Palforzia
Peanut (*Arachis hypogaea*) Allergen Powder-dnfp

PRESCRIPTION AND ENROLLMENT FORM

Palforzia Pathway™

Fax completed form to: **1-844-708-0011**. For any questions, please call **1-844-PALFORZ (1-844-725-3679)**.

*Required field

FOR PATIENTS

1. Patient Information

First name (please print)* | Middle initial | Last name* | Date of birth (mm/dd/yyyy)* | ☐ Male ☐ Female Gender*

Address* | City* | State* | ZIP code*

Name of parent/legal guardian | Relationship to patient

Parent/legal guardian primary phone number* ☐ Mobile ☐ Home | Secondary name and phone number ☐ Mobile ☐ Home

Parent/legal guardian email

OK to leave detailed voicemail?* ☐ Yes ☐ No | OK to leave detailed text message (message and data rates may apply)?* ☐ Yes ☐ No

FOR PRESCRIBER

2. Diagnosis and Clinical Information*

☐ Z91.010 Allergy to peanuts
☐ T78.01XA Anaphylactic reaction due to peanuts, initial encounter
☐ T78.01XD Anaphylactic reaction due to peanuts, subsequent encounter
☐ T78.01XS Anaphylactic reaction due to peanuts, sequela
☐ Other: _____

3. Initial Dose Escalation Appointment: To be filled in by prescriber in partnership with patient*

Anticipated date of Initial Dose Escalation appointment (mm/dd/yyyy)

Select patient's preferred specialty pharmacy below, if known.

☐ Walgreens Specialty Pharmacy (Central)
☐ Walgreens Specialty Pharmacy (Community): _____
☐ IDN: _____

4. Prescription Information: PALFORZIA*

Directions: Open capsule(s) or sachet associated with the current dose level and empty the entire dose of PALFORZIA powder onto a few spoonfuls of refrigerated or room temperature semisolid food, at approximately the same time each day as instructed by your healthcare provider. Mix well. Do not swallow capsules. Consume the entire volume of the prepared mixture promptly by mouth.

Note: Titrated Up-Dosing prescription for entire course of therapy shall include all the following formulations (each prescription is for 1 pack; please indicate for each prescription how many packs are allowed):

Initial Dose Escalation: Initial Dose Escalation is administered on a single day under the supervision of a healthcare professional. Please select the Initial Dose Escalation Card appropriate for the patient's age.

Toddler (1 through 3 years old) Initial Dose Escalation Card cannot be dispensed to a patient beyond the age indicated.

☐ PALFORZIA - Initial Dose Escalation Card (4 - 17 years old) Qty: ____ Refill: ____
☐ PALFORZIA - Initial Dose Escalation Card (1 - 3 years old) Qty: ____ Refill: ____

Up-Dosing:

PALFORZIA - 1 mg (Level 0) is limited to ONLY the Toddler (1 through 3 years old)

☐ PALFORZIA - 1 mg (Level 0) Quantity: _____ Refill: _____
☐ PALFORZIA - 3 mg (Level 1) Quantity: _____ Refill: _____
☐ PALFORZIA - 6 mg (Level 2) Quantity: _____ Refill: _____
☐ PALFORZIA - 12 mg (Level 3) Quantity: _____ Refill: _____
☐ PALFORZIA - 20 mg (Level 4) Quantity: _____ Refill: _____
☐ PALFORZIA - 40 mg (Level 5) Quantity: _____ Refill: _____

Up-Dosing (cont'd):

☐ PALFORZIA - 80 mg (Level 6) Quantity: _____ Refill: _____
☐ PALFORZIA - 120 mg (Level 7) Quantity: _____ Refill: _____
☐ PALFORZIA - 160 mg (Level 8) Quantity: _____ Refill: _____
☐ PALFORZIA - 200 mg (Level 9) Quantity: _____ Refill: _____
☐ PALFORZIA - 240 mg (Level 10) Quantity: _____ Refill: _____
☐ PALFORZIA - 300 mg (Level 11), 15-count sachets Quantity: _____ Refill: _____

Maintenance (monthly supply):

Dispense of 90 day count is subjective to insurance approval.

☐ PALFORZIA - 300 mg (30 Day), 30-count sachets Quantity: _____ 1 Carton Refill: _____
☐ PALFORZIA - 300 mg (90 Day), 30-count sachets Quantity: _____ 3 Cartons Refill: _____

Number of Prescriptions Written: _____

5. Prescriber Information*

First name | Middle initial | Last name | Specialty

Practice name | Practice phone # | Office fax #

Primary contact name | Primary contact phone #

Practice address (location where patient will receive care) | City | State | ZIP code

Prescriber NPI # | Group NPI # | Prescriber tax ID #

6. Complete Statement of Medical Necessity, Certification and Consent*

By signing below, I certify that (1) I am the physician, or a designated agent of the healthcare provider/practice who has prescribed PALFORZIA and based on my independent clinical judgment, the Stallergenes Greer therapy I prescribed is medically necessary and is in the best interest of the patient listed above; (2) I have any consent or authorization required under federal law or state law for the release of the patient's information on this form to Stallergenes Greer and its affiliates, agents, and contractors and business partners (collectively, "Stallergenes Greer") for benefits verification, to assess the patient's eligibility for participation in PALFORZIA Pathway programs, and coordination of dispensing PALFORZIA; (3) I will comply with state-specific prescription requirements and understand non-compliance with these requirements could result in further outreach by the patient's specialty pharmacy; (4) I understand that information I provide on this form, if signed by the patient, will be used by Stallergenes Greer as authorized by the patient. I authorize Stallergenes Greer to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. This authorization includes permitting Stallergenes Greer to communicate to payers on my behalf to confirm this patient's health plan eligibility and benefits; (5) I understand I am under no obligation to prescribe any Stallergenes Greer products or to participate in the PALFORZIA Pathway program and I have not received and will not receive any benefit from Stallergenes Greer for prescribing a Stallergenes product; (6) No free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale; (7) The information provided on this form is accurate to the best of my knowledge.

Prescriber signature (no stamps) **Dispense as written** | Date (mm/dd/yyyy)

Prescriber first and last name (please print) | Prescriber NPI #

Prescriber signature (no stamps) **Substitutions permitted** | Date (mm/dd/yyyy)

Attending physician (if applicable)

FOR PATIENTS

7. Patient Insurance Information

Please include front and back copies of all insurance cards and complete this section.

Pharmacy Benefit Insurance Name	Primary Insurance Name	Secondary Insurance Name
Insurance carrier	Insurance carrier	Insurance carrier
ID #	ID #	ID #
Group # / BIN/PCN #	Group #	Group #
Insurance phone #	Insurance phone #	Insurance phone #
Policyholder name (if not the patient)	Policyholder name (if not the patient)	Policyholder name (if not the patient)
Employer name (if applicable)	Relationship to patient	Relationship to patient

☐ Patient is enrolled in a qualified health plan (QHP) or a government-funded healthcare program such as Medicare, Medicaid, VA, DoD, or TRICARE.

☐ Patient has commercial insurance and understands may be eligible for the PALFORZIA Pathway Co-Pay Savings Program, information available at PalforziaCoPay.com.

☐ Patient does not have insurance. By selecting this option, the PALFORZIA Pathway™ Patient Hub will review the Patient Assistance Program ("PAP") eligibility and criteria with patient. Additional form and consent required to be completed by patient and Health Care Professional to check eligibility.

8. Patient Authorization and Consent

By completing and submitting this form, I acknowledge that I may receive calls / text messages from or on behalf of Stallergenes Greer at the telephone number(s) that I provide. I understand these communications may be sent using an autodialer or artificial/prerecorded voice at the telephone number(s) that I provide. Message and data rates may apply. Recurring messages; frequency may vary.

Marketing Opt-in (optional)

☐ Check here to receive helpful marketing tools and resources from Stallergenes Greer to support me on my treatment journey with PALFORZIA. By checking this box, I consent to receive marketing information, offers, and educational materials related to peanut allergy and/or Stallergenes Greer and its therapies, including Stallergenes Greer's customer relationship marketing program. I understand that my consent is not required or a condition of purchasing Stallergenes Greer therapies or receiving support from Stallergenes Greer through the PALFORZIA Pathway Support Program. I understand that Stallergenes Greer and companies acting on its behalf will only use my personal data described in (https://www.stagrallergy.com/privacy-policy/). I also understand I may opt out of receiving information from Stallergenes Greer within future communications.

Name of parent/legal guardian

Signature of parent/legal guardian _____ Date (mm/dd/yyyy)

PALFORZIA Pathway Patient Authorization

I hereby authorize my healthcare prescribers, health plans, payors, pharmacies, and their respective contractors and agents ("my healthcare organizations") to disclose my health information, including medical, laboratory, and other information related to my diagnosis of or eligibility for therapy and treatment of my medical condition ("my information") with Stallergenes Greer, and its affiliates, agents, and contractors, (collectively, "Stallergenes Greer") as described below. I understand that certain parties such as, my pharmacy providers and/or their contractors may receive financial remuneration from Stallergenes Greer for disclosing my information to Stallergenes Greer, and for providing support services to me, including sending me communications, pursuant to this authorization.

I authorize my healthcare organizations to disclose my health information with Stallergenes Greer in order for Stallergenes Greer to enroll me in PALFORZIA Pathway, provide me with patient services and administer the PALFORZIA Pathway program. I authorize Stallergenes Greer to: (1) contact me or my healthcare organizations, or others I have identified, for the activities described in this authorization; (2) confirm my health plan eligibility and benefits, and determine whether I may be eligible for financial assistance programs; (3) provide me with patient services, including reimbursement support; and (4) use and disclose my information for safety reasons or as required by law. I understand this authorization is voluntary and that if I do

FOR PATIENTS

8. Patient Authorization and Consent (continued)

PALFORZIA Pathway Patient Authorization (continued)

not sign this form, my treatment, payment for my treatment by my healthcare prescribers and pharmacy, and my eligibility for benefits will not be affected, but I will not have access to the support described above.

I understand that once my health information has been disclosed to Stallergenes Greer, federal or state privacy laws may no longer protect it and it may be further redisclosed. I may cancel this authorization at any time by notifying Stallergenes Greer at 1-844-PALFORZ (1-844-725-3679). My cancellation will not be effective until after Stallergenes Greer receives it and my healthcare organizations are notified of it by Stallergenes Greer, and it will not apply to any of my information disclosed in reliance on this authorization prior to my cancellation. I am entitled to a copy of this signed authorization, which expires at the earlier of five (5) years or other time period required under the state in which I reside, from the date it is signed by me. For CA Residents under CA Law, if any entity seeks and authorization from an individual for a use or disclosure of protected health information, the entity shall provide the individual with a copy of the signed authorization. To obtain a digital copy or additional copies of signed authorization, I have the right to contact Stallergenes Greer at 1-844-PALFORZ (1-844-725-3679).

_____

Name of parent/legal guardian*

_____ _____

Signature of parent/legal guardian* Date (mm/dd/yyyy)*

_____

Authorized legal guardian relationship to patient*