RELYVRIO™ Enrollment Form – Amylyx Care Team (ACT)™ Support Program

INSTRUCTIONS FOR HEALTHCARE PROFESSIONAL

To prescribe RELYVRIO and enroll your patient in the ACT Support Program, follow these 3 steps:

1. Have your patient carefully read the Patient Authorization & Consent on pages 2 and 3.
2. Have your patient fill out the Patient Information section on page 4 and sign Section I (Patient HIPAA Authorization for Use and Disclosure of Protected Health Information) and Section II (Patient Consent to Participate in ACT).
3. Complete the designated Healthcare Professional sections of the Enrollment Form, including the Prescription Information section (the form cannot be processed without healthcare professional's attestation and signature), and fax to 1-844-283-0375. Please complete all fields to minimize delays. For immediate inquires, please call 1-866-318-2989.

INSTRUCTIONS FOR PATIENT

To enroll in the ACT Support Program, follow these 3 steps:

1. Carefully read the Patient Authorization & Consent section on pages 2 and 3, and sign Section I (Patient HIPAA Authorization for Use and Disclosure of Protected Health Information) and Section II (Patient Consent to Participate in ACT) in the Patient Information section on page 4 of the Enrollment Form. This will enable you to enroll and participate in the ACT Support Program and receive support from ACT.
2. Complete the Patient Information section on page 4 with your information.
3. Optional: Check the box in Section III on page 4 to opt in to receive marketing communications, if you prefer to do so.

The ACT Support Program provides support to eligible patients with ALS who have been prescribed RELYVRIO (sodium phenylbutyrate and taurursodiol). Information contained in this form is used by ACT Support Program to facilitate access to RELYVRIO and as otherwise described in this form.

PHONE: 1-866-318-2989 **PROGRAM FAX: 1-844-283-0375** **EMAIL: amylyxcareteam@amylyx.com**

Patient Authorization & Consent

Please read the following Patient HIPAA Authorization for Use and Disclosure of Protected Health Information and Patient Consent to Participate in ACT and if you agree to their terms, please sign in the areas indicated on page 4 of the Enrollment Form. Your signed Enrollment Form will be submitted to ACT. Please retain the signed Enrollment Form including this Patient Authorization & Consent for your records.

I. Patient HIPAA Authorization for Use and Disclosure of Protected Health Information

By signing in the area indicated on page 4 of the Enrollment Form, I authorize my healthcare professionals, including my physicians and pharmacies ("My Providers"), and my health insurance plan ("My Plan") to use and share my identifiable medical information (such as information about my diagnosis and treatment) and my identifiable insurance information (collectively, "My Information") with Amylyx Pharmaceuticals, Inc., and its, affiliates, representatives, agents, and contractors ("Amylyx") so that Amylyx can have discussions with my doctor about completing this form and processing my prescription, provide me with information, assistance, and support through ACT ("Patient Support") as described below; administer and analyze the effectiveness of ACT; ask if I am interested in participating in market research; address adverse events and product quality complaints; carry out other business purposes related to RELYVRIO; and comply with law. I understand and agree that my pharmacies may receive payment from Amylyx in exchange for sharing My Information with Amylyx. Once My Information has been shared with Amylyx, federal privacy laws may no longer protect the information. However, Amylyx agrees to protect My Information by using and disclosing it only for purposes described in this authorization. I may refuse to sign this authorization and doing so will not affect my treatment, insurance coverage, or eligibility for benefits for which I am otherwise entitled. However, refusing to sign this authorization means that I cannot participate in ACT. I may cancel or revoke this authorization at any time by mailing a letter to ACT (43 Thorndike St, Cambridge, MA 02141) or by sending an email to amylyxcareteam@amylyx.com. If I revoke this authorization, My Providers and My Plan will stop using and sharing My Information (as described above), but my revocation will not affect uses and disclosures of My Information made in reliance upon this authorization prior to my revocation. This authorization expires ten (10) years from the date of my signature or earlier if required by state or local law, unless I revoke it before then. I will receive a copy of my signed authorization.

Please sign Section I on page 4 of this Enrollment Form to document your agreement to this HIPAA Authorization for Use and Disclosure of Protected Health Information.

II. Patient Consent to Participate in ACT

ACT is a program administered by Amylyx that provides Patient Support to eligible patients who have been prescribed RELYVRIO. Patient Support includes: (1) Providing reimbursement and financial support (such as investigating insurance coverage, confirming out-of-pocket costs, and reviewing eligibility for financial assistance); (2) Working with patients and their healthcare professionals to fill their prescriptions; and (3) Providing patients with disease and medication-related educational resources and communications. By signing in the area indicated on page 4 of the Enrollment Form, I confirm that I would like to enroll in ACT and that I want Amylyx to provide me with Patient Support. ACT is an optional program. I may withdraw from ACT at any time by mailing a letter to ACT (43 Thorndike St, Cambridge, MA 02141) or by sending an email to amylyxcareteam@amylyx.com. Amylyx may use My Information and share it with My Providers or My Plan in connection with providing Patient Support and for the other purposes described in the authorization above. For example, Amylyx may communicate with me (such as by mail, phone, email, or text message*) or my Authorized Representative, use My Information to tailor ACT-related communications to my needs, and share information with My Providers about dispensing RELYVRIO to me. Amylyx may de-identify My Information and use the de-identified information for Amylyx's business purposes. If my insurance information changes at any time while I am participating in ACT, I will notify ACT as soon as possible.

For California residents: By signing Section II on the Enrollment Form, I also acknowledge that I have reviewed and understand Amylyx's Privacy Notice, available at amylyxcareteam.com.

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

Please sign Section II on the Enrollment Form to document your agreement to this Patient Consent to Participate in ACT.

III. Opt In to Receive Marketing Communications (Optional)

By checking the box in the area indicated on page 4 of the Enrollment Form, I authorize Amylyx and companies working with Amylyx to contact me regarding other opportunities, such as for customer surveys. I understand that I am not required to provide this consent as a condition of receiving any Amylyx medicine or participating in ACT. I understand that I may opt out of these communications at any time via the link/contact information available in all communications.

Please check Section III on the Enrollment Form if you would like to opt in.

ACT Amylyx Care Team

relyvrio™ (sodium phenylbutyrate and taurursodiol) for oral suspension 3 g/1 g

RELYVRIO™ Enrollment Form – Amylyx Care Team (ACT)™ Support Program

Fax completed form to 1-844-283-0375

1. Patient Information (Patient Section)

First Name: | Last Name: | Social Security #: | Gender: M ☐ F ☐ | Date of Birth (MM/DD/YYYY): | Preferred Language: ☐ EN ☐ Other:

Address: | City: | State: | Zip Code: | Email Address:

Phone #: | Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening ☐ No Preference | **Permission to Leave Message:** ☐ Yes ☐ No | Caregiver and/or Authorized Representative Information: Name: | Phone #: | **Authorization to Call:** ☐ Yes ☐ No

Insurance Information: ☐ N/A

Please complete the information below and provide copies of the front and back of insurance and prescription benefit cards.

Primary Insurance: | Policyholder Name: | Primary Policy #: | Primary Group #: | Policyholder Date of Birth: ___/___/___

Secondary Insurance: | Policyholder Name: | Secondary Policy #: | Secondary Group #: | Policyholder Date of Birth: ___/___/___

Do you have a separate pharmacy benefit card? ☐ Yes ☐ No | Cardholder Name: | Pharmacy Benefit Name: | Policy or Identification #: | Rx BIN #: | Rx PCN #: | Group #:

Preferred Specialty Pharmacy (Selection will be honored if permitted by patient's insurance): ☐ Accredo Health Group Inc. ☐ Optum Frontier Therapies ☐ CVS Specialty

I. Patient HIPAA Authorization for Use and Disclosure of Protected Health Information

I have read, understand, and agree to the Patient HIPAA Authorization for Use and Disclosure of Protected Health Information on page 2.

Signature of Patient or Authorized Representative: | Date (MM/DD/YYYY): ___/___/___

II. Patient Consent to Participate in ACT

I have read, understand, and agree to the Patient Consent to Participate in ACT on page 3.

Signature of Patient or Authorized Representative: | Date (MM/DD/YYYY): ___/___/___

III. ☐ I opt in to receive marketing communications

Authority of Authorized Representative to Sign for Patient (if applicable):
☐ Healthcare Proxy ☐ Power of Attorney ☐ Other: _____

2. Healthcare Professional Information (Healthcare Professional Section)

First Name: | Last Name: | Specialty: | NPI #: | Practice Name: | Tax ID #:

Address: | City: | State: | Zip Code:

Office Contact Name: | Office Contact Email Address: | Office Phone #: | Office Fax #:

3. Statement of Medical Necessity (Healthcare Professional Section)

☐ **Primary diagnosis:** ICD-10 G12.21 (ALS)

☐ **ALS Diagnosis:** Date of Diagnosis: ___/___/___

Current or Most Recent Treatment:

☐ Edaravone: _____ Date (MM/DD/YYYY): ___/___/___ Duration: _____

☐ Riluzole: _____ Date (MM/DD/YYYY): ___/___/___ Duration: _____

☐ Other: _____ Date (MM/DD/YYYY): ___/___/___ Duration: _____

Allergies: _____

4. Prescription Information (Healthcare Professional Section)

Prescription for RELYVRIO (3 g sodium phenylbutyrate and 1 g taurursodiol):

Initial Rx: ☐ Dispense **5** 7-Count Carton of RELYVRIO (28-day supply) (NDC 7306303504) for initial use.

Instruction for Use: Take 1 packet per day for the first 3 weeks, followed by 1 packet in the morning and 1 packet at night thereafter (1 packet should be mixed with approximately 1 cup (8 oz) of room temperature water).

Maintenance Rx: ☐ Dispense **1** 56-Count Carton of RELYVRIO (28-day supply) (NDC 7306303503), with #_____ of refills (maximum 11 refills), for ongoing maintenance.

Instruction for Use: Take 1 packet in the morning and 1 packet at night (1 packet should be mixed with approximately 1 cup (8 oz) of room temperature water).

Administration: ☐ Oral ☐ Via feeding tube

Other Instructions: _____

☐ **Dispense as Written**

Signature: _____ Date (MM/DD/YYYY): ___/___/___

OR

☐ **Substitutions Permissible**

Signature: _____ Date (MM/DD/YYYY): ___/___/___

Interim Access Program (Optional, at no cost to patient; For commercially insured patients only*)

☐ Yes, I authorize Amylyx to provide up to **two** months of RELYVRIO to the above-named patient at no cost until the patient's prescription coverage is secured. I authorize Amylyx to forward this prescription to the Interim Access Program designated pharmacy to dispense RELYVRIO directly to the above-named patient. I understand that patient signatures for the Patient HIPAA Authorization for Use and Disclosure of Protected Health Information and Patient Consent to Participate in ACT are needed to expedite enrollment in the Interim Access Program.

Prescription for RELYVRIO (3 g sodium phenylbutyrate and 1 g taurursodiol):

Initial Rx: ☐ Dispense **5** 7-Count Carton of RELYVRIO (28-day supply) (NDC 7306303504) for initial use.

Maintenance Rx: ☐ Dispense **1** 56-Count Carton of RELYVRIO (28-day supply) (NDC 7306303503) for ongoing maintenance.

*Patients insured through Medicaid, Medicare, VA, DoD, TRICARE®, and other governmental insurance are NOT eligible for this program. Eligibility for the Interim Access Program is assessed on a case-by-case basis and depends on the patient experiencing a delay in insurance coverage.

Healthcare Professional Attestation

By signing below, I certify and acknowledge that (1) RELYVRIO is medically necessary and is in the best interests of the patient identified on this form; (2) The information in this form is accurate and complete to the best of my knowledge; (3) I am submitting this form to ACT to enroll my patient in ACT; (4) Services provided by or on behalf of Amylyx and/or ACT do not include the provision of treatment or medical advice or replace the treatment and medical advice provided by me; (5) My decision to prescribe RELYVRIO was, and in the future will be, based solely on my determination of medical necessity; (6) I have obtained the required authorizations and consents from my patient to release my patient's referenced medical and/or other patient information relating to my patient's treatment to Amylyx and ACT and have provided signed copies of these authorizations to my patient; (7) I will comply with 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 by the pharmacy); and (8) I authorize Amylyx and its agents or contractors to forward a prescription for RELYVRIO, by fax or by any means allowed under applicable law, to a pharmacy within the ACT network.

Print Name: _____

Healthcare Professional Signature: _____ Date (MM/DD//YYYY): ___/___/___