ADSTILADRIN®
(nadofaragene firadenovec-vncg)
suspension, for intravesical use / 3 x 10^{11} viral particles/mL

Ferring Access Support Enrollment Form

Access Coverage Support and Financial Assistance
For assistance call: 1-844-NADOnow (1-844-623-6669)
Monday-Friday 9 a.m. – 6 p.m. EST

Please complete form and fax to 1-833-322-5233

1. PATIENT INFORMATION (REQUIRED)

Patient Name (full):		
Gender: ◯ Male ◯ Female ◯ Other	**Date of Birth:** / /	
Street Address:		**Apt #:**
City:	**State:**	**Zip Code:**
Mobile Phone: - -	**Home Phone:** - -	
Preferred Phone: ◯ Mobile ◯ Home	Best Time to Call: ◯ AM ◯ PM	
Email:		
Alternate Caregiver/Contact:	Phone: - -	
Relationship:	Email:	

Text Message Allowed: ◯ Yes ◯ No

By checking "Yes", I am indicating that I allow text messages to disclose to myself or caregiver that I have an upcoming appointment to receive treatment in connection with a Ferring medicine. Text HELP for Help; STOP to opt out. Message & data rates may apply. Message frequency varies. For Mobile Terms & Conditions and for Privacy Policy, go to Privacy Policy.

2. INSURANCE INFORMATION (REQUIRED)

☐ **CHECK IF UNINSURED** (If checked, skip to Section 3)

Include a copy of the front and back of all medical insurance cards and prescription benefit insurance cards OR complete information below.

Insurance	Primary Medical	Secondary Medical (e.g.: MediGap coverage)	Prescription
Name & Type			
Phone Number			
Policy ID #			
Group #			
Policy Holder Name			
Policy Holder DOB	/ /	/ /	/ /
Relationship to Patient			
			PCN #:
			BIN #:

3. PATIENT ASSISTANCE PROGRAM (PAP)

(OPTIONAL: If patient wants to be screened for eligibility)

The Ferring Access Support Patient Assistance Program (PAP) provides ADSTILADRIN at no cost to eligible patients. PAP only covers the cost of the product that will be shipped to the site of administration and does not cover administration or other services. Participation in the PAP is free and Ferring does not collect any fees from people seeking assistance. To be considered for PAP, please complete the sections below.

My household makes $_____ annually before subtracting any taxes and deductions. (Include wages, Social Security, Social Security disability, unemployment, pensions, and any other income.) There are ____ people in my household. (Include all people in your household, including the patient.)

4. HEALTHCARE PROVIDER & TREATMENT INFORMATION (REQUIRED)

Name (full):		
Prescriber NPI #:	**State License #:**	
Practice Name:	**Tax ID #:**	
Street Address:		**Suite #:**
City:	**State:**	**Zip Code:**
Office Phone: - -	Best Time to Call: ◯ AM ◯ PM	
Office Fax: - -	**Communication Preferences** ◯ **Fax** ◯ **Phone Call** ◯ **Email** ◯ **Portal**	
Contact Name (full):	**How will you access ADSTILADRIN?** (check one) ◯ **Buy & Bill via medical benefit (order through specialty distributor)** or ◯ **Frontier Specialty Pharmacy (via pharmacy)**	
Contact Email:		

FERRING PHARMACEUTICALS Uro-Oncology

Patient Name (full): _____ Date of Birth: ____ / ____ / _____

HEALTHCARE PROVIDER & TREATMENT INFORMATION CONTINUED

Treatment Coding:	ICD	HCPCS
	◯ C67.0 Malignant neoplasm of trigone of bladder ◯ C67.1 Malignant neoplasm of dome of bladder ◯ C67.2 Malignant neoplasm of lateral wall of bladder ◯ C67.3 Malignant neoplasm of anterior wall of bladder ◯ C67.4 Malignant neoplasm of posterior wall of bladder ◯ C67.5 Malignant neoplasm of bladder neck ◯ C67.6 Malignant neoplasm of ureteric orifice ◯ C67.8 Malignant neoplasm of overlapping sites of bladder ◯ C67.9 Malignant neoplasm of bladder, unspecified ◯ D09.0 Carcinoma in situ of bladder ◯ Z85.51 Personal history of malignant neoplasm of bladder	J9029 **CPT** 51720

Anticipated treatment date of ADSTILADRIN®: / /

Treatment location: ◯ 11: Physician Office ◯ 19/22: Outpatient Treatment Center ◯ 24: Ambulatory Surgery Center

Product Shipment Information (if administered in a different location than provided above).

Facility Name:	Contact Name:	
Facility Phone: - -	Facility Fax: - -	
Street Address:		Suite #:
City:	State:	Zip Code:

5. PRESCRIPTION (REQUIRED)

Date: / /	ADSTILADRIN 75 mL at a concentration of 3 x 10^{11} viral particles (vp)/mL, instilled once every three (3) months	Directions for use: Administered by intravesical instillation by a Healthcare Provider	Special instructions:
Qty: 1 carton = 4 vials = 80 mL			
Refills:			
List or attach current medications:		List any medication allergies: ◯ No known drug allergies	

I verify that the patient and healthcare provider information on this enrollment form was completed by me or at my direction and I have discussed with my patient and informed patient of the Ferring Access Support ("Program") enrollment. The information contained herein is complete and accurate to the best of my knowledge. I understand that I must comply with my practicing state's specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements may result in the dispensing pharmacy reaching out to me.

By signing below, I certify that: (1) I am prescribing ADSTILADRIN (nadofaragene firadenovec-vncg) ("Product") for the patient identified in Section 1 above, this prescription is medically necessary for the patient and that it will be used as directed; I will be supervising the patient's treatment, and that the information I have provided above is complete and accurate to the best of my knowledge; (2) I have received the appropriate permission and consent from the patient to comply with applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and applicable state laws needed to release to Ferring and its designated agents and service providers the patient-related information on this form for the purposes of verifying the patient's insurance coverage for Product, confirming prior authorization requirements for the Product, if needed, providing information on appeals of denials of claims, assisting with financial assistance resources and information, such as co-pay support or free drug patient assistance programs for which the patient may be eligible, coordinating delivery of Product, contacting the patient with educational materials about the patient's prescription medication or to evaluate the effectiveness of the Program; regarding the Program and other support services including but not limited to communications about treatment and treatment reminders, and providing my patient with other education and support available through the Program associated with the Product; and (3) If applicable, I authorize the above prescription to be forwarded to the specialty pharmacy affiliated with patient's insurance plan or chosen by the named patient or by my office on the named patient's behalf.

If my patient is eligible for the Ferring Access Support Patient Assistance Program ("PAP") and enrolls in the PAP, I further agree to the following: (1) The assistance will be provided in the form of free product that will be shipped to my office prior to product administration; (2) If product is shipped to my office, I will receive and secure my patient's medication at my office until it is administered to my patient; (3) any medications supplied by Ferring as a result of enrollment in the PAP are for the use of the named patient only and will not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (such as Medicare, Medicaid, or other benefit provider) for reimbursement; (4) the Product will be provided only to the eligible patient at no charge of any kind; (5) Ferring may change or cancel the PAP at any time and Ferring reserves the right to terminate my patient's enrollment in the PAP at any time; (6) I will notify Ferring immediately if the Product is no longer medically necessary for this patient's treatment or if my patient's insurance or financial status changes.

SIGN HERE

_____ **Prescriber signature (Dispense as written/Do not substitute)**

_____ **Prescriber signature (Substitute allowed)**

_____ / _____ / _____ **Date**

6. PATIENT TERMS OF PARTICIPATION, FINANCIAL ELIGIBILITY AND PATIENT PRIVACY NOTICE

Authorization to Disclose Health Information

I, or my authorized representative, authorize my healthcare team and staff, my pharmacies, and my insurance provider, to use and disclose information related to my medical condition, prescription for **ADSTILADRIN® (nadofaragene firadenovec-vncg)** ("the Product"), financial information and insurance coverage to Ferring, its designated third-party service providers and authorized parties involved in administering the services listed below ("Patient Support Program"). I understand that this information may include details about my medical condition, treatment, and insurance coverage, as well as identifying information about me, including, for example, my name, address, and date of birth (the "Authorized Information"). I understand that my Authorized Information will be used for the following purposes:

- Determine my eligibility for financial assistance or help me access any applicable co-pay support, alternate funding, and free drug programs;
- Perform research and data analytics to develop and evaluate products, services, materials, and treatments, and improve the Patient Support Program;
- Provide me with disease management and other educational materials, as well as information about the Product, Ferring's services and programs, and surveys about my experience;
- Contact me for reasons related to the Patient Support Program, including but not limited to notifying me of important changes and updates, appointment reminders, to obtain further information or clarification regarding any adverse event that I may experience;

I understand that once my Authorized Information has been disclosed to Ferring, it may no longer be protected by federal privacy law and could be re-disclosed to others but that Ferring intends to use and disclose my Authorized Information received pursuant to this authorization only for the purposes described above, or as required by law.

I understand the pharmacy that is dispensing my Product may receive financial remuneration from Ferring for disclosing my Authorized Information to Ferring and for providing support services to me, including sending communications to me via mail or email, for purposes of my participation in the Patient Support Program detailed in this authorization. I understand that I can withdraw this authorization anytime by calling Ferring Access Support at 1-844-NADOnow or mailing a letter with my notice of revocation to PO Box 2355 Morristown, NJ 07962. I understand that if I do revoke the authorization, it will thereafter be invalid, but that uses and disclosures made in reliance on the authorization prior to its revocation will not be invalidated. I understand that I am not required to sign this form and, if I do not, I will not be able to participate in the Patient Support Program, but such refusal will not affect my eligibility to obtain medical treatment, or to be prescribed the Product, if applicable, or eligibility for insurance coverage, or other benefits. This authorization expires three (3) years after the date I sign it below, unless a shorter period is mandated by state law. I understand that I am entitled to receive a copy of this authorization.

My signature below certifies that I have read, understood, and agree to the release of my Authorized Information pursuant to the Authorization to Disclose Health Information above.

6. PATIENT TERMS OF PARTICIPATION, FINANCIAL ELIGIBILITY AND PATIENT PRIVACY NOTICE (CONTINUED)

PAP Notice

I understand that if I have opted to be screened by Ferring Access Support Patient Assistance Program ("PAP") and participate in the PAP, I acknowledge and authorize Ferring and/or its third-party service providers to record all communications with PAP representatives for the purposes set forth herein. I further understand and acknowledge that such recordings may contain Authorized Information.

I understand that if I have opted to be screened for PAP that I am consenting to having the PAP perform an electronic verification of my financial information to verify my eligibility and process my application. By signing this form, I consent to have my income electronically verified and that I understand I am providing "written instructions" under the Fair Credit Reporting Act ("FCRA") authorizing the PAP to obtain information from my credit profile, solely for the purpose of determining financial qualifications for the PAP. I understand that this authorization allows the PAP to perform this process as needed for the duration of my participation in the PAP.

If I qualify for and enroll in the PAP I acknowledge the program will provide Product at no cost to me in the form of free product sent to my healthcare provider prior to product administration. Participation in the PAP is free; Ferring does not collect any fees from people seeking Ferring assistance. Assistance is dependent on my ability to meet the eligibility criteria for the PAP. The PAP does not have any obligation to provide the program services to me and is not liable in the provision of these services. The PAP may be changed or discontinued without notice. I will not seek reimbursement for any assistance provided under the PAP. I will notify the PAP if my insurance or financial situation changes. If I am a member of a Medicare plan including a Medicare Prescription Drug plan and am qualified for the PAP assistance, I will: (1) be eligible to obtain the medication from the PAP for a calendar year term (2) not purchase this medication under my Medicare plan while enrolled in the PAP; (3) if applicable, not submit claims nor seek true out-of-pocket (TrOOP) credit for the medication provided during my enrollment; (4) allow the PAP to provide written notification to my Medicare plan, if applicable, that I am receiving Product at no cost outside of the Medicare Part D benefit.

Ferring Privacy Notice

Ferring will retain each category of Authorized Information for as long as necessary to fulfill the purposes outlined here and in its Privacy Notice, available at https://ferringusa.com/privacy, or as required by law to meet its legal obligations. Ferring does not knowingly "sell" the information collected through this form. However, it may share your information with trusted third parties in limited circumstances, as described in this document and in its Privacy Notice. If you wish to exercise your privacy rights—including accessing, correcting, deleting your information collected via this form, or limiting its sharing with third parties—you may do so at any time by calling 1-888-FERRING (1-888-337-7464) or by submitting a Data Subject Contact Form, available via the Privacy Notice at https://ferringusa.com/privacy/.

My signature below certifies that I have provided accurate and complete information and that I have read, understood, and agree to the terms above.

Patient Signature Required

Who is signing this consent:
☐ **Patient**
☐ **Authorized Patient Representative**
Signature of Patient/Authorized Patient representative:
Date: ____ / ____ / _____

SIGN HERE

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