VONJO connect

PRESCRIPTION AND ENROLLMENT FORM

- Call VONJO Connect™ at **1-888-284-3678** or visit **VonjoConnect.com**
- Healthcare providers please complete and sign the appropriate sections of this form, have the patient sign Section 3, and fax it to VONJO Connect at **1-888-284-8084** or email to **VonjoConnect@rxallcare.com**

1 PATIENT AND AUTHORIZED REPRESENTATIVE INFORMATION

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial:_____ Date of Birth: ___ /___ /____

Street: _____ Unit: _____ City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Mobile Phone: _____ Email: _____

Preferred Contact Method: ◯ Phone ◯ Email Best Time to Call: ◯ Morning ◯ Afternoon ◯ Evening Sex: ◯ Male ◯ Female

Preferred Language: ◯ English ◯ Spanish ◯ Other: _____ US Resident: ◯ Yes ◯ No

AUTHORIZED REPRESENTATIVE INFORMATION

Last Name: _____ First Name: _____ Relationship to Patient: _____

Phone: _____ Email: _____

2 INSURANCE INFORMATION Please provide copies of all medical and prescription insurance cards (front and back).

Does the patient have any form of insurance coverage? ◯ Yes ◯ No

Is there a PA on file? ◯ Yes ◯ No (Please include PA determination letter if available.)

Policyholder Full Name: _____ Policyholder Date of Birth: ____ /____ /____

Primary Medical Insurance: _____

Insurance Phone: _____ Group #: _____ ID #: _____

Prescription Insurance: _____ RxGroup: _____ RxBIN: _____ RxPCN: _____

Secondary Medical Insurance: _____

Insurance Phone: _____ Group #: _____ ID #: _____

Prescription Insurance: _____ RxGroup: _____ RxBIN: _____ RxPCN: _____

3 PATIENT AUTHORIZATION STATEMENT

My signature below certifies that I have read, understand, and agree to the Patient Authorization Statement below and continued on page 3.

SIGN HERE **Patient Signature:** _____ **Date:** ____ /____ /____

OR

SIGN HERE **Authorized Representative Signature:** _____ **Date:** ____ /____ /____

I am signing on behalf of the patient, and I affirm that I have the legal right to do so, through a valid power of attorney to act on behalf of the patient.

My signature on this form authorizes my doctor(s), healthcare providers, health plan or payer, and my pharmacy to disclose to Sobi Inc. ("Company") and its third party suppliers, vendors, and other service providers supporting VONJO Connect (collectively, the "Service Providers") information about me (for example, my name, address, insurance policy number, and income) and my medical condition (for example, my diagnosis or medications) (together, "Protected Health Information and/or Personally Identifiable Information"). This Personally Identifiable 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 Service Providers may be compensated by Sobi. The Service Providers will use and give out my information to (i) assist in my enrollment in VONJO Connect 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 material and other information materials related to the VONJO Connect offerings; (iii) verify, investigate, assist with, and coordinate my coverage for VONJO® (pacritinib) with my payer; (iv) coordinate prescription fulfillment; (v) assess my eligibility for patient assistance and/or benefits, if necessary and applicable; and (vi) assist with analyses of the efficiencies and performance of services provided by Service Providers. *(continued on page 3)*

VONJO connect

PRESCRIPTION AND ENROLLMENT FORM

Patient Last Name: _____ First Name: _____ Date of Birth: ____/____/____

4 PREFERRED DELIVERY METHOD

◯ Onco360 ◯ Biologics Specialty Pharmacy ◯ IOD/MID/Institution Name: _____

Phone: _____ Fax: _____

5 PRESCRIBER INFORMATION

Last Name: _____ First Name: _____ Office/Institution Name: _____

Street: _____ Suite: _____ City: _____ State: _____ ZIP Code: _____

NPI #: _____ Medicaid Provider ID #: _____ Tax ID #: _____

Office Contact Name: _____ Phone: _____

Fax: _____ Email: _____

Submitter Information (if different than above). Last Name: _____ First Name: _____

Facility or Office Name: _____

Phone: _____ Fax: _____ Email: _____

6 PRESCRIBER CERTIFICATION STATEMENT

I hereby attest that I am the prescribing healthcare provider and I agree to submit requests to VONJO Connect because I have determined that VONJO® (pacritinib) is medically appropriate for my patient, 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 Service Providers for the purpose of providing my patient with access and reimbursement assistance for VONJO, assisting in initiating or continuing therapy, and/or evaluation of the patient's eligibility for patient support offerings, if any. I authorize the Service Providers, as my designated agent and on behalf of my patient, to forward a prescription for VONJO, by fax or other means under applicable law, to an appropriate pharmacy that dispenses VONJO. I also certify that this prescription complies with all appliable state and local laws. I agree to notify the Service Providers if I become aware at any time in the future of changes in my patient's circumstance that would affect their eligibility, including, but not limited to, changes in health insurance status or coverage, financial status, or United States residency status. I understand that I am under no obligation to prescribe any Sobi products and that I have not received, nor will I receive any benefit from Sobi for doing so. Furthermore, I will not seek reimbursement from any third-party payer or government entity for any product that may be provided free of charge through a support program offered by VONJO Connect. I acknowledge I may be contacted by email, postal mail, or fax using the information I've provided, and I understand my personal information will be used and disclosed by VONJO Connect in accordance with Sobi's privacy policy, available at https://sobi-northamerica.com/privacy-policy.

My signature below certifies that I have read, understood, and agree to this Prescriber Certification Statement.

SIGN HERE **Prescriber Signature:** _____ **Date:** ____/____/____

Stamp signature not allowed. *This form cannot be processed without an original signature.*

7 CLINICAL INFORMATION Attach any applicable clinical notes.

Primary Diagnosis Code (ICD-10): _____ RECENT Patient Platelet Count Value (K/μL): _____ Date: _____

Does patient also have a diagnosis of Anemia? ◯ Yes ◯ No

Current therapies patient is taking (include dose): _____

Other: _____ Prior Treatment: _____

8 VONJO QUICKSTART PROGRAM

The VONJO QuickStart Program can provide a limited supply of VONJO, at no cost, to eligible new patients experiencing an insurance-related delay in coverage. Please evaluate my patient for the VONJO QuickStart Program.

◯ I confirm that my patient is new to VONJO and is experiencing an insurance-related delay in coverage.

9 PHARMACY PRESCRIPTION

The prescriber must comply with his/her state specific prescription requirements, such as e-prescribing, state specific prescription forms, fax language, etc. Noncompliance with state specific requirements may result in outreach to the prescriber.

◯ VONJO® (pacritinib) 100-mg capsules (NDC # 72482-100-12)

Directions: _____ Quantity: _____ ◯ Refill(s): _____

SIGN HERE **Prescriber Signature:** _____ **Date:** ____/____/____

Dispense as written

OR

SIGN HERE **Prescriber Signature:** _____ **Date:** ____/____/____

Substitution permitted

Stamp signature not allowed. *This form cannot be processed without an original signature.*

ICD-10=*International Classification of Diseases, Tenth Edition*; NDC=National Drug Code.

VONJO connect

PRESCRIPTION AND ENROLLMENT FORM

Patient Last Name: _____ First Name: _____ Date of Birth: _____/_____/_____

3 PATIENT AUTHORIZATION STATEMENT (continued)

I agree to enrollment in the VONJO Copay Assistance Program if I am eligible. 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 of my signature or until I am no longer receiving VONJO® (pacritinib) or enrolled in VONJO Connect, whichever is later, unless a shorter period is mandated by state law. I understand that I do not have to sign this Authorization, but if I do not, I may 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 VONJO Connect. My choice as to whether to sign this form will not change the way my doctors, healthcare providers, or payers treat me. If I no longer wish to participate in VONJO Connect, I shall inform my healthcare providers and/or the administrators of VONJO Connect 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 VONJO Connect at 50 Bearfoot Road, Northborough, MA 01532. Cancellation of this Authorization will be valid when received by the administrators of VONJO Connect. 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 request a copy of the information my healthcare providers or payers have given to the Service Providers.

If I am being evaluated for assistance under the VONJO Patient Assistance Program (PAP), I agree to allow Service Providers to use my demographic information, including, but not limited to, my 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 in reviewing eligibility under the PAP. Service Providers reserve the right to ask for additional documents and information at any time. If I am eligible to participate in the VONJO PAP I understand that: (i) continued enrollment in the PAP is not guaranteed, (ii) re-enrollment is not automatic, (iii) I cannot submit a claim or seek reimbursement or credit for product I receive under the VONJO PAP from my insurance provider or payer, and (iv) no payer, third party, or patient may be charged for PAP product provided under the PAP program. 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 residency.

I agree to allow Service Providers to contact me via email or cell phone using the contact information provided in this form, unless I otherwise inform VONJO Connect that I do not wish to receive text messages. I understand that receiving text messages is optional and I can participate in VONJO Connect without agreeing to receive text messages. I understand that by providing my cell phone number on this form I agree to receive text messages with the following conditions:

- Service Providers may send an autodialed pre-recorded text message (standard text message and data rates apply).
- I can opt out at any time by calling 1-888-284-3678 or replying "STOP" to the text messages.
- Service Providers are not responsible if a communication is not delivered due to technical difficulties like server issues, phone carrier outages, or discontinued service.
- I am aware that anyone who can open or have access to my phone might see the text messages.
- If my mobile operator is not participating in text messaging services, I will not receive text messages.
- I CANNOT report product complaints or adverse events (like side effects) by text message. To report these, please call VONJO Connect at 1-888-284-3678.

This Authorization Statement is governed by and interpreted in accordance with the laws of the state of Massachusetts, excluding Massachusetts conflict of law rules, and applicable federal law.