Cystaran (cysteamine ophthalmic solution) 0.44%

PRESCRIPTION & ENROLLMENT FORM

☐ New patient ☐ Current patient

Note: This form is intended for prescriber use only.
If faxed, the fax must come from MD office or hospital (should not be faxed by patient).

Phone: 877-534-9627 Fax: 866-889-1510

PATIENT INFORMATION (Include the front and back copy of the patient's insurance card)

Patient name _____

Date of birth _____ ☐ Male ☐ Female

Street address _____

City _____ State _____ Zip _____

Parent/guardian (if applicable) _____ ☐ Principle contact

Home phone _____ Work phone _____

Cell phone _____ Evening phone _____

E-mail address _____

Insurance company name _____

Insurance company phone # _____

Insured name _____

Insured employer _____

Relationship to patient _____

Identification # _____ Policy/group # _____

Prescription card ☐ No ☐ Yes If yes, carrier _____

Policy # _____ Group # _____

Eligible for Medicare? ☐ No ☐ Yes Eligible for Medicaid? ☐ No ☐ Yes

PRESCRIBER INFORMATION

Date _____ Time _____

Prescriber name _____

Prescriber practice title _____

Street address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

License # _____ DEA # _____

Physician Medicaid UPIN # _____ NPI# _____

MD specialty _____

CLINICAL INFORMATION

ICD-9 code: 270.0 Cystinosis ICD-10 code: _____

Secondary ICD-9: _____ Secondary ICD-10: _____ Other _____

Other drugs used to treat the disease _____

☐ NKDA ☐ Known drug allergies _____

PRESCRIBING INFORMATION

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 of 15-mL Cystaran.

Dispense:

___ 1-month supply (4 bottles) ___ 3-month supply (12 bottles) ____ Refills

Shipping instructions: _____

Deliver product to: ☐ Patient home ☐ Other

PRESCRIBER SIGNATURE

By signing below, I certify that the prescribed therapy is medically necessary.

Physician printed name _____

Physician signature _____ Date _____
(No stamps) (Dispense as written)

Physician signature _____ Date _____
(No stamps) (Substitutions permitted)

This prescription is valid only if transmitted by means of a facsimile machine.

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. Drug names are the property of their respective owners.

Walgreens

PATIENT AUTHORIZATION

I, or my authorized representative, herby authorize Walgreen Co., and its affiliates, representatives, agents, and contractors (collectively "Walgreens") to use and disclose all of my individually identifiable health information; protected health information (except psychotherapy notes), including but not limited to information about my 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 Walgreens (collectively "Information), to Leadiant Biosciences, Inc., and its affiliates, representatives, agents, and contractors, including any patient assistance program administrator(s) for CystaranTM (collectively, "Leadiant Biosciences").

The Information is being used and disclosed for purposes of: (1) providing, coordinating, managing, and contacting me about my prescriptions (including medication refill and adherence reminders), treatment, patient support, and other services related to my Leadiant Biosciences therapies; (2) establishing my benefits eligibility, including for any financial or reimbursement support services offered by or on behalf of Leadiant Biosciences; (3) communicating with me and my healthcare providers, health plans, and other payors about my medical care; and (4) providing me with information about current or future products or services offered by Walgreens.

I understand that Walgreens will receive a fee from Leadiant Biosciences in exchange for (1) providing me with certain materials and information described above, and (2) using or disclosing certain Information pursuant to this Authorization. I also understand that once my Information has been shared with Leadiant Biosciences, it might be re-disclosed by Leadiant Biosciences and privacy laws may no longer protect it. I understand that I may revoke this Authorization at any time, in writing, by sending written notification to Walgreen Co. Privacy Office, 200 Wilmot Road, Mail Stop 9000, Deerfield, Illinois 60015. I understand that my revocation is not effective to the extent that action has already been taken based on this Authorization.

I understand that signing this Authorization is voluntary. If I do not sign this form, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to additional patient support, financial, or related services offered by Leadiant Biosciences. This Authorization will expire ten (10) years after the date on which I sign it. I understand that I have the right to receive a copy of this Authorization.

_____ _____

Patient or Authorized Representative Signature | If Authorized Rep, state basis for authority

_____ _____

Patient Printed Name | Date

Walgreens

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