

Healthcare Providers: Please fax this completed and signed form to CRESEMBA Support SolutionsSM. Remember to complete the prescription drug information and obtain healthcare provider and patient signatures. **Patient MUST read and sign the Patient Authorization Statement on pages 3 and 4.**



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

1. PATIENT INFORMATION

Name*: _____ Date of Birth*: _____
Sex*: Male Female Phone: _____ Phone Type: Home Work Mobile
Home Address*: _____
City*: _____ State*: _____ ZIP*: _____
Email: _____
Alternate Contact Name: _____ Relationship: _____ Phone: _____
Permission to contact patient? Yes No Best Time to Contact: _____

2. CURRENT INSURANCE INFORMATION*

Patient has no insurance
 Patient has insurance pending with (name of insurer): _____
Patient Insurance Plan:
 Medicare Part D Medicaid Private/Commercial Medicare Advantage
Insurer Name: _____ Insurer Phone: _____
Subscriber Name: _____ Policy ID: _____ Group No.: _____
Prescription Insurer Name: _____
PBM Subscriber ID: _____ PBM Phone No.: _____
PBM BIN No.: _____ PBM Group No.: _____

3. ASSESSMENT FOR ASTELLAS PATIENT ASSISTANCE PROGRAM*

The patient's Social Security number is required to assess income eligibility for the Astellas Patient Assistance Program.
Patient's Social Security Number: - -

4. SHIPPING INFORMATION

Please note: Product cannot be shipped to P.O. boxes.
Ship to patient 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. DISCHARGE INFORMATION*

Discharge Planner (or facility contact): _____
Phone: _____ Fax: _____
Post-Discharge Physician: _____ Phone: _____
Estimated Discharge Date: _____ Discharge Location: _____
Product Formulation Post-Discharge: _____ Product Need-By Date: _____
Preferred Pharmacy: _____
Pharmacy Address: _____
City: _____ State: _____ ZIP: _____

6. PRESCRIBER INFORMATION

Prescriber Name (First, Last)*: _____
Practice Name*: _____ Specialty*: _____
Office Contact: _____
(If different from discharge planner/facility contact in Section 5)
Address*: _____
City*: _____ State*: _____ ZIP*: _____
Phone*: _____ Fax*: _____
Medicaid/Medicare Provider No.*: _____ Tax ID No.*: _____
State License No.*: _____ UPIN/NPI*: _____

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

In order for us to send medication to your patient, the prescription information must be complete and accurate.
Patient Name: _____ **Date of Birth:** _____
Relevant Diagnosis Codes (It is the responsibility of the prescribing physician to determine the correct diagnosis and applicable code for each patient):
____ B44.0 _____ B44.7 _____ B46.0 _____ B46.3 _____ B46.8
____ B44.1 _____ B44.89 _____ B46.1 _____ B46.4 _____ B46.9
____ B44.2 _____ B44.9 _____ B46.2 _____ B46.5 _____ Other^a

^aPlease contact CRESEMBA Support Solutions if desired code is not listed.

- Maintenance Dose of CRESEMBA (isavuconazonium sulfate) 186-mg capsules
Instructions: Take ____ 186-mg capsule(s) orally per _____ hours for _____ days
Dispense: _____ -day supply Refills: _____
- Loading Dose of CRESEMBA (isavuconazonium sulfate) 186-mg capsules (If not previously administered) Instructions: Take 2 capsules (372 mg) orally every 8 hours for 6 doses (48 hours)

Doctor/Prescriber Signature X _____ **Date:** _____

Dispense as Written – Stamped signatures cannot be accepted.

Prescriber Certification: My signature below certifies that I have read, understand, and agree to the Prescriber Certification Statement on page 4.

Prescriber Signature X _____ **Date:** _____
(This form cannot be processed without an original signature.)

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

Complete this additional (optional) prescription for CRESEMBA QUICK START+ Program one-time, 7-day supply of CRESEMBA 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) 186-mg capsules
Instructions: Take ____ 186-mg capsule(s) orally per _____ hours for _____ days
Dispense: 7-day supply Refills: 0
- Loading Dose of CRESEMBA (isavuconazonium sulfate) 186-mg capsules (If not previously administered)^b Instructions: Take 2 capsules (372 mg) orally every 8 hours for 6 doses (48 hours)

Prescriber Signature X _____ **Date:** _____
(Stamps not accepted)

Healthcare Providers: Please fax this completed and signed form to CRESEMBA Support SolutionsSM. Remember to complete the prescription drug information and obtain healthcare provider and patient signatures. **Patient MUST read and sign the Patient Authorization Statement on pages 3 and 4.**

Phone: 1-800-477-6472 **Fax:** 1-866-317-6235
Hours: Monday–Friday, 9 AM–8 PM ET
Website: www.CRESEMBA Support Solutions.com



SUPPORT

Astellas (“Company”), has developed an integrated approach of customized access and reimbursement support to help patients minimize potential barriers to accessing CRESEMBA® (isavuconazonium sulfate) (hereinafter referred to as “CRESEMBA Support Solutions” or “Support”). This Support is designed to help healthcare providers and patients evaluate a patient’s coverage and reimbursement options for CRESEMBA. The prescriber and patient signatures on page 1 and page 4 authorize the Service Providers (defined on page 3) to perform any or all of the following, if necessary, to assist with patient access to CRESEMBA.

- Perform benefits verification/prior authorization (PA) if PA is required by payor
- Assist with benefits appeal
- Make referral to other independent programs or alternate sources that may be available to provide patient with assistance as allowed under the law
- Determine eligibility for the free drug program through the Astellas Patient Assistance Program
- Provide educational support

Perform benefits verification/prior authorization (PA) if PA is required by payor – A benefits verification allows a Service Provider to call a patient’s insurance plan to investigate specific coverage for CRESEMBA. During the call, a Service Provider may inquire about patient eligibility for benefits, coverage restrictions, deductible, copayment or coinsurance, benefit maximum amounts, and any other payor requirements. A Service Provider may provide the healthcare provider with a summary of the benefits verification research.

If PA is required, a Service Provider will use reasonable efforts to provide the healthcare provider information on what to submit to the payor, the submission process, and an estimation of how long it will take the payor to make a determination.

Assist with benefits appeal – If a payor denies coverage for CRESEMBA, Service Providers may assist the healthcare provider with appealing the payor’s decision. This means that a Service Provider may use reasonable efforts to provide the healthcare provider and/or the pharmacy provider information on what to submit to the payor, the submission process, and an estimation of how long it will take the payor to make a determination.

Make referral – A Service Provider may refer patient to other independent programs or alternate sources that may be available to provide patient with assistance as allowed under the law.

Determine eligibility for the free drug program through the Astellas Patient Assistance Program – The Astellas Patient Assistance Program was established to provide certain Astellas medications at no cost to eligible, uninsured patients. A Service Provider may obtain information from patients, such as insurance status and income, in order to determine eligibility. If a patient is approved, a Service Provider will notify both the healthcare provider and patient and ship the CRESEMBA prescription to the patient.

Provide educational support – The Service Providers and the Company may provide educational and other information on CRESEMBA via mail, email, phone, or other methods of communication. This may include activities like sending educational and/or other materials or other similar programs to promote patient education on and medication adherence to CRESEMBA.



9. PATIENT AUTHORIZATION STATEMENT

Patient Authorization Statement

My signature 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 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 information pursuant to this Authorization. I understand that CRESEMBA Support Solutions is a component of Astellas Pharma Support SolutionsSM and that the Service Providers may be compensated by Astellas. The Service Providers will use and give out my 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 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 information and use or disclose the de-identified information (in individual or aggregated form) for any legitimate business purposes. I understand that the Service Providers will make reasonable efforts to keep my information private; however, I understand that once my information has been disclosed to the Service Providers, how the Service Providers further disclose my information may no longer be protected under federal and state privacy laws.

This authorization will last for three (3) years from the date on page 4 or until I am no longer receiving CRESEMBA or enrolled in CRESEMBA Support Solutions, whichever is later. 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 sign this form will not change the way my doctors, healthcare providers, or payors treat me. If I no longer wish to participate in CRESEMBA Support Solutions, I shall inform my healthcare providers and/or the administrators of CRESEMBA Support Solutions in writing that I do not want them to share any more information with the Service Providers, but it will not change any actions that took place before I told them. 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 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.

9. PATIENT AUTHORIZATION STATEMENT (cont.)

If an application is submitted to determine my eligibility for assistance from the Astellas Patient Assistance Program (PAP), I agree to allow 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 my credit information and information derived from public and other sources, including information from a consumer reporting agency (credit bureau), to estimate my income in conjunction with the eligibility determination process performed to determine my eligibility under the PAP. 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.

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.

My signature below certifies I have read and understand the Patient Authorization Statement.

Patient Name (please print)*: _____

Patient Signature*

X _____

Date: _____

If signed by a representative, please describe the representative's authority to act on behalf of the patient (Note: Office personnel cannot sign on behalf of the patient):

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

Representative Signature*

X _____

Date: _____

PRESCRIBER CERTIFICATION STATEMENT

By signing on page 1, 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) capsules is medically appropriate and I have explained such to my patient. 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.

If my patient obtains CRESEMBA via the Astellas Patient Assistance Program, I understand that (a) no third party or patient can be charged for CRESEMBA provided under such program and (b) that no free product should be sold, traded, or distributed for sale. I also understand that the provision of free drug as part of the Astellas Patient Assistance Program is not contingent upon future purchase or prescribing of CRESEMBA.

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