, medical condition and health (my "Information") to Strongbridge Biopharma plc (the manufacturer of KEVEYIS), its Strongbridge CareConnection Patient Support Program, and their respective agents, contractors, and third-party vendors, including providers of alternate sources of funding for prescription drug costs (collectively, "the Program") so that the Program may: (1) help to verify, assist with, and coordinate insurance coverage or otherwise obtain payment for my treatment with KEVEYIS; (2) coordinate my receipt of, and payment for, KEVEYIS; (3) conduct analytics to gain insight into and support the effectiveness of the Program; and (4) provide me with adherence reminders and support for KEVEYIS including email or text.

I understand that once my Information has been disclosed to the Program, state and federal privacy laws may no longer protect the Information and that it may be subject to further disclosure by the Program. I also understand that the Program intends to use and disclose my Information only for the purposes described in this Authorization and that results of the analytics will only be shared outside of the Program after being anonymized. I understand that my pharmacy, health insurance company and healthcare providers may receive payment from Strongbridge Biopharma plc in exchange for disclosing my Information to the Program and/or for providing me with therapy support services. I understand that I do not have to sign this Authorization and that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be affected if I do not sign it. I also understand, however, that if I do not sign this Authorization, the Program cannot provide me with assistance.

This Authorization will remain in effect for one (1) year, unless I cancel my enrollment before then. I understand that I may cancel (revoke) the Authorization at any time by sending a written notice of cancellation to: Strongbridge CareConnection Patient Support Program, 900 Northbrook Drive, Suite 200, Trevose PA 19053. I understand that if I do cancel this Authorization, the cancellation will be effective for each of my healthcare providers and health plans/insurers upon receipt by each such entity, respectively, but will not affect any information already disclosed.

I understand that I am entitled to a copy of this Authorization after signing on the previous page.

Strongbridge CareConnection Patient Support Services

By signing this Authorization, I understand I am giving Strongbridge Biopharma® plc, its affiliates, and business partners permission to use the personal information provided in this registration form to contact me by mail, email, telephone call, or in person about disease and product information, disease or product related events, support services, market research, and to share other promotional information. By submitting this form, I consent to these uses and agree to the Strongbridge Biopharma privacy statement located at www.strongbridgebio.com/privacy-statement. I understand I can opt-out by clicking on the unsubscribe link in future communications or by sending a letter with my full contact information (e.g. name, address, email, phone, etc.) to Strongbridge CareConnection patient support program, 900 Northbrook Drive #200, Feasterville-Trevose, PA 19053.