cystaran®
(cysteamine ophthalmic solution) 0.44%

ENROLLMENT FORM

Leadiant Biosciences

To begin, please have each eligible patient (1) read the terms and conditions, (2) complete section 1 and 2 of this enrollment form, and (3) sign the authorization in section 4. The remaining sections must be completed by a health care professional for complimentary product in accordance with the Prescription Drug Marketing Act of 1987. This program is intended for CYSTARAN® patients. See Terms and Conditions on page 3.

Fax this completed form, along with a valid prescription for CYSTARAN® and patient authorization form to: 1-866-889-1510. For assistance, please call: 1-877-534-9627.

1 PATIENT INFORMATION

Patient First Name | **Patient Last Name**

Gender ☐ Male ☐ Female

Date of Birth (MM/DD/YYYY) | **US Resident** ☐ Yes ☐ No

Address | **City**

State | **Zip** | **Cellular Phone Number**

Alternate Phone Number | **Email Address**

Preferred Language

2 INSURANCE INFORMATION

☐ **Please attach a copy of both sides of the patient's insurance card(s).**

☐ Patient does not have insurance

☐ Yes ☐ No Is the patient enrolled in a government-funded healthcare program, such as Medicare, Medicaid, VA, DoD, or Tricare®?

3 CLINICAL INFORMATION

ICD-10 code:

Secondary ICD-10:

☐ Other

Other drugs used to treat the disease:

Please list any allergies:

4 PATIENT SIGNATURES

I have read and agree to the Patient Authorization on pages 2-3.

Patient Signature* | **Date**

(Patient signature and date are required for services)

Relationship to Patient

Initials denote I agree to CYSTARAN® Voucher Program Terms and Conditions.

Initial here

* Original signature required. If required by applicable law, please attach copies of all prescriptions on official state prescription forms.

5 PRESCRIBER INFORMATION

Prescriber Name

Prescriber NPI # | **Prescriber State License #**

Address | **City**

State | **Zip** | **Fax Number**

Office Contact Name | **Phone Number**

Preferred Language | **Alternative Phone Number**

6 CYSTARAN® VOUCHER PROGRAM (OPTIONAL)

I authorize AllianceRx Walgreens Prime to dispense a free, one-time, 28-day supply of CYSTARAN®. There is no purchase obligation to participate in the Voucher Program. Terms and Conditions apply. This program is optional. See CYSTARAN® Voucher Program Terms and Conditions on pages 3-4.

Dosage:

☐ Instill 1 drop in each eye every waking hour.

Dispense:

☐ 28-day supply (4 bottles). No refills.

Has patient previously redeemed a voucher for CYSTARAN®? ☐ Yes ☐ No

If a patient has previously redeemed a voucher for CYSTARAN®, they are not eligible for participation in the Voucher program again. If patient has previously redeemed a voucher for free product, voucher request will be treated as a standard prescription.

7 PRESCRIBING INSTRUCTIONS FOR CYSTARAN® (cysteamine ophthalmic solution) 0.44%

Dosage:

☐ Instill 1 drop in each eye every waking hour.

☐ Alternate instructions (Please place alternate directions below)

Minimum dispense is 1 shipment containing 4 bottles 15-mL CYSTARAN®

Dispense:

☐ 28-day supply (4 bottles). ☐ 3-month supply (12 bottles).

Refills #:

Deliver product to: ☐ Patient home ☐ Other

8 PRESCRIBING CERTIFICATION*

I certify that the information provided in this CYSTARAN® Prescription & Enrollment Form is complete and accurate to the best of my knowledge. I have prescribed CYSTARAN® based on my judgment of medical necessity. I acknowledge that any patient selected for this program is not currently receiving CYSTARAN® and has not been previously enrolled in the Voucher Program. I authorize the forwarding of this prescription and the information to the dispensing specialty pharmacy. I understand that neither I nor the patient should seek reimbursement for any free or discounted product received under the Voucher program.

Prescriber Signature (no stamps) (Dispense as written) | **Date**

Prescriber Signature (no stamps)(Substitutions permitted) | **Date**

cystaran®
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Leadiant Biosciences

CYSTARAN® VOUCHER PROGRAM PATIENT AUTHORIZATION

I, or my authorized representative, hereby authorize my health care provider and pharmacy to disclose my health and personal information to Leadiant Biosciences, Inc., the manufacturer of CYSTARAN® and the provider of the CYSTARAN® Voucher Program, and its affiliates, representatives, agents, and contractors (collectively "Leadiant") in connection with the CYSTARAN® Voucher Program, or support services related to patient assistance programs, in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and related federal regulations and rules. The support provided through this program is not contingent on any further purchase.

Description of Health & Medical Information That May Be Disclosed

My health care provider may disclose individually identifiable health and other information that supports my participation in the CYSTARAN® Voucher Program. Information disclosed may include my name, address, date of birth, medical condition, prescription, treatment, care management, and health insurance; and any other personal information including all demographic information, email addresses, phone numbers, and other information in the possession or control of my health care provider. I understand that my pharmacy may receive payment from Leadiant for providing information to Leadiant pursuant to this authorization.

Authorized Purposes

The authorized purposes are: (1) to evaluate my eligibility for inclusion in the CYSTARAN® Voucher Program and (2) if my participation in the program is approved, to administer the program to me and dispense one free 28-day supply of product.

Expiration of Authorization

My authorization shall expire (1) when my participation in the CYSTARAN® Voucher Program is not approved or (2) after one (1) year from the date of your signature, whichever is earlier.

Acknowledgments

1. I understand that once Leadiant receives my information based on this authorization, my medical and health information may be subject to re-disclosure and will no longer be protected by federal privacy regulations. I further understand and agree that AllianceRx Walgreens Prime may retain my medical and health information as disclosed under this authorization after this authorization expires for the purposes related to the administration of the CYSTARAN® Voucher Program. I also understand that the information disclosed may be used in the event of an audit.
2. I understand that signing this authorization is voluntary, and that I may refuse to sign this authorization form. Unless allowed by law, my refusal to sign will not affect my ability to obtain health plan benefits or treatment from my health care provider. However, I understand that I may not be included in the CYSTARAN® Voucher Program, and that I may not have access to additional patient support, financial or other related services offered by Leadiant, if I refuse to sign this authorization form.
3. I understand that I may revoke my authorization at any time by providing a written notice of the same to Walgreen Co. Privacy Office, 200 Wilmot Road, Mail Stop 9000, Deerfield, Illinois, 60015. However, I understand that if I revoke this authorization, it will not affect prior disclosures made in reliance on this authorization.
4. I understand that completing this enrollment form does not guarantee that I will qualify for the CYSTARAN® Voucher Program.
5. I understand that medicine received under the CYSTARAN® Voucher Program shall not be sold, traded, bartered, or transferred. Leadiant Biosciences reserves the right to change or cancel the CYSTARAN® Voucher Program at any time.
6. I understand that I am entitled to receive a copy of this Authorization once it has been signed.
7. I understand and agree to the following:

   I agree to communications from Leadiant Biosciences, AllianceRx Walgreens Prime, and/or parties acting on their behalf to determine my eligibility for the CYSTARAN® Voucher Program, and for other non-marketing purposes related thereto. I agree to be contacted by Leadiant Biosciences, AllianceRx Walgreens Prime, and/or parties working on their behalf for these purposes using an autodialer or prerecorded voice at the telephone number(s) provided. If I have a caregiver, he or she has also agreed to receive such communications from Leadiant Biosciences, AllianceRx Walgreens Prime, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Leadiant Biosciences, AllianceRx Walgreens Prime, and/or other parties acting on their behalf to contact my caregiver for such purposes. I understand that I (and, if applicable, my caregiver) can opt-out of these communications at any time by contacting AllianceRx Walgreens Prime at 1-877-534-9627.

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Leadiant Biosciences

CYSTARAN® VOUCHER TERMS AND CONDITIONS

Terms & Conditions
The patient, or health care provider on the patient's behalf, must provide a completed enrollment form and a valid prescription to the CYSTARAN® Voucher Program. The program is valid for one 28-day trial supply of CYSTARAN® (4 bottles). Limit one offer per patient. No purchase is necessary. Patients have no obligation to continue to use CYSTARAN® after the program ends. This voucher is only accepted at AllianceRx Walgreens Prime.

Offer valid in the United States and Puerto Rico, and void where prohibited by law. Not valid in the Commonwealth of Massachusetts. Offer may be rescinded, revoked or amended at any time without notice. Offer expires on December 31, 2022.

This trial offer is not health insurance. This voucher is not intended to address delays or gaps in health insurance coverage for the specified prescription.

This offer cannot be combined with any other savings, rebate coupon, free trial, free sample or other similar offer for the specified prescription.

It is illegal to sell, purchase, or trade this voucher card (or to offer to do so).

Eligibility Criteria
This offer is limited to one voucher redemption per patient. Must be 18 years of age or older to redeem this voucher. For patients under 18 years of age, the voucher may only be redeemed by the patient's parent, or a guardian over 18 years of age.

Patient Agreement
By redeeming this voucher, you (the patient) acknowledge that you meet the eligibility criteria and will comply with these terms and conditions.

1. You certify that you will comply with the terms of your health insurance contract, if any, and shall (if required) provide notice of the existence and/or value of this voucher.
2. You must not submit (or cause to be submitted) any claim for reimbursement for product dispensed pursuant to this voucher to any third-party payer, including Medicaid, Medicare, or other federal or state programs. You cannot apply the value of the free product received through this voucher toward any government insurance benefit out-of-pocket spending calculations, such as Medicare Part D True Out-of-Pocket Costs (TrOOP).
3. You certify that you have not received a free sample of CYSTARAN®.