Instructions for Prescribers

To help a patient enroll in the Chiasma Access & Patient Support (CAPS) program, please follow these steps:

1. Have your patient read pages 2 and 3 of the Enrollment Form and sign and date at the bottom of both pages
2. Complete page 4 of the Enrollment Form and sign and date the Prescriber Authorization. Be sure to fill out all sections on this page
3. If available, copy both sides of the patient's insurance card and pharmacy benefit card
4. **Fax pages 2-4** of the Enrollment Form with copies of the cards mentioned above to **1-833-7GO-CAPS (1-833-746-2277)**

Your patient will be contacted by his or her CAPS Case Manager in 1 to 2 business days to initiate the enrollment process. Your office will also receive a confirmation that the form was received.

Tear off "Instructions for Patients" section below to give to your patient.

Instructions for Patients

1. Read pages 2 and 3 of the Enrollment Form and sign and date at the bottom of both pages
2. Make sure your doctor or staff has your insurance card and pharmacy benefit card
3. Your doctor will fill out the rest of the Enrollment Form and fax it back to us
4. You will receive a call from a CAPS Case Manager within 1 to 2 business days to continue the enrollment process. Be sure to answer this call—please be aware that it may come from an unfamiliar number

Please fax pages 2-4 of this form to 1-833-7GO-CAPS (1-833-746-2277). For questions, call 1-833-3GO-CAPS (1-833-346-2277).

CHIASMA®

Patient Information and Consent

Please read this page carefully and if you agree, sign and date where indicated on page 3. After you have done so, please make a copy for your records.

Chiasma Access & Patient Support

The Chiasma Access & Patient Support (CAPS) program is an optional service that provides comprehensive and personalized support for you throughout your journey with MYCAPSSA® (octreotide) delayed-release oral capsules. After signing on the next page, you'll be assigned a personal CAPS Case Manager who will help support you with:

1. Comprehensive assistance with understanding and navigating insurance for both you and your doctor
2. Specialty Pharmacy assistance to help make the process of ordering and receiving MYCAPSSA as easy as possible
3. Educational resources for patients and caregivers*
4. Appointment reminders, helpful tips for dosing and titration, and additional support along the way*

For more information or if you have questions, please call 1-833-3GO-CAPS (1-833-346-2277). CAPS Case Managers are available Monday-Friday, 8:30 am-7:00 pm ET.

*Contact your healthcare provider with any questions about your individual health.

Consent to Enroll in the Chiasma Access & Patient Support Program

I am enrolling in the Chiasma Access & Patient Support program ("Program") and authorize Chiasma and its third-party business partners, vendors, and agents ("Partners") to provide me with services under the Program, as described above and as may be added in the future. Such services include medication and adherence communications and support, medication dispensing coordination, reimbursement and financial assistance services, disease and medication education, and support services for family members and caregivers ("Services"). The MYCAPSSA copay program is available only to patients who reside in the United States or Puerto Rico, and who have commercial prescription insurance coverage or Federal Employees Health Benefits (FEHB) Program coverage for MYCAPSSA. The copay program is not available to patients who are covered by Medicare, Medicaid, TRICARE, or any other federal or state government plans, or who are uninsured.

I agree that, in connection with the Services, Chiasma and its Partners may use information about me and share this information with my healthcare providers, specialty pharmacies, insurers, and caregivers listed on page 4 of this form. I also authorize Chiasma and its Partners to contact me by mail, telephone, email, or text* with disease state information and information about Chiasma products, promotions, services, and research studies, and to ask my opinion about such information and topics, including through market research and disease-related surveys. I further authorize Chiasma and its Partners to de-identify my health information and use it for research, education, and commercial purposes. I understand that Chiasma and its Partners may share identifiable health information with one another in order to de-identify it for these purposes and as needed to perform the Services and to send the communications listed above.

I understand that I do not have to enroll in the Program and that I can still receive MYCAPSSA, as prescribed by my physician. I may opt out of individual Services offered by the Program or opt out of the Program entirely at any time by notifying a Program representative by telephone at 1-833-3GO-CAPS (1-833-346-2277) or by sending a letter to Chiasma Access & Patient Support, 140 Kendrick Street, Building C East, Needham, MA 02494.

*Chiasma and its Partners will only text with your permission; some fees may apply.

By signing below, I certify that I have read all information on page 2, I understand the Consent to Enroll in the Chiasma Access & Patient Support program on page 2, and I consent to my enrollment in the Program.

X

Signature of Patient or Patient Representative Date

Printed Name Relationship to Patient (if signed by a Patient Representative)

Please fax pages 2-4 of this form to 1-833-7GO-CAPS (1-833-746-2277). For questions, call 1-833-3GO-CAPS (1-833-346-2277).

CHIASMA®

Patient Information and Consent

Authorization to Use and Share Health Information as Part of the Chiasma Access & Patient Support Program

Please read this page carefully and if you agree, sign and date below. After you have done so, please make a copy for your records.

I am enrolling in the Chiasma Access & Patient Support (CAPS) program (the "Program") provided by Chiasma and its third-party business partners, vendors, and other agents ("Partners"). I authorize my healthcare providers and their staff, my health insurer, and the pharmacy that dispenses my Chiasma medication to use and disclose to Chiasma and its Partners health information about me, including information related to my medical condition and treatment, health insurance coverage and claims, prescription (including fill/refill information), and referral to and enrollment in the Program (my "Information") for the purposes of enrolling me in and providing services under the Program, and for the other purposes described in the Consent to Enroll in the Chiasma Access & Patient Support Program section on page 2.

Once my Information has been disclosed to a third party, I understand that federal privacy laws may no longer protect it. However, I understand that Chiasma and its Partners agree to use and disclose my Information only as allowed by me in the Consent to Enroll in the Chiasma Access & Patient Support Program section on page 2. I understand that the pharmacy that is dispensing my Chiasma medication may receive payment from Chiasma for the expense of putting together and sending data about its dispensing of MYCAPSSA to me. I understand that I do not have to sign this authorization. A decision by me not to sign this authorization will not affect my ability to obtain medical care, insurance coverage, access to health benefits, or Chiasma medicines. However, if I do not sign this authorization, I understand that I will not be able to participate in the Program.

I understand that this authorization shall remain in effect throughout my participation in the Program unless and until I take it back. I may change my mind and take back this authorization at any time by writing to Chiasma Access & Patient Support, 140 Kendrick Street, Building C East, Needham, MA 02494, or by calling 1-833-3GO-CAPS (1-833-346-2277). I understand that taking back this authorization will end my participation in the Program, and will not affect any use or disclosure of the Information made before my request is received and processed.

By signing below, I certify that I have read all information on page 3, I understand the Authorization to Use and Share Health Information, and I authorize the use and disclosure of my protected health information as outlined above.

X

Signature of Patient or Patient Representative | Date

Printed Name | Relationship to Patient (if signed by a Patient Representative)

Please fax pages 2-4 of this form to 1-833-7GO-CAPS (1-833-746-2277). For questions, call 1-833-3GO-CAPS (1-833-346-2277).

CHIASMA®

Mycapssa® (octreotide) capsules 20mg

Enrollment Form
Chiasma Access & Patient Support

CAPS® Chiasma Access & Patient Support

To Be Completed by Prescriber

1: Patient Information

First Name:	MI:	Last Name:
Gender: ☐ Male ☐ Female	Date of Birth:	Last 4 Digits of Social Security #:
Address:		
City:	State:	Zip:
Email:	Phone #:	
Caregiver Name:	Caregiver Phone #:	
Allergies:	Current Medications:	

2: Insurance Information (check the relevant box)

Attach a copy of both sides of the patient's insurance card.

❍ Medicare ❍ Medicaid ❍ Commercial/Private ❍ Other ❍ Uninsured

Primary Insurance Payer:	Insurance Name:
Phone #:	Policy ID #:
Group #:	BIN:
PCN:	Policy Holder's Name:
Policy Holder's Date of Birth:	Policy Holder's Relationship to Patient:

3: Prescriber Information

First Name:	MI:	Last Name:
Prescriber NPI #:	Prescriber Tax ID #:	
Facility Name:		
Facility Address:		
City:	State:	Zip:
Facility Phone #:	Preferred Fax #:	
Primary Contact Name:	Title/Role:	
Primary Contact Phone #:	Primary Contact Email:	

4: Treatment and Prescribing Information

☐ ICD-10/Diagnosis: E22.0 ☐ Other ICD-10/Diagnosis _____

Rx Treatment: MYCAPSSA® (octreotide) delayed-release oral capsules NDC: 69880-120-28
Dispense as written.
Please check a box below for medication strength

☐ **MYCAPSSA 40 mg Dosing Schedule**
Dispense: MYCAPSSA 20 mg capsules
Sig: Take 1 capsule PO BID
QTY: 56 **Number of Refills:** _____

☐ **MYCAPSSA 60 mg Dosing Schedule**
Dispense: MYCAPSSA 20 mg capsules
Sig: Take 2 capsules PO QAM and 1 capsule PO QPM
QTY: 84 **Number of Refills:** _____

☐ **MYCAPSSA 80 mg Dosing Schedule**
Dispense: MYCAPSSA 20 mg capsules
Sig: Take 2 capsules PO BID
QTY: 112 **Number of Refills:** _____

Prescriber Authorization

I authorize Chiasma, as my designated agent, to forward the prescription to a specialty pharmacy in order to dispense MYCAPSSA capsules to my patient. I understand that state law may require the pharmacy to contact me directly and that the information I provide on this form, if signed by my patient, will be used by Chiasma as herein authorized by my patient. If my patient is not enrolling in the Chiasma Access & Patient Support program, I certify that I have my patient's HIPAA authorization for the release of the patient's identification and insurance information to Chiasma for benefits verification and coordination of dispensing of MYCAPSSA. I understand that I am under no obligation to prescribe any Chiasma product and that I have not received nor will I receive any benefit from Chiasma for prescribing a Chiasma product. I attest that I am not on the HHS/OIG list of Excluded Individuals.

X

Licensed Prescriber Signature (required – no stamps)

Printed Name Date

Please fax pages 2-4 of this form to 1-833-7GO-CAPS (1-833-746-2277). For questions, call 1-833-3GO-CAPS (1-833-346-2277).

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