AMRYT Assist

MYCAPSSA® (octreotide) capsules
Patient Support Services

Enrollment Form

Phone: 1-833-346-2277 • Fax: 1-833-746-2277

Mycapssa® (octreotide) capsules 20mg

Instructions

To prescribe MYCAPSSA for your patient, please follow these steps:

1. ◯ Complete the Prescription form in its entirety. **Sections 1, 3, 4 as well as your Prescriber Authorization signature and date are mandatory.**
2. ◯ If available, please include a copy both sides of the patient's insurance card and/or pharmacy benefits card.
3. ◯ To streamline the process and if possible, please have your patient sign the Patient Consent so they can take advantage of MYCAPSSA's support program, Amryt Assist.
4. ◯ **Fax the Prescription Form and if available, the patient-signed Consent Form to 1-833-746-2277 with an up-to-date medication list.**

Your patient and your office will hear from Amryt Assist to confirm these forms have been received.

Fax completed and signed forms to 1-833-746-2277

For questions, call 1-833-346-2277.

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AMRYT PHARMA

Mycapssa®
(octreotide) capsules 20mg

Prescription

To Be Completed by Prescriber

Fax to 1-833-746-2277

1: Patient Information* (all fields this section are mandatory)

First Name:	MI:	Last Name:
Gender at Birth: ☐ Male ☐ Female	Last 4 of SS#:	Date of Birth:
Address:		
City:	State:	Zip:
Cell:	Alternate:	
Email:		
Caregiver Name:		☐ Ok to leave message
Email:	Phone #:	
Allergies:	Current Medications:	
Household Income (Annual) $	# of People in Household:	

❍ No known drug allergies (NKDA)

2: Insurance Information (check the relevant box and complete as much as possible)

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

☐ Medicare ☐ Medicaid ☐ Commercial/Private ☐ Other ☐ Uninsured

Primary Insurance Payer:	Plan 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* (all fields this section are mandatory)

The prescriber is to comply with his/her state 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.

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

4: Treatment and Prescribing Information (mandatory)

Rx Treatment: MYCAPSSA® (octreotide) delayed-release oral capsules NDC: 69880-120-28. Dispense as written.

Please check a box below for medication strength* (mandatory)

Patient, at any time, has been prescribed octreotide or lanreotide

☐ **yes** ☐ **no**

☐ **ICD-10/Diagnosis: E22.0 (acromegaly and pituitary gigantism)**

☐ Other ICD-10/Diagnosis: _____

☐ ICD-10/Diagnosis: F40.231 (needle phobia)

☐ **MYCAPSSA 40 mg**
Recommended Starting Dose

Dispense: MYCAPSSA 20 mg capsules

Sig: Take 1 capsule PO BID

❍ *QTY:* 56

❍ *QTY:* 168

Number of Refills:_____

☐ **MYCAPSSA 60 mg**

Dispense: MYCAPSSA 20 mg capsules

Sig: Take 2 capsules PO QAM and 1 capsule PO QPM

❍ *QTY:* 84

❍ *QTY:* 252

Number of Refills: _____

☐ **MYCAPSSA 80 mg**

Dispense: MYCAPSSA 20 mg capsules

Sig: Take 2 capsules PO BID

❍ *QTY:* 112

❍ *QTY:* 336

Number of Refills: _____

QuickStart Program (Optional, at no cost to patient)

☐ Yes, I authorize Amryt to provide up to 2 months of MYCAPSSA to my patient at no cost until the patient's prescription coverage is secured. I authorize Amryt to forward this prescription to the QuickStart Program designated pharmacy to dispense MYCAPSSA directly to the above-named patient.

☐ **40 MG: Dispense 20 mg capsules** QTY 28 3 refills
Sig: Take 1 capsule PO BID

☐ **60 MG: Dispense 20 mg capsules** QTY 42 3 refills
Sig: Take 2 capsules PO QAM and 1 capsule PO QPM

☐ **80 MG: Dispense 20 mg capsules** QTY 56 3 refills
Sig: Take 2 capsules PO BID

Prescriber Authorization* (mandatory)

I authorize Amryt Pharmaceuticals, Inc. and its agents as my designated agent and on behalf of my patient to (1) forward this statement of medical necessity to furnish any information on this form to and recruit necessary patient information from the insurer of above-named patient and (2) forward this prescription, by any means under applicable law, fax or other mode of delivery, to the pharmacy. I certify that the rationale for prescribing MYCAPSSA is for a primary diagnosis of acromegaly and I will be supervising the patient's treatment accordingly.

☐ I would like this prescription to serve as a free medication application if coverage cannot be secured.

X _____

Licensed Prescriber Signature (required – no stamps)

Printed Name Date

ATTENTION: E-prescribe or use the official state prescription form where required by state law. No stamped signatures or signing on behalf of the prescriber.

AMRYT Assist

MYCAPSSA® (octreotide) capsules
Patient Support Services

Patient Consent

Fax to 1-833-746-2277

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.

Patient Authorization

By signing this Authorization, I authorize my prescribers, pharmacists, including any specialty pharmacy that receives my prescription for my Amryt product and other healthcare providers (together "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my Protected Health Information, including but not limited to medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and or group numbers (together, "Protected Health Information") to Amryt, its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Amryt") including providers of alternate sources of funding for prescription drug costs, and other service providers supporting Amryt Assist (the "Program") for Healthcare Providers and patients for the purposes described below. Specifically, I authorize disclosure of my Protected Health Information in order to:

I. Enroll me in, and contact me by mail, email, phone and text* about the Program, including online support, financial assistance services, co-pay assistance, specialist services, and compliance and persistency services
II. Communicate with my Healthcare Providers and Insurers about benefits, coverage and medical care, including compliance with Product treatments
III. Provide me with educational materials, information and services related to my treatment experience with MYCAPSSA®(octreotide) and my condition
IV. Conduct surveys, data analytics, market research and other internal business activities related to the Program and MYCAPSSA
V. Contact me as otherwise required or permitted by law

I understand that pharmacies that ship my medication may be paid to share this information with the Program to help provide the offerings requested for me. Once my Protected Health Information has been disclosed to Amryt, I understand that federal privacy laws no longer protect the information. However, Amryt agrees to protect my Protected Health Information by using and disclosing it only for the purposes described in this Authorization or as permitted by law.

I understand that I may refuse to sign this Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me, but I will not have access to the Program and the services provided by Amryt under the Program. If I refuse to sign the Authorization, or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from the Program. This Authorization will last for a period of ten (10) years (unless earlier termination is required by applicable state law). I understand that I may cancel this Authorization at any time in the future, except to the extent that actions have been taken in reliance on the Authorization, by telephone at 1-833-346-2277 or by sending a letter to Amryt Pharmaceuticals, Attn: Amryt Assist, 160 Federal Street, 21st floor, Boston, MA 02110. I understand that revoking this Authorization will end further uses and disclosure of my Protected Health Information by the parties identified above except to the extent those uses and disclosures have been made in reliance upon this Authorization as permitted by applicable law. I am entitled to receive a copy of this Authorization.

This authorization will expire 10 years after the date that it is signed unless a shorter period is mandated by state law, or I revoke my authorization before then. I understand that I, as the patient or caregiver, have a right to receive a copy of this signed form over the time that it is valid.

I certify that I have read all information above, 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.

Please Sign Here

X _____

Signature of Patient or Patient Representative | Date

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

Fair Credit Reporting Act (FCRA) Authorization

☐ By checking this box, I am providing written instructions authorizing the Amryt and its vendor to obtain my consumer report from a consumer reporting agency to be used solely for the eligibility determination if applying for Patient Assistance Program.

X _____

Signature of Patient or Patient Representative | Date

Consent for Marketing Communications

☐ By checking this box, I authorize the use of my Information for Amryt marketing activities and consent to receive marketing and promotional communications from Amryt, including information about opportunities to participate in market research. I hereby give consent to Amryt, its affiliates and agents to send communications to me via the contact information I have provided to Amryt, including postal address, email address and telephone number (for purposes of voice calls and/or SMS text messages). I understand that this consent will be in effect until I cancel such consent.

X _____

Signature of Patient or Patient Representative | Date

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