Filsuvez® (birch triterpenes) topical gel

# Patient Enrollment Form

Fax completed form to Chiesi Total Care℠ at
**1-877-914-0591** | Phone: **1-833-670-6464**

Chiesi TOTAL care℠

Chiesi Total Care (the "Program") provides product support to eligible patients who have been prescribed a Chiesi USA, Inc. ("Chiesi") product. Program support may include: (1) reimbursement and financial support (such as investigating insurance coverage, confirming out-of-pocket costs, and reviewing eligibility for financial assistance and copay programs); (2) working with patients and pharmacies to fill prescriptions; (3) home infusion support (if applicable); and (4) providing disease-, medication-, and adherence-related educational resources and communications, including access to a Chiesi Patient Education Liaison.

| **Patient Name:** | **Date of Birth** (MM/DD/YY): / / |
|---|---|

## Enrollment into Chiesi Total Care

By signing this authorization form ("Authorization"), I confirm I would like to enroll in the Program and authorize Chiesi USA, Inc., and its affiliates, service providers, agents, and successors (together, "Chiesi") to provide me with Program support. I authorize Chiesi, my healthcare providers, and their staff, my health plan, patient assistance programs, and my pharmacies to process and share my personal health information (such as information about my diagnosis, treatment, and lab results), personal identifying information (such as contact information and program preferences), and insurance information (such as prescriptions and plans) (together my "Information") in order to enroll me in the Program, provide Program support, administer the Program, meet legal obligations, conduct other business activities, and complete government reporting activities. For example, Chiesi may use my Information to communicate with me (such as by mail, phone, email, and text message*), tailor Program-related communications and services to my needs, and share my Information with my healthcare providers to dispense Chiesi products to me. Chiesi may also de-identify my Information, combine it with information about other patients, and use the results for Chiesi's and its affiliate's business purposes. I understand that once my Information is disclosed, my Information may no longer be protected by federal privacy laws and could be re-disclosed. However, Chiesi will only process and disclose my Information as described in this Authorization. Additional information on Chiesi's privacy practices can be found at https://www.chiesiusa.com/privacy-policy/.

For California Residents: By completing this form and submitting it for the purposes of enrollment in the Chiesi Total Care Program, you understand that Chiesi USA, Inc. may collect and use your Personal Information for the business purposes noted in the Chiesi Privacy Policy located at https://www.chiesiusa.com/privacy-policy/. To opt-out of the use of this Personal Information, you may email us at us.privacy@chiesi.com or by contact us via phone at 1-866-271-8587. Only you, or someone legally authorized to act on your behalf, may make an opt-out request. Please note that Chiesi USA, Inc. does not sell or share Personal Information as defined in the California Consumer Privacy Act ("CCPA").

I understand that this Program is optional. I can refuse to sign this Authorization and refusing to sign will not affect my treatment, insurance coverage, or eligibility for benefits or Chiesi products. However, I understand that I need to sign this form to participate in the Program.

I understand that I may cancel this Authorization at any time or receive a copy of this Authorization by mailing a letter requesting cancellation to Chiesi Total Care, 24 Summit Park Drive, Pittsburgh, PA 15275. I may also revoke my authorization to receive automated calls or text messages by replying STOP to any text from Chiesi Total Care or by contacting Chiesi Total Care in writing at the address above. Upon cancellation, to the extent required by applicable law and personal data rights, Chiesi will no longer process my Information. I understand my cancellation will not apply to any of my Information already used or disclosed based on this Authorization prior to receipt of the cancellation. Unless canceled earlier, this Authorization expires ten (10) years from the date signed below, or as otherwise required by state or local law.

By signing below, I acknowledge that my pharmacy will receive payment from Chiesi for disclosing my Information to Chiesi. I acknowledge that if I am eligible for infusion co-pay assistance, the payment will be submitted to my healthcare facility where the infusion occurred. I acknowledge that if I am enrolled in a government-funded healthcare program, I am not eligible for and will not accept any co-pay assistance from Chiesi Total Care. I understand and agree that if my insurance information changes at any time while I am participating in the Chiesi Total Care Program, I will notify Chiesi Total Care as soon as possible, and any such change may affect my eligibility for such assistance programs.

**By signing below, I also acknowledge that I have read and agree to the terms and conditions of the Chiesi Total Care support programs on page 2 of this document.**

**Feedback:** We greatly appreciate your feedback. Please indicate whether you would like to be contacted by Chiesi about opportunities for you to provide feedback to us (such as Program feedback surveys or market research):

◯ **YES**, I would like to be contacted to provide feedback. ◯ **NO**, I would not like to be contacted to provide feedback.

**Text:** Please indicate whether you authorize Chiesi to send text messages to the number(s) you provide. Your consent to receiving text messages is not a condition of receiving medication or services from Chiesi.

◯ **YES**, I consent to receive text messages. ◯ **NO**, I do not consent to receive text messages.

| **Patient or Legal Guardian Signature:** | **Signature Date** (MM/DD/YY): / / |
|---|---|

Please specify any additional contacts with whom Chiesi Total Care is allowed to discuss your Information:

| **Additional Contact Name:** | **Relationship to Patient:** |
|---|---|
| **Prescriber's Name** (Print): | |
| **Name of Institution/Practice Name:** | |
| **Office Contact Person:** | **Office Phone:** |

* Additional charges may apply. I understand that my telephone provider may charge me fees for calls or texts I receive, and I agree that Chiesi Total Care will not pay those fees.

Filsuvez® (birch triterpenes) topical gel

# Patient Enrollment Form

Fax completed form to Chiesi Total Care℠ at
**1-877-914-0591** | Phone: **1-833-670-6464**

Chiesi TOTAL care℠

## Chiesi Total Care Terms and Conditions

**Chiesi Total Care Patient Support Services Program Terms and Conditions**

To enroll in Chiesi Total Care (the "Program") and to assess eligibility for patient support services of the Program, patient must complete the Program Enrollment and Authorization Form and have a valid prescription for an eligible product of the Program. Additional documentation may be required. The patient must be a resident of the United States or one of its territories. If the patient is incapable of acting on their own behalf or if the patient is under 18 years old, enrollment into the Program may be completed by another person acting on their behalf (such as a parent or legal guardian).

A patient who receives healthcare benefits under any plan or program funded in whole or in part by federal or state governments including Medicare, Medicare Part D, Medicare Advantage, Medigap, Medicaid, TRICARE, Veterans Affairs (VA), Department of Defense, State Prescription Assistance Plans (SPAPs) (other than health insurance for federal government employees), or any state healthcare program such as Medicaid, Children's Health Insurance Program, programs funded under Maternal and Child Health Program, or programs funded under Social Services Block Grant (collectively, "Government-funded Plans") are not eligible for the financial patient support services of the Program. If a change in prescription drug coverage should occur, the patient must notify the Program; such change may affect eligibility for the support services provided in the Program. Patients who have been prescribed a product for an indication that is not consistent with the US Food and Drug Administration-approved labeling will not be eligible for financial patient support services offered through the Program.

Patients residing in or receiving treatment in certain states may not be eligible for certain patient support services of the Program. Patients may not seek reimbursement for value received from the Program. The Program does not obligate the use of any specific medication or healthcare provider.

Program benefits may not be sold, purchased, traded, or offered for sale, purchase, or trade. The Chiesi Total Care patient support services are not valid where prohibited by law, taxed, or otherwise restricted. Offer subject to change or discontinuance without notice. Restrictions, including monthly maximums, may apply. This is not health insurance.

This is a voluntary program. Patients who choose not to enroll in the Program will be able to receive medication. Patients may participate in Chiesi Total Care without participating in a patient support services program of Chiesi Total Care. After enrolling in Chiesi Total Care, participants may opt out by contacting the Program, as outlined in the Chiesi Total Care Enrollment and Authorization Form. Patients must renew their eligibility by December 31 of each year to continue to receive support under the Program.

By participating in the Program, participants acknowledge that they understand and agree to comply with the Program Terms and Conditions.