KRESLADI™ Treatment Referral Form

Please fax completed form to 609-228-7929
To reach a Case Navigator, call 844-725-8227

Patient Information

First Name: _____ Last Name: _____ Middle Initial: ____

Gender: _____ DOB: _____ Last 4 of SSN: _____ Preferred Language: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Email: _____ Primary Phone: _____ Secondary Phone: _____

Authorized Representative (parent/legal guardian; required if patient is a minor): _____

****Please provide front and back copy of patient's insurance information****

Prescriber Information

Prescriber Name: _____ License #: _____

NPI#: _____ Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

If CRNP or PA-C, include Supervising Physician info, if applicable:

Supervising MD Name: _____ License #: _____

Clinical Information

Height: _____ Weight: _____ Date Height and Weight Obtained: _____ Clinic Infusion: _____ × _____

ICD-10 Diagnosis Code: _____ Allergies: _____

☐ No Known Drug Allergies (NKDA)

Insurance Information

Primary Insurance Name: _____ Primary Insurance Phone: _____

Subscriber Name: _____ ID#:_____ Group#: _____

Pharmacy Benefit Plan Name: _____ ID#: _____ Group#: _____ BIN: _____

Secondary Insurance Name: _____ Secondary Insurance Phone: _____

Subscriber Name: _____ ID#:_____ Group#: _____

KRESLADI Prescription and Dosing Information

Medication: KRESLADI (marnetegragene autotemcel) suspension

Minimum Medication Dose: 2 × 10^6 CD34+ cells/kg of body weight

Quantity: 1 Dose supplied as 1 or 2 infusion bags

Volume: Each infusion bag contains approximately 30 mL

Rate or Length of Infusion: Over a period of less than 10 minutes for each infusion bag

Frequency: One time

Route of Administration: Intravenous infusion

Refills: No Refills

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic. Prescriber signature required (sign below): (Physician attests this is their legal signature. NO STAMPS.)

_____	_____	_____	_____
Date	Dispense as Written	Date	No Substitution Allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing the information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. All rights in the product names, trade names, or logos of all third-party products that appear in this form, whether or not appearing with the trademark symbol, belong exclusively to their respective owners.

Authorization to Use/Disclose Health Information

I hereby authorize my/my child's treating physicians, health insurance plan(s), pharmacies, or other healthcare providers (collectively "Healthcare Providers") to use and disclose my/my child's protected health information related to my/my child's medical condition relevant to a Rocket Pharmaceuticals gene therapy to Rocket Pharmaceuticals and its contractors and business partners. This authorization is made for the purpose of enrolling me/my child in Rocket Pharma Cares™, providing me/my child with patient services, and administering the Rocket Pharma Cares program. I understand that once my/my child's health information has been disclosed, federal privacy laws may no longer protect the information. However, Rocket Pharmaceuticals agrees to protect my/my child's health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. I understand that I have the right to revoke this Authorization at any time by mailing a letter to Rocket Pharmaceuticals, 9 Cedarbrook Drive, Cranbury, NJ 08512 ATTN: Patient services or visiting www.RocketPharmaCares.com. I understand that if I revoke this Authorization, I/my child will no longer be able to receive Rocket Pharma Cares services.

This Authorization shall remain valid for ten (10) years from the date the Authorization is signed unless earlier revoked by my written request or in accordance with local laws. I understand that I have a right to receive a copy of this consent form.

I understand that signing this consent form is voluntary and that my enrollment in any of the services and/or programs described above is entirely voluntary. I further understand that my/my child's treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my authorization of this disclosure, but if I do not sign this consent form, I/my child will not be able to receive Rocket Pharma Cares services.

I understand that certain parties, such as my/my child's pharmacy provider, may receive remuneration (payment) from Rocket Pharmaceuticals in connection with the activities described in this consent form.

PATIENT AUTHORIZATION (to be completed by Patient or authorized representative)

By signing this form, I acknowledge that I understand and agree to the terms of this form. My signature certifies that I have read, understood, and agree to the release and use of my and/or my child's personal information, including sensitive personal information, pursuant to the Authorization to Use/Disclose Health Information and as otherwise stated on this form.

Patient Name (Printed)

Signature of Patient

Date (MM/DD/YYYY)

Signature of Patient Representative*

Date (MM/DD/YYYY)

***If signed by Patient Representative, please explain authority / relation to act on behalf of patient:**

Please read the following statements and mark each box:

- ☐ I hereby authorize the Rocket Pharma Cares Program to use my PHI to contact me by mail, e-mail, text, phone, or any communication method I request for the purposes as described herein.
- ☐ Further, I understand that this program guarantees that I will receive KRESLADI [NDC: 83537-034-01] rather than other products. No substitutions will be made or given.

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