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* | Last 4 digits of SSN of the primary insurance subscriber (for insurance verification)*

Name of parent/legal guardian | Relationship to patient

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

Parent/legal guardian email

OK to leave detailed voicemail that includes treatment information?* ☐ Yes ☐ No

OK to leave detailed text message that includes treatment information?* ☐ Yes ☐ No

FOR PRESCRIBER

2. Diagnosis and Clinical Information

☐ ICD 10 Code Z91.010 (Allergy to peanuts) ☐ 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.

☐ AllianceRx-Walgreens Specialty Pharmacy ☐ Optum Specialty Pharmacy
☐ CVS Specialty Pharmacy ☐ Unknown

4. Prescription Information

Prescription for PALFORZIA

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. Do not swallow capsules.

☐ PALFORZIA - Initial Dose Escalation Card Quantity: _____ Refill: _____

Up-Dosing
Open capsule(s) or sachet and empty 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. Do not swallow capsules.

☐ 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: _____

Number of Prescriptions Written: _____

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)
Open sachet and empty 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.

☐ PALFORZIA - 300 mg, 30-count sachets Quantity: _____ 1 Carton Refill: _____

5. Prescriber Information

First name* | Middle initial | Last name* | Specialty

Practice name | Practice phone # | Office fax #

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 and Consent

By signing below, I certify that (1) Based on my independent clinical judgment, the Aimmune Therapeutics (Aimmune) therapy I prescribed is medically necessary and is in the best interest of the patient listed above; (2) I have any consent required under federal law or state law for the release of the patient's information on this form to Aimmune and its affiliates, agents, and contractors and business partners (collectively, "Aimmune") for benefits verification 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 Aimmune as authorized by the patient. (5) I authorize Aimmune 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 Aimmune to communicate to payers on my behalf to confirm this patient's health plan eligibility and benefits.

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 does not have insurance. If you would like us to check eligibility for PALFORZIA™ Patient Assistance Program ("PAP"), please complete PALFORZIA Pathway Patient Authorization in section 8.

8. Patient Authorization and Consent

Patient Consent – Telecommunications and Marketing Opt-in (optional)

By completing and submitting this form, I acknowledge that I may receive nonmarketing calls / text messages from or on behalf of Aimmune 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.

☐ Check here to receive helpful marketing tools and resources from Aimmune 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 Aimmune and its therapies, including Aimmune's customer relationship marketing program. I understand that my consent is not required or a condition of purchasing Aimmune therapies or receiving support from Aimmune through the PALFORZIA Pathway Support Program.

Name of parent/legal guardian

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

Patient Consent – PALFORZIA Pathway Co-pay Savings Program and Patient Assistance Program (optional)

Please note that if a patient may need financial assistance through the PALFORZIA Pathway Patient Assistance Program, a signature is also required in the PALFORZIA Pathway Patient Authorization section below.

☐ I understand that I may be eligible for assistance through the PALFORZIA Pathway Co-pay Savings Program or the Patient Assistance Program ("PAP"), and I grant permission for the PALFORZIA Pathway Support Program to determine my eligibility for these programs.

☐ I understand that if my insurance does not cover my Aimmune therapy, I may be eligible to participate in the PALFORZIA Pathway PAP. I grant permission to the PALFORZIA Pathway Support Program to check my eligibility. I certify that my household income is $_____ / year and there are _____ individuals in our household. I recognize that as part of determining my eligibility for PAP, my household income may be subject to verification.

☐ I understand that I am providing "written instructions" authorizing Aimmune and its vendor under the Fair Credit Reporting Act ("FCRA") to obtain information from my credit profile or other information from a consumer agency for the purpose of determining financial qualifications for patient support programs administered by Aimmune that I am applying to now or in the future.

Name of parent/legal guardian

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

PALFORZIA Pathway Patient Authorization (optional)

I hereby authorize my healthcare prescribers, health plans, payors, pharmacies, and their respective contractors and agents ("my healthcare organizations") to share my personal and health information ("my information") related to my Aimmune therapy with Aimmune Therapeutics, Inc, and its affiliates, agents, and contractors, (collectively, "Aimmune") as described below. I understand that my pharmacy, prescribers and/or their contractors may receive financial remuneration from Aimmune for disclosing my information to Aimmune, and for providing support services to me, including sending me communications, pursuant to this authorization.

FOR PATIENTS

8. Patient Authorization and Consent (continued)

PALFORZIA Pathway™ Patient Authorization (continued)

I authorize my healthcare organizations to share my information with Aimmune in order for Aimmune to: (1) contact me or my healthcare organizations, or others I have identified, about my disease or treatment; (2) confirm my health plan eligibility and benefits, and determine whether I may be eligible for financial assistance programs; (3) provide me with reimbursement support; (4) engage with me for internal business purposes, including quality control, support-enhancing surveys and market research; (5) send me marketing information, offers, and educational materials related to peanut allergy and/or Aimmune therapies, including the PALFORZIA Pathway Support Program; and (6) use and disclose my information for safety reasons or as required by law. I understand that if I do not sign this form, I will still be eligible for health plan benefits, and my treatment and payment for my treatment by my healthcare prescribers and pharmacy will not be affected, but I will not have access to the Aimmune support described above.

I understand that once my health information has been disclosed to Aimmune, federal privacy laws may no longer protect it and it may be further redisclosed. I may cancel this authorization at any time by notifying Aimmune at 1-844-PALFORZ (1-844-725-3679). My cancellation will not be effective until after Aimmune receives it and my healthcare organizations are notified of it by Aimmune, 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 ten (10) years or other time period required under the state in which I reside, from the date it is signed by me.

_____

Name of parent/legal guardian*

_____ _____

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

_____

Authorized legal guardian relationship to patient*