MAVENCLAD® (cladribine) 10-mg tablets PRESCRIPTIONS AND SERVICE REQUEST FORM

MSLifeLines®

Send Fax 1-866-227-3243 | **Questions? Call Us 1-877-447-3243**

Services Requested ☐ Benefits Verification ☐ Financial Assistance ☐ Nursing Support

1 | Patient Information *(Please complete any necessary tests prior to starting MAVENCLAD treatment)*

First Name _____ Last Name _____ Phone Number _____ ☐ Home ☐ Work ☐ Cell

Date of Birth (MM/DD/YYYY)_____ Gender (optional) _____ Okay to leave voicemail? ☐ Yes ☐ No Preferred Language _____

Home Address _____ Email _____

City_____ State _____ Zip _____ Preferred Method of Communication ☐ Phone ☐ Email ☐ Text (opt-in below)

2 | Patient Authorization

2A | I have read and understand the **Authorization to Use and Disclose Health and Other Personal Information** and agree to the terms on page 2.

SIGNATURE

_____ _____

PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE Date

Authority/relationship of personal representative *(if applicable):*

☐ Legal Guardian ☐ Power of Attorney

_____

PERSONAL REPRESENTATIVE FULL NAME *(if applicable)*

2B | ☐ By checking this box, I confirm that I have read and understand the **Opt-in for Marketing Text Messages** and agree to the terms on page 2.

3 | Patient Insurance Information *(Please include a copy of both sides of the insurance card)*

Type of Insurance

☐ Employer ☐ Medicaid ☐ Medicare ☐ Healthcare Exchange

☐ No Insurance ☐ Other: _____

Has prior authorization (PA) been initiated? ☐ Yes ☐ No

If "Yes", PA status: ☐ Approved ☐ Denied ☐ In Progress

Primary Insurance _____ Prescription Insurance _____

Cardholder Name (if different than patient) _____ RxID # _____ Rx Group # _____

ID # _____ Group # _____ Phone # _____ Rx BIN _____ Rx PCN _____ Phone # _____

4 | Patient Medical History

Last DMD _____ Date of Last Dose _____ Previous MS DMDs _____

5 | Prescriber Information

First Name _____ Last Name _____ Office/Clinic/Institution Name _____

Address _____ Office Contact Name _____

City _____ State _____ Zip _____ Office Contact Phone _____ Office Ext _____

NPI # _____ Tax ID # _____ Office Fax _____

State License # (PR only) _____ Office Contact Email _____

6 | MAVENCLAD 10-mg tablets Prescription Information

Preferred Specialty Pharmacy _____ Prescription already sent? ☐ Yes ☐ No Pharmacy Phone _____ Fax _____

PATIENT WEIGHT

_____ ☐ lbs ☐ kg

TREATMENT COURSE:

☐ Year 1 ☐ Year 2 ☐ Other (Year 1 and 2 completed)

Is your patient ready to start therapy? ☐ Yes ☐ No ☐ Unknown

If no, what is the intended date to start therapy? _____

In the tables below, check the row corresponding to the number of tablets to prescribe **in the first cycle (month 1) and again in the second cycle (month 2).**

6A | Number of MAVENCLAD 10-mg tablets per cycle

Instructions for Use: Take by mouth as directed per package instructions. No refill.

Weight Range: ~lb (kg)	MONTH 1 Total # of Tablets Authorized in 1st Cycle
☐ 88 to <110 lb (40 to <50 kg)	**4**
☐ 110 to <132 lb (50 to <60 kg)	**5**
☐ 132 to <154 lb (60 to <70 kg)	**6**
☐ 154 to <176 lb (70 to <80 kg)	**7**
☐ 176 to <198 lb (80 to <90 kg)	**8**
☐ 198 to <220 lb (90 to <100 kg)	**9**
☐ 220 to <242 lb (100 to <110 kg)	**10**
☐ ≥242 lb (110 kg and above)	**10**

Weight Range: ~lb (kg)	MONTH 2 Total # of Tablets Authorized in 2nd Cycle
☐ 88 to <110 lb (40 to <50 kg)	**4**
☐ 110 to <132 lb (50 to <60 kg)	**5**
☐ 132 to <154 lb (60 to <70 kg)	**6**
☐ 154 to <176 lb (70 to <80 kg)	**7**
☐ 176 to <198 lb (80 to <90 kg)	**7**
☐ 198 to <220 lb (90 to <100 kg)	**8**
☐ 220 to <242 lb (100 to <110 kg)	**9**
☐ ≥242 lb (110 kg and above)	**10**

7 | Prescriber Authorization | PRIMARY DIAGNOSIS: ICD-10 code G35

- I certify the prescribed therapy is medically necessary for the treatment of relapsing forms of multiple sclerosis, and that this information is accurate to the best of my knowledge.
- I authorize EMD Serono, Inc. to be my designated agent (1) to provide any information on this form to the insurer of the above-named patient and (2) to forward the above prescription by any method, under applicable law, to the pharmacy chosen by the above-named patient.
- I hereby certify that my office has obtained HIPAA-compliant authorization from the above-named patient to disclose medical and other protected health information necessary for EMD Serono to provide the services described in the Authorization on the following page, including assisting the patient with obtaining insurance coverage for MAVENCLAD.

SIGNATURE

_____ _____ _____

Provider Signature *(Dispense as Written)* *(Substitution Permissible)* **Date**

Complete form and fax to MS LifeLines at 1-866-227-3243. An incomplete form may delay treatment or patient enrollment in MS LifeLines.

EMD SERONO

MSLifeLines®

Authorization to Use and Disclose Health and Other Personal Information

I authorize my treating physician(s), pharmacy(ies), health insurance company(ies), prescription drug plan(s), and other parties providing me health care or paying for my health care (collectively, "My Health Care Providers and Plans") to disclose my personal and protected health information ("Health Information") to EMD Serono, Inc. and its agents and representatives (collectively "EMD Serono"). My Health Information may include, but is not limited to, information regarding my diagnosis of and treatment for multiple sclerosis ("MS"), information included in a Prescription and Service Request Form, and any other information deemed relevant by My Health Care Providers and Plans that may be considered sensitive or specially protected by law. EMD Serono may use and further disclose my Health Information to My Health Care Providers and Plans or other third parties in order to: (1) enroll me in and administer the MS LifeLines Support Program and contact me by mail, email, or by live call at the telephone number(s) listed below, or to any future telephone number(s) provided by me; (2) conduct a benefits investigation and coordinate my insurance coverage for any prescribed EMD Serono product(s); (3) facilitate the filling of my prescription for and the delivery and administration of that product(s); (4) contact me regarding the MS LifeLines Support Program and conduct quality assurance, surveys, and other internal business activities in connection with the MS LifeLines Support Program; and (5) conduct marketing activities that includes, but is not limited to, providing me with educational and promotional materials, information, special offers, and services related to my therapy or my medical condition and/or to conduct market research activities that includes contacting me to participate in focus groups, surveys, or interviews that may be funded or sent by EMD Serono, a MS LifeLines Support Program, or an EMD Serono affiliate.

I understand that once my information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws (eg, the Health Insurance Portability and Accountability Act [HIPAA]) or state privacy laws and may be further disclosed to others. However, I understand that EMD Serono will not release my personally identifiable information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent.

For more information on your privacy rights and choices, please see EMD Serono's privacy notice at https://www.emdserono.com/us-en/privacy-policy.html.

I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive any EMD Serono product, my treatment, payment for treatment, eligibility for or enrollment in health benefits, but it will limit my ability to receive MS LifeLines Support Program services. I understand that this authorization will remain in effect for 10 years, or such shorter period as may be required by state law, from the date of my signature unless I revoke it earlier by contacting EMD Serono in writing at EMD Serono & MS LifeLines, 200 Pier 4 Boulevard. Boston, MA 02210. If I revoke this authorization, My Health Care Providers and Plans will stop disclosing this information to EMD Serono, and EMD Serono will stop using and disclosing my information, as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization.

I understand that certain of My Health Care Providers and Plans may receive compensation in exchange for their disclosure of my information to EMD Serono. I also understand that I have the right to receive a signed copy of this authorization.

To authorize your consent, please complete Step 2: Patient Authorization on page 1, including signature line.

Opt-In for Automated Marketing Text Messages

I authorize EMD Serono, Inc. (or its agents), to send marketing text messages to the cell phone number(s) listed (or to any future telephone number(s) provided by me to EMD Serono, Inc. or its agents) using an automatic telephone dialing system on a recurring basis. This consent also enables EMD Serono to contact me by text message to provide me with MS LifeLines Support Program services. Signing this consent is not a condition of participating in the MS LifeLines Support Program or purchasing products, goods, or services from EMD Serono. I understand that my mobile phone service provider may charge me fees for texts sent to me, and I agree that EMD Serono will have no liability for the cost of any such calls or texts. At any time, I may withdraw my consent to receive text messages by replying "STOP" via return text message or contacting EMD Serono in writing at EMD Serono & MS LifeLines, 200 Pier 4 Boulevard. Boston, MA 02210.

To authorize your consent, please check the box listed in Step 2: Patient Authorization on page 1.

MS LifeLines is an educational support service for people living with MS and their families, and is sponsored by EMD Serono, Inc.