Zanvastro™ (zilganersen)

Patient Enrollment Form

IONIS EVERY STEP™ SUPPORT SERVICES

Fax: 1-888-454-8488 | **Phone:** 1-844-399-5544
Hours of Operation: Monday-Friday, 9 AM to 6 PM ET

Complete this form for each patient. Bolded fields with asterisks (*) are required for a patient to access Ionis Every Step™ support.

1 | Patient Information

***First Name:** _____ ***Last Name:** _____ ***DOB:** _____

Gender: ☐ Male ☐ Female ***Street Address:** _____ ***City:** _____ ***State:** _____

***ZIP Code:** _____ ***Primary Phone # (mobile preferred):** _____ **Email:** _____

Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening **Language:** ☐ English ☐ Spanish ☐ Other _____

Patient Representative/Family Member Information *(if applicable)*

Representative/Family Member Full Name: _____ **Relationship to Patient:** _____

Phone #: _____ **Email:** _____

2 | Prescriber Information

***Prescribing Provider Name:** _____ ***Specialty:** _____

Practice Name: _____ **Office Contact Name:** _____

***Practice Address:** _____ ***City:** _____ ***State:** _____ ***ZIP Code:** _____

***Office Phone #:** _____ ***Office Fax #:** _____ **Email:** _____

***Prescribing Provider NPI #:** _____ **Prescribing Provider Tax ID #:** _____

3 | Site of Care That Administers ZANVASTRO

☐ **Check if site of care (SOC) is unknown**

Facility Name: _____

Office Contact Name: _____

Address: _____ **City:** _____

State: _____ **ZIP Code:** _____ **Phone #:** _____ **Fax #:** _____

Administering Physician Name: _____ ☐ **Select if same as Prescribing Provider**

Administering Physician NPI #: _____ **Administering Physician Tax ID #:** _____

Scheduled Dose Date: _____

Place of Service Code (POS): ☐ **Physician office (11)** ☐ **Off-campus outpatient hospital (19)** ☐ **Inpatient hospital (21)**

☐ **On-campus outpatient hospital (22)** ☐ **Ambulatory surgical center (24)** ☐ **Other** _____

4 | Diagnosis and Clinical Information

Include available supporting documentation from diagnosis and treatment decision: MRI imaging confirmation and results of genetic testing for *GFAP* variant.

***ICD-10-CM Diagnosis Code:** G31.86

Has patient participated in Early Access Program (EAP)/clinical trials? ☐ Yes ☐ No

☐ Presence of *GFAP* variant confirmed

5 | Procurement

☐ Buy and Bill (Specialty Distributor): CuraScript SD ☐ Specialty Pharmacy: Accredo — *complete prescription on page 2* ☐ Unknown

6 | Prescriber Authorization

I have received authorization to release the medical and/or other patient information relating to this therapy to Ionis Every Step™ and its affiliates, agents, and representatives to use and disclose as necessary for prior authorization processing and fulfillment of the prescription. I certify that, to the best of my knowledge, the patient and physician information in this form is complete, accurate, and consistent with applicable privacy regulation.

SIGN

_____ _____ _____

***Prescriber/Authorized Representative Signature** ***Printed Prescriber/Authorized Representative Name** (if applicable) ***Today's Date**

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7 | Insurance Information *(Please include both sides of all insurance cards with this Enrollment Form)*

☐ **Check here if uninsured**

Primary Insurance: _____ **Phone #:** _____

Policy #/Member ID: _____ **Group #:** _____

Policyholder Name (if not patient): _____ **Policyholder DOB:** _____

Patient has secondary insurance coverage: ☐ Yes ☐ No *(Please include both sides of all insurance cards with this Enrollment Form)*

8 | ZANVASTRO Prescription Information *(Optional)*

ZANVASTRO (zilganersen) injection, for intrathecal use, is supplied as carton containing one single-dose vial of ZANVASTRO and one single-dose vial of artificial cerebrospinal fluid (aCSF) diluent. ZANVASTRO is administered every 3 months by intrathecal injection.

Prescriber Instructions: Comply with state-specific requirements (eg, e-prescribing, state-specific prescription form, fax language). Either **1)** fill out the information below and provide signature, OR **2)** send an e-prescription to Specialty Pharmacy.

☐ †**Rx:** ZANVASTRO injection, for intrathecal use, 56 mg/2.8 mL (20 mg/mL), 1 carton, NDC: 71860-304-01 Refills ☐ 3 ☐ Other _____

By signing this form, I am indicating a prescribing decision has been made. In addition, I am certifying treatment with ZANVASTRO indicated above is medically necessary for this patient.

PRESCRIPTION FOR SPECIALTY PHARMACY

☐ **Dispense as Written** SIGN _____ _____

†Prescriber Signature (Prescriber attests this is his/her legal signature. NO STAMPS) †Today's Date

†All fields are required for valid prescription if you choose to complete this section.

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Direct your interested patient to read and complete the Patient Authorization and Consent form below to enroll in Ionis Every Step™. They can also enroll online at ZANVASTRO.com/Enroll. Bolded fields with asterisks (*) are required for a patient to access Ionis Every Step support.

***Patient First Name:** _____ ***Last Name:** _____ ***DOB:** _____

9 | Patient Authorization and Consent

Patient Authorization for the Use and Disclosure of Personal Information and Personal Health Information:
I authorize my healthcare provider(s) and staff, pharmacies, and health plans ("Providers") to share with and receive from Ionis Pharmaceuticals, Ionis Every Step™, and their personnel, service providers, and affiliates (altogether "Ionis") my personal information as described in this consent ("Consent"). My personal information includes contact, demographic, and financial information, as well as health insurance and benefit, and health information, such as prescription, medical condition and treatment information (commonly referred to as "Protected Health Information" or "PHI") (altogether "Information"). Uses of my Information include verifying treatment and payment decisions with my HCPs; investigating and assisting with coordination of coverage for Ionis medicines; coordinating prescription fulfillment and financial or affordability assistance, keeping Ionis and Providers informed about my prescription status, and participating in Ionis Every Step Patient Support Programs. I understand my Information may no longer be protected by state and federal law, but Ionis will only use my Information for these purposes and in accordance with applicable laws and the Ionis Privacy Policy (https://www.ionis.com/privacy-policy).

Ionis Every Step Patient Support Programs (the "Program") will receive and use my Information to determine if I qualify for the Program, to enroll me in the Program, to administer the Program, and to engage with me on Ionis' product(s) and topics of potential interest to me. Further, I understand Ionis may use my Information to inform my healthcare provider about my participation in the Program and to conduct occasional satisfaction surveys, data and marketing analytics, scientific research of non-identified data, and other internal business activities to better meet patient needs. For these purposes, Ionis may contact me by mail, email, fax, phone, voicemail, automated contact, and other mutually agreed upon means.

Voluntary Consent:
I understand that I do not have to sign this Consent to receive treatment with an Ionis product, payment for treatment, or insurance enrollment or benefits. However, if I do not sign, I understand I cannot receive Ionis Every Step Patient Support Programs. I understand that Providers may receive payment from Ionis for the Providers' services rendered in connection with this Consent. This Authorization expires ten (10) years from the date, unless a shorter period is required by law.

I understand that I have the right to cancel this Consent and obtain a copy of this authorization after I have signed it at any time by calling Ionis Every Step at 1-844-399-5544 or by submitting a written notice to: Ionis Every Step, 1620 Century Center Pkwy, Ste 110, Memphis, TN 38134-8822. After receiving my cancellation notice, the Providers and Ionis will discontinue sharing my Information with each other, but prior disclosures remain unaffected and my participation in Ionis Every Step Patient Support Programs will end.

Ionis Every Step Content SMS/Text Messaging Consent:
I expressly consent to receive text messages from or on behalf of Ionis Every Step Patient Support Programs at the mobile telephone number that I provide. I understand (1) message and data rates may apply, (2) I can opt out of text at any time by texting STOP to the number provided in any text message, and (3) I can get help for text messages by texting HELP. If Ionis Every Step updates its purposes or Privacy Policy, I also understand that additional text messaging terms and conditions may be provided to me in the future as part of an opt-in confirmation text message. The terms and conditions of Ionis Every Step communications are in this Consent and the Ionis Privacy Policy can be found at https://www.ionis.com/privacy-policy.

Ionis Marketing Communications Consent:
I authorize Ionis to contact me by mail, email, phone, fax, automated contact, and other mutually agreed upon means regarding other potential topics of interest to me, customer surveys, or occasionally for market research purposes. Ionis will not sell or trade my Information to any unrelated third party. I understand I am not required to provide this consent as a condition of receiving any Ionis product or Patient Support Program and I can opt-out later.

Please check all required (*) boxes to qualify for Patient Support Programs including, but not limited to, financial assistance programs that may apply to you.

☐ **I consent to the Patient Authorization for the Use and Disclosure of Personal Information and Personal Health Information written above.***
☐ I consent to receiving text messages. Please see Ionis Every Step Content SMS/Text Messaging Consent written above.
☐ I consent to receiving other resources related to my medicine or disease using my information provided on this form. Please see Ionis Marketing Communications Consent written above.

By signing below, I certify that I have read and agree to the use of the Information in this Consent and participation in Patient Support Programs.

SIGN

_____ _____ _____
***Patient/Authorized Representative Signature** ***Printed Patient/Authorized Representative Name** (If applicable) ***Today's Date**

If signed by an authorized representative, please indicate below the authority to act on behalf of the patient:

☐ Court Appointed ☐ Parent/Guardian ☐ Power of Attorney, including authority to make healthcare decisions

☐ Other _____

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