ITF ARC
ACCESS • RESOURCES • CARE

Patient Name__________________________ Date of Birth__/__/____

DUVYZAT™ (givinostat) Patient Start Form

Fax or mail the completed form to ITF ARC.
FAX: 855-748-3272 Mail: ITF ARC, PO Box 5490 Louisville, KY 40255

Questions?
Call ITF ARC at 855-448-3272, Monday–Friday, 8 AM–8 PM ET.

Patient Information:

Prescriber Attestation: I have written authorization on file to disclose this information for purposes of investigating access to DUVYZAT.

Please check primary contact ❑ Patient ❑ Parent/Caregiver

Patient Information

First Name________________ Last Name___________________________ Date of Birth __/__/____ Gender: ❑ Male ❑ Female ❑ Other Gender_________

Address____ City_______________ State_______ ZIP_________ Email___________________________

Phone____ ❑ Home ❑ Cell ❑ Other Best time to call: ❑ Morning ❑ Afternoon ❑ Evening

Preferred Language: ❑ English ❑ Spanish ❑ Other____

Parent/Guardian/Caregiver Information

First Name______________________________ Last Name______________________________ Relationship to Patient_____________________________

Address____ City_______________ State_______ ZIP_________ Email__________________________

Phone____ ❑ Home ❑ Cell ❑ Other Best time to call: ❑ Morning ❑ Afternoon ❑ Evening

Preferred Language: ❑ English ❑ Spanish ❑ Other____

Insurance Information:

Please attach copies of the front and back of the patient's prescription, medical, and secondary insurance cards.

❑ Patient has no insurance

Medical Insurance Information

Primary____

ID #________________________ Group #______________________

Phone_____________ Policy Holder___________________________

Relationship to Patient_____________________________________

Secondary____

ID #________________________ Group #______________________

Phone_____________ Policy Holder___________________________

Relationship to Patient_____________________________________

Prescription Insurance Information

Primary____

Rx Member ID #______________ Rx BIN______________ Rx PCN______________

Rx Group #__________________ Phone______________ Policy Holder___________

Relationship to Patient____

Secondary____

Rx Member ID #______________ Rx BIN______________ Rx PCN______________

Rx Group #__________________ Phone______________ Policy Holder___________

Relationship to Patient____

Patient Financial Information (information used solely to assess the patient for determining eligibility for the DUVYZAT Patient Assistance Program if needed):

Please see Patient Authorization below and on pages 3 and 4 to validate this information through a financial assessment screening.

Annual Household Income $_____________________ Household Size (number of people living in the household)_______________

Patient Authorization: Authorization to Share My Health Information

By signing below, I acknowledge that I have read and agree to the Patient Authorization set forth on pages 3 and 4 of this Start Form.

Patient/Guardian/Legally Authorized Representative Signature________________________ Date (mm/dd/yyyy) __/__/____

Relationship____

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Prescriber Information:

Prescriber First Name__________________________ Prescriber Last Name__________________________ Prescriber Specialty__________________________

Facility Name____________________________________ Facility Address__________________ City_______________ State___________ ZIP___________

NPI #____________________ State License #________________ Facility Contact Name______________________________ Role__________________________

Phone____ Fax____ Email____

Prescription (Both prescriptions to be filled out by prescriber only):

For prescription fulfillment by pharmacy after benefit investigation

DUVYZAT oral suspension: 8.86 mg/mL

Height: Feet___ Inches________ Weight________kg Date__/__/____

Directions and dose (check one of the following recommended dosages for patients 6 years of age and older for the treatment of DMD or fill in "Other"):

❑ **10 kg to less than 20 kg:** Take 2.5 mL (22.2 mg) orally twice daily with food
Quantity: 1 bottle of 140 mL

❑ **20 kg to less than 40 kg:** Take 3.5 mL (31 mg) orally twice daily with food
Quantity: 1 bottle of 140 mL

❑ **40 kg to less than 60 kg:** Take 5 mL (44.3 mg) orally twice daily with food
Quantity: 2 bottles of 140 mL

❑ **60 kg or more:** Take 6 mL (53.2 mg) orally twice daily with food
Quantity: 3 bottles of 140 mL

❑ Other____

Refills____

For prescription fulfillment by pharmacy for temporary supply (Quick Start or Bridge)

DUVYZAT oral suspension: 8.86 mg/mL

Directions and dose (check one of the following recommended dosages for patients 6 years of age and older for the treatment of DMD or fill in "Other"):

❑ **10 kg to less than 20 kg:** Take 2.5 mL (22.2 mg) orally twice daily with food
Quantity: 1 bottle of 140 mL Refills: up to 1

❑ **20 kg to less than 40 kg:** Take 3.5 mL (31 mg) orally twice daily with food
Quantity: 1 bottle of 140 mL Refills: up to 3

❑ **40 kg to less than 60 kg:** Take 5 mL (44.3 mg) orally twice daily with food
Quantity: 2 bottles of 140 mL Refills: up to 2

❑ **60 kg or more:** Take 6 mL (53.2 mg) orally twice daily with food
Quantity: 3 bottles of 140 mL Refills: up to 2

The dosage of DUVYZAT may be modified if the patient experiences a decrease in platelets, diarrhea, or an increase in triglycerides.

Prescriber Authorization (no stamps)

Prescriber Signature for Prescription Substitution Permitted______________________________ Date__/__/____ Date__/__/____

Prescriber Signature for Prescription Dispense as Written (no stamps)______________________________ Date__/__/____ Date__/__/____

Prescriber Authorization: I certify that I have prescribed DUVYZAT as described above based on my professional judgment of medical necessity. I authorize ITF Therapeutics LLC, its affiliates, agents, and contractors (collectively, ITF) 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. I authorize the release of medical and/or other patient information relating to DUVYZAT therapy to agents of ITF Therapeutics LLC, and service providers (including, but not limited to DUVYZAT-dispensing pharmacies) to use and disclose as necessary for prior authorization processing and fulfillment of the prescription. I authorize ITF's specialty pharmacy partners to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

Certain states require "brand medically necessary" or similar language to be handwritten by the prescriber if he/she has made this determination in his/her independent clinical judgment. The prescriber should comply with state-specific prescription requirements.

Patient Clinical Information:

Previous and Current Therapies: Please attach a list of all therapies the patient is currently taking or has previously taken.

Gene therapy: ❑ Yes ❑ No

DUVYZAT (givinostat): ❑ Current, please specify____________________ ❑ Discontinued ❑ Not Applicable

Exon-skipping therapy: ❑ Current, please specify____________________ ❑ Discontinued ❑ Not Applicable

Emflaza (deflazacort): ❑ Current, please specify____________________ ❑ Discontinued ❑ Not Applicable

Agamree (vamorolone): ❑ Current, please specify____________________ ❑ Discontinued ❑ Not Applicable

Corticosteroids: ❑ Current, please specify____________________ ❑ Discontinued ❑ Not Applicable

Other____

Any known allergies____ ❑ No Known Allergies

❑ Confirm patient has Duchenne muscular dystrophy (DMD) Provide patient's *ICD-10-CM* Code: ❑ G71.01 ❑ Other____________________

❑ Ambulatory ❑ Non-ambulatory

Baseline platelet count____________x 10^9/L Date__/__/____ Baseline triglycerides___________mg/dL Date__/__/____

Duvyzat™ (givinostat)

Patient Authorization for Services by the ITF ARC Program

❑ By checking this box, I consent to receive autodialed marketing calls and text messages from and on behalf of ITF at the phone number(s) I have provided. I understand that consent is not a requirement of any product purchase or enrollment. Message frequency may vary. Message and data rates may apply. I may opt out at any time by texting STOP or calling 855-448-3272.

I authorize the disclosure and use of my personal information for the following purposes:

1) Use and Disclosure of Personal Information

I authorize:

(a) My healthcare providers, their staff, pharmacies and health insurance plans ("my healthcare providers") to disclose personal and medical information to ITF Therapeutics LLC and its agents, contractors (together "ITF") for the purposes set forth in (b)

(b) ITF to use and disclose information shared by me and my healthcare providers to help me access ITF products and services, which may include:

- Working with my health insurance plan to verify my insurance and understand benefits for ITF products and services;
- Communicating with my healthcare providers and health plans about benefits, coverage and medical care;
- Coordinating a prescription for an ITF medicine with a pharmacy;
- Evaluating my eligibility for ITF programs to potentially assist with financial out-of-pocket costs for ITF products or no-cost medication programs for ITF products;
- Confirming the financial information I provided in the Patient Financial Information section on page 1, by conducting a non-credit inquiry through third-party credit bureaus for purposes of evaluating my potential eligibility for the ITF patient assistance program;
- Opting in for marketing purposes including contacting me by mail, electronic mail, telephone (including leaving voicemail message), and text messages to discuss ITF services and my health benefits for DUVYZAT (rates for text messaging may be charged by my mobile carrier);
- Sharing information or materials for an ITF product that relates or supports treatment of my medical condition;
- Using my de-identified information to conduct internal data analyses

(c) That I understand that if I receive free medications from ITF, I will

- Not seek payment or reimbursement from any healthcare provider or health insurance plan for such free medication
- Not sell or give the medication to anyone because it is illegal to do so
- Take care to safeguard any medication I receive
- Not transfer or share the medication with anyone other than myself for whom it is prescribed

2) Use my de-identified data for research and publication purposes; to conduct data analytics, market research, and ITF ARC–related business activities; and/or to contact me about ITF ARC services

This form is complete and accurate to the best of my knowledge. I will update my information promptly if any of the information reflected on this form changes by contacting ITF ARC at 855-448-3272.

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