CRESEMBA® (isavuconazonium sulfate) 372 mg for injection 74.5 mg • 186 mg capsules

SUPPORT SOLUTIONS℠

Website: CRESEMBASupportSolutions.com
Phone: 1-800-477-6472
Fax: 1-866-317-6235

CRESEMBA Support Solutions Enrollment Form

Healthcare Providers: Please complete this form, including the patient's and healthcare provider's signatures, and fax it to CRESEMBA Support Solutions at 1-866-317-6235. **The patient MUST read the Patient Authorization Statement on pages 3-5 and sign on page 1 to verify that they have read, understand, and agree to the statement.**

Please note: All fields denoted with an asterisk (*) are required fields.

1. PATIENT INFORMATION

First Name*: | Last Name*: | Date of Birth*: | Sex: ☐ Male ☐ Female

Home Address*: | City*: | State*: | ZIP*:

Cell Phone: | Home Phone: | Email:

Alternate Contact Name: | Relationship: | Phone:

Permission to Contact Patient? ☐ Yes ☐ No Best Time to Contact: | Preferred Language: ☐ English ☐ Spanish ☐ Other _____ Translators for other languages may be available.

2. CURRENT PRESCRIPTION DRUG INSURANCE*

Patient Has: ☐ No Insurance ☐ Medicare Part D ☐ Medicare Advantage ☐ Medicaid ☐ Private/Commercial

Insurer Name: | Insurer Phone: | Subscriber Name:

Policy ID #: | Group ID #: | BIN #:

3. ASSESSMENT FOR ASTELLAS PATIENT ASSISTANCE PROGRAM*

Evaluate the patient for the Astellas Patient Assistance Program?

☐ Yes ☐ No

4. PRODUCT SHIPPING INFORMATION

Please note: Product cannot be shipped to P.O. boxes.

Ship to the patient's home address indicated above in Section 1*: ☐ Yes ☐ No If No, ship to the address below.

Shipping Location: ☐ Patient ☐ Facility Site Name (if applicable):

Contact Person Name: | Address:

City: | State: | ZIP:

5. PATIENT AUTHORIZATION FOR CRESEMBA SUPPORT SOLUTIONS*

My signature below certifies that I have read, understand, and agree to the Patient Authorization Statement on pages 3-5.

Patient Name (please print): _____

Patient Signature X _____ Date _____

or

Representative Signature X _____ Date _____

I am signing on behalf of the patient and I hereby affirm that I have the legal right to do so, that I am the parent or legal guardian of the patient, or that I otherwise have a valid power of attorney to act on behalf of the patient.

Please describe your relationship to the patient: _____

CRESEMBA® (isavuconazonium sulfate) 372 mg for injection 74.5 mg•186 mg capsules

SUPPORT SOLUTIONS℠

Website: CRESEMBASupportSolutions.com
Phone: 1-800-477-6472
Fax: 1-866-317-6235

6. PRESCRIBER AND PRACTICE INFORMATION

Prescriber Name* (First and Last):	Specialty:	Practice Name*:
Office Contact Name:	Office Contact Phone*:	Fax*:
Address*:		
City*:	State*:	ZIP*:
Medicaid/Medicare Provider Number*:		Tax ID Number*:
State License Number*:		UPIN/NPI*:

7. PATIENT DISCHARGE INFORMATION (IF APPLICABLE)

Discharge Planner (or Facility Contact):	Phone:	Fax:
Post-Discharge Healthcare Provider:	Phone:	Estimated Discharge Date:
Product Formulation Post-Discharge:	Product Need-By Date:	
Preferred Pharmacy:	Pharmacy Address:	
City:	State:	ZIP:

8. PRESCRIBER CERTIFICATION*

My signature below certifies that I have read, understand, and agree to the Prescriber Certification Statement on pages 5-6.

Prescriber Signature X _____ Date _____

Stamped signatures not accepted. This form cannot be processed without an original signature.

9. PRESCRIPTION FOR CRESEMBA® (isavuconazonium sulfate) capsules*

Patient Name: **Date of Birth:**

Relevant Diagnosis Codes[a] (It is the responsibility of the prescribing healthcare provider to determine the correct diagnosis and applicable code for each patient):

☐ B44.0 ☐ B44.1 ☐ B44.2 ☐ B44.7 ☐ B44.89 ☐ B44.9 ☐ B46.0 ☐ B46.1 ☐ B46.2 ☐ B46.3 ☐ B46.4 ☐ B46.5 ☐ B46.8 ☐ B46.9 ☐ Other[b]

[a]These codes are provided as a convenience and represent the most commonly used diagnosis codes. This is not intended to be an exhaustive list, and prescribers should ensure they are using the correct code for the applicable diagnosis. [b]Please contact CRESEMBA Support Solutions if desired code is not listed.

☐ Maintenance dose of CRESEMBA (isavuconazonium sulfate) _____ mg capsules
Instructions: Take _____ capsule(s) orally per _____ hours for _____ days Dispense: _____-day supply Refills: _____

☐ Loading dose of CRESEMBA (isavuconazonium sulfate) _____ mg capsules (if not previously administered)
Instructions: Take _____ capsule(s) orally per _____ hours for _____ days

Doctor/Prescriber Signature X _____ Date _____

Stamped signatures not accepted. Dispense as written.

10. (OPTIONAL) PRESCRIPTION FOR CRESEMBA QUICK START+® PROGRAM ONE-TIME SUPPLY

Complete this additional (optional) prescription for the QUICK START+ Program, which can provide a one-time, 7-day supply of CRESEMBA capsules at no cost to eligible patients who experience a delay in insurance coverage. The shipment will be made to the address designated in Section 4.

Patient Name: **Date of Birth:**

☐ Maintenance dose of CRESEMBA (isavuconazonium sulfate) _____ mg capsules
Instructions: Take _____ capsule(s) orally per _____ hours for _____ days Dispense: _____-day supply

☐ Loading dose of CRESEMBA (isavuconazonium sulfate) _____ mg capsules (if not previously administered)
Instructions: Take _____ capsule(s) orally per _____ hours for _____ days Dispense: 2-day supply

Prescriber Signature X _____ Date _____

Stamped signatures not accepted.

Website: CRESEMBASupportSolutions.com
Phone: 1-800-477-6472
Fax: 1-866-317-6235

PATIENT AUTHORIZATION STATEMENT

My signature on page 1 authorizes my doctor(s), my healthcare providers, my discharge planners, my health plan or payor, and my pharmacy to disclose to Astellas ("Company") and its third-party suppliers, vendors, and other service providers supporting CRESEMBA Support Solutions (collectively, the "Service Providers") information about me (for example, my name, Social Security number, address, insurance policy number, and income) and my medical condition (for example, my diagnosis or medications) (together, "Personally Identifiable Information"). This Personally Identifiable Information can include spoken or written facts about my health and insurance benefits. It can include copies of records from my healthcare providers or health plans about my health or healthcare. I understand that my healthcare providers and my pharmacy may receive remuneration, or payment, for disclosing my Personally Identifiable Information pursuant to this Authorization. I understand that CRESEMBA Support Solutions is a component of Astellas Pharma Support Solutions℠ and that the Service Providers may be compensated by Astellas. The Company and Service Providers will use and disclose my Personally Identifiable Information to (i) assist in my enrollment in CRESEMBA Support Solutions and to contact me and/or the person legally authorized to sign on my behalf; (ii) provide me and/or the person legally authorized to sign on my behalf with educational and other materials, information, and support related to CRESEMBA Support Solutions; (iii) verify, investigate, assist with, and coordinate my coverage for CRESEMBA® (isavuconazonium sulfate) with my payor; (iv) coordinate prescription fulfillment; (v) assess my eligibility for patient assistance and/or benefits, if necessary; (vi) make referrals to other independent programs or alternate sources that may be available to provide assistance to me as allowed under the law, if necessary; and (vii) assist with analyses of the efficiencies and performance of Support provided by Service Providers. In some instances, the Service Providers may de-identify my Personally Identifiable Information. Service Providers and Company may use or disclose the de-identified information (in individual or aggregated form) for any legitimate business purposes. I understand that the Company and Service Providers will make reasonable efforts to keep Personally Identifiable Information private; however, I understand that once my Personally Identifiable Information has been disclosed to the Service Providers, it may no longer be protected under federal and state privacy law and could be disclosed to others.

This authorization will last for three (3) years from the date of my signature on this form or until I am no longer receiving CRESEMBA or enrolled in CRESEMBA Support Solutions, whichever is later, unless a shorter period is required by law. I do not have to sign this authorization, but if I do not, I will not be able to have my insurance coverage verified, have alternate sources of assistance researched, or access other support provided by or on behalf of CRESEMBA Support Solutions. My choice as to whether to

Website: CRESEMBASupportSolutions.com
Phone: 1-800-477-6472
Fax: 1-866-317-6235

sign this form will not change the way my doctors, healthcare providers, or payors treat me. I have the right to revoke or cancel this authorization, in writing, at any time by providing written notice to my healthcare providers and/or the administrators of CRESEMBA Support Solutions. Cancellation of this authorization will be valid when received by the administrators of CRESEMBA Support Solutions. I understand that, if I cancel my authorization, the Company and the Service Providers will no longer be able to provide me with the services described above. I also understand that a cancellation is not effective to the extent that any person or entity has already acted in reliance on my authorization. I know I have a right to see or copy the information my healthcare providers or payors have given to the Service Providers.

I authorize Company and Service Providers to access my consumer report from a consumer reporting agency (credit bureau), other credit information, and public record information (collectively "Financial Records") to estimate my income in conjunction with determining my eligibility for assistance from the Astellas Patient Assistance Program. I authorize Company and Service Providers to use my demographic information, including but not limited to Social Security number, date of birth, name, and/or address, as needed to access such Financial Records to estimate my income in conjunction with the eligibility determination process performed to determine my eligibility under the Astellas Patient Assistance Program. Company and Service Providers reserve the right to ask for additional documents and information at any time. I agree to notify my healthcare providers if I become aware in the future of changes that would affect my eligibility, including, but not limited to, changes in health insurance status or coverage, financial status, and United States residing status.

By signing this form, I affirm that the patient information provided on this form is true and complete to the best of my knowledge. I understand that submitting this form does not guarantee that I will qualify for the Astellas Patient Assistance Program. If I qualify for and receive free medication from the Astellas Patient Assistance Program, I agree to comply with the Astellas Patient Assistance Program rules, and I will not get reimbursed for the assistance I receive from anyone else, including from an insurance program, another charity, or from a health savings, flexible spending, or other health reimbursement account. I understand that any medicines supplied by the Astellas Patient Assistance Program shall not be sold, traded, bartered, or transferred. I further understand that the support provided through the Astellas Patient Assistance Program is not contingent on any future purchase.

I understand that I am entitled to receive a copy of this Authorization Statement after I have provided my signature.

This Authorization Statement is governed by and interpreted in accordance with the laws of the state of Illinois, excluding Illinois conflict of law rules, and applicable federal law.

Website: CRESEMBASupportSolutions.com
Phone: 1-800-477-6472
Fax: 1-866-317-6235

Astellas is committed to the safety and effectiveness of our products, in the event you experience an adverse drug event or side effect, Astellas requests your consent to be able to contact you, your family member and/or your healthcare provider. This contact may be via phone, email, or any commonly used electronic form or medium. The purpose of this follow up is to help us at Astellas to better understand the event you experienced in relation to our product.

For additional information regarding how Astellas handles personal information, please visit our Privacy Policy link at: https://www.astellas.com/us/privacy-policy.

PRESCRIBER CERTIFICATION STATEMENT

By signing on page 2, I hereby attest that I am the prescribing healthcare provider, and I agree to submit requests to CRESEMBA Support Solutions because I have determined that CRESEMBA® (isavuconazonium sulfate) is medically appropriate and I have explained such to my patient. To the best of my knowledge, the patient and physician information in this form is complete and accurate. I certify that I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act [HIPAA] of 1996) to the Service Providers for the purpose of providing access and reimbursement support, assisting in initiating or continuing therapy, and/or the evaluation of the patient's eligibility for support. I authorize Service Providers, as designated agents and on behalf of my patients, to forward a prescription for CRESEMBA, by fax or other mode of delivery, to a pharmacy.

I also certify that this prescription complies with all applicable state and local laws.

If applying for the Astellas Patient Assistance Program, I certify that this patient has no insurance and is not eligible for other public health insurance programs. I agree to notify the Service Providers if I become aware at any time in the future of changes in my patient's circumstances that would affect his or her eligibility, including, but not limited to, changes in health insurance status or coverage, financial status, United States residency status, or the indication for which CRESEMBA has been prescribed for this patient. I understand that Astellas reserves the right to change or terminate the Astellas Patient Assistance Program at any time or refuse to provide CRESEMBA under the Astellas Patient Assistance Program to any patient.

I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. If my patient obtains CRESEMBA via the Astellas Patient Assistance Program, I understand that (a) any medication supplied under the Astellas Patient Assistance Program is for the use of the patient named on this form only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (including the patient or any third party payor) for reimbursement; (b) I will receive and secure my patient's medication at my office separate from commercially

Website: CRESEMBASupportSolutions.com
Phone: 1-800-477-6472
Fax: 1-866-317-6235

purchased medication until it's dispensed to my patient, when applicable; (c) I will comply with and abide by my State Practitioner Dispensing Laws for authorized prescribers, when applicable; and (d) the provision of free drug as part of the Astellas Patient Assistance Program is not contingent on any future purchase or prescribing of CRESEMBA.

I acknowledge I may be contacted by email, postal mail, or fax using the information I've provided, and I understand my personal information will be used and disclosed by Astellas in accordance with Astellas' privacy policy, available at www.astellas.com/us/privacy-policy.

I certify that a copy of the Patient Authorization Statement has been given to the patient named on page 1 and their representative and that I have provided my patient with a description of CRESEMBA Support Solutions.