SAJAZIR™ (icatibant) Injection Enrollment Form

Phone: +1 (888) 360-8482 (VITA) FAX: +1 (888) 385-8482 (VITA) Website: www.cyclevita.life

1. PATIENT INFORMATION

Patient Name (First, Last):	Date of Birth:		Gender:
Street Address:	City:	State:	ZIP:
Email Address:	Cell Phone:	Home Phone:	Preferred Language:
Caregiver Name (if applicable):	Relation to patient:	Caregiver Phone (if different from patient):	

2. INSURANCE INFORMATION *(attach front and back copies of all insurance cards)*

☐ **Patient does NOT have insurance**

Primary Insurance Company Name:	Primary Insurance Cardholder Name:	Relation to Patient:
Primary Insurance Policy Number:	Primary Insurance Group Number:	Primary Insurance Phone Number:
Pharmacy Plan Name:	PCN Number:	BIN Number:
Pharmacy Plan Policy Number:	Pharmacy Plan Group Number:	Pharmacy Phone Number:
Secondary Insurance Plan Name:	Secondary Insurance Cardholder Name:	Relation to Patient:
Secondary Insurance Policy Number:	Secondary Insurance Group Number:	Secondary Insurance Phone Number:

3. PRESCRIBER INFORMATION

Prescriber Name (First, Last):	Facility/Clinic Name:		
State Medical License Number:	NPI Number:		
Facility/Clinic Street Address:	City:	State:	ZIP:
Prescriber Email:	Prescriber Phone Number:	Prescriber FAX:	
Office Contact Name (First, Last):	Office Contact Email:	Office Contact Phone Number:	

4. PRESCRIPTION (SAJAZIR™ (Icatibant) Injection)

☐ **Preferred Specialty Pharmacy:** ______________________________

Diagnosis: ☐ ICD-10 D84.1 (HAE)
☐ Other: ______________________________

Dispense: ☐ One (1) syringes (NDC: 70709-013-01 / 70709001301)
☐ Three (3) syringes (NDC: 70709-013-03 / 70709001303)

Refill:

Directions:
- Administer (1) 30 mg injected subcutaneously in the abdominal area
- If response is inadequate or symptoms recur, additional injections of 30 mg may be administered at intervals of at least 6 hours
- Do not administer more than 3 injections in 24 hours
- Patients may self-administer upon recognition of an HAE attack

Allergies:
☐ NKDA ☐ Known: ______________________________

Medications:
☐ None ☐ Known: ______________________________

Special Instructions:

Prescriber Declaration: I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Cycle Vita – SAJAZIR™ (icatibant) Injection based on my professional judgment of medical necessity. I authorize CYCLE Pharmaceuticals or its affiliated companies or subcontractors, including in-network specialty pharmacies, through the Cycle Vita – SAJAZIR™ (icatibant) Injection Hub ("the Program") to forward this prescription electronically, by facsimile, or by mail to the relevant in-network pharmacy for the above-named patient. I also authorize the Program to perform any steps necessary to obtain reimbursement for Cycle Vita – SAJAZIR™ (icatibant) Injection, including but not limited to insurance verification and case assessment. I understand that the Program may need additional information, and I agree to provide it as needed for the purposes of reimbursement. I also authorize the Program to perform any steps necessary to obtain reimbursement for Cycle Vita – SAJAZIR™ (icatibant) Injection, including but not limited to insurance verification, case assessment and necessary steps to facilitate coverage decision. Prescriber's signature (sign below) (Physician attests this is his/her legal signature. NO STAMPS.)

Prescriber Signature: X______________________________ ☐ Dispense As Written (DAW) Date: ______________

Patient Name (Printed):	**Date of Birth:**

Patient Authorization for Use and Disclosure of Personal Health Information (PHI)

I understand that I must complete this enrollment form before I can receive assistance through the CYCLE Pharmaceuticals, Ltd., Cycle Vita – SAJAZIR™ (icatibant) Injection Hub. As part of this process, CYCLE and its agents and contractors (collectively, "CYCLE") will need to obtain, review, use and disclose PHI as described below.

To ensure I have access to the Cycle Vita – SAJAZIR™ (icatibant) Injection Hub benefits for which I may qualify AND to ensure my Personal Health Information (PHI) is appropriately protected in compliance with applicable federal laws and regulations:

- I further authorize my healthcare providers (HCPs) and health plans to disclose my PHI as described below to an authorized CYCLE Health Care Professional (HCP) in connection with Cycle Vita – SAJAZIR™ (icatibant) Injection Hub, and I authorize CYCLE to use and disclose the information for the purposes stated in this authorization.
  1. Information to Be Disclosed: Personal health information (PHI), including information about me (for example, name, mailing address, financial information, and insurance), my past, current and future medical condition and information provided on this form to include information concerning Adverse Events (AE).
  2. Persons Authorized to Disclose My Information: My HCPs, including any pharmacy that fills my prescription medication, and any health plans or programs that provide me healthcare benefits.
  3. Persons to Whom My Information May Be Disclosed: A qualified HCP, a nurse, individuals representing CYCLE, including third-party administrator responsible for the administration of the Cycle Vita – SAJAZIR™ (icatibant) Injection, appropriate third parties under contract to CYCLE, such as the CYCLE Pharmacovigilance Agency and product manufacturer(s) to properly address any Adverse Event (AE). I understand my PHI will only be shared in accordance with my consent as described within this form.
  4. Purposes for Which the Disclosures Are to Be Made: Disclosures of PHI may be made to CYCLE so that CYCLE may use and disclose the PHI for purposes of completing the enrollment process, verifying my enrollment form and establishing my eligibility for Cycle Vita – SAJAZIR™ (icatibant) Injection Hub and benefits that may include:
     a. Insurance and Reimbursement Assistance: Authorization allows for professional assistance at no charge on Patient's behalf for Claims Settlement, Claims Submission – to health insurers (for payment); communication of relevant claim information to/from HCPs and Insurance carriers.

Confidentiality Statement: This facsimile is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately and call +1 (888) 360-8482 to obtain instructions as to the proper destruction of the transmitted material.

©2022 Cycle Pharmaceuticals
All rights reserved. US-SJR-2200003 / February 2022

b. Reimbursement Support: Financial Assistance, including CYCLE's sponsored Co-Pay Assistance, is available only for eligible patients. Co-Pay assistance allows CYCLE Pharmaceuticals LTD. to pay associated Co-Payments due to Insurance providers on behalf of the Patient.

c. Patient Benefits Investigation & Payer Prior-Authorization Support: Cycle Vita – SAJAZIR™ (icatibant) Injection Hub will contact, investigate, and arrange for Patient's eligible coverage with their respective Health Insurer and/or PBM (Pharmacy Benefit Manager), as well as support and appropriately assist with Prior-Authorizations.

d. Patient Education and Information: CYCLE and the Cycle Vita – SAJAZIR™ (icatibant) Injection Hub will provide Patients with full education on SAJAZIR™ (icatibant) Injection administration, relevant disease area information and product information updates; in addition to pertinent updates and information on events for patients. This includes advocacy communication from national and international patient advocacy groups.

e. Access to Manufacturer / CYCLE: This will allow CYCLE to alert Patients receiving Cycle Vita – SAJAZIR™ (icatibant) Injection Hub about relevant product and market updates, product recalls, Adverse Event notifications, and available resources, including adherence tools and other programs to benefit patients with Hereditary Angioedema (HAE).

5. Limits of Protections after Disclosure. I understand that once my PHI has been disclosed hereunder, federal privacy law may no longer restrict its use or disclosure.
6. Option to Refuse. I understand I am not required to sign this Authorization as a condition to receive treatment with CYCLE's products, or payment for health care; enrolling in a health plan; or establishing eligibility for benefits. However, by refusing to authorize disclosure of my PHI to a qualified and authorized CYCLE HCP, I also understand that I am knowingly foregoing possible access to the Cycle Vita – SAJAZIR™ (icatibant) Injection Hub benefits.
7. Copy of Authorization and Ability to Cancel Authorization. I understand I will be given a copy of this Authorization after I sign it; and my Authorization shall remain in effect until it expires (i.e. 5 years from the date sign below unless a shorter period is required by the law of my state residence), or unless I revoke Authorization at any time by contacting Cycle Vita – SAJAZIR™ (icatibant) Injection Hub (toll-free), at +1 (888) 360-8482 (VITA) Monday through Friday, from 8:00am to 8:00pm EST, by FAX, at +1 (888) 385-8482 (VITA) or in writing to CYCLE Pharmaceuticals Ltd., PO Box 130059, Boston, MA 02113.
8. I understand that my pharmacy, health insurers and third-party vendors may receive payment from CYCLE as the manufacturer in exchange for securely sharing my PHI to an authorized CYCLE's HCP for the sole purpose of providing me access to important patient support as described above.

Confidentiality Statement: This facsimile is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately and call +1 (888) 360-8482 to obtain instructions as to the proper destruction of the transmitted material.

©2022 Cycle Pharmaceuticals
All rights reserved. US-SJR-2200003 / February 2022

Patient Name (Printed):	**Date of Birth:**

WRITTEN AUTHORIZATION *(to be completed by Patient)*

I have read and understood the Patient Authorization Information (starting on Page 2) and by signing this form authorize the use and disclosure of my health information as described above.

***Signature NOT required to begin benefit investigation. Authorization may also be collected verbally upon completion of benefit investigation with Cycle Vita™.**

____

Patient Name (Printed)

____ ______________________

Signature of Patient Date

____ ______________________

Signature of Patient Representative* Date

*If signed by Patient Representative, please explain authority / relation to act on behalf of patient:

____

Please read the following statements and mark each box:

☐ I hereby authorize the Cycle Vita – SAJAZIR™ (icatibant) Injection Hub to use my PHI to contact me by mail, e-mail, text, phone, or any communication method I request for the purposes as described herein.

☐ Further, I understand that this program guarantees that I will receive Cycle Vita – SAJAZIR™ (icatibant) Injection Hub [(NDC: 70709-013-01) / (NDC: 70709-013-03)] rather than other products. By signing, I elect to receive the generic product specified within this enrollment form. No substitutions will be made or given.

Confidentiality Statement: This facsimile is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately and call +1 (888) 360-8482 to obtain instructions as to the proper destruction of the transmitted material.

©2022 Cycle Pharmaceuticals
All rights reserved. US-SJR-2200003 / February 2022