Sarepta Gene Therapy Enrollment Form

SareptAssist: To learn more about SareptAssist, call 1-888-727-3782, Monday through Friday (8:30am – 6:30pm ET)

SareptAssist is a patient support program offered by Sarepta Therapeutics, designed to provide information to help patients initiate the process to receive gene therapy treatment.

The SareptAssist team will provide information on:

- Insurance benefits
- Financial assistance options
- Treatment logistics
- Ongoing education and support

Instructions for Completing the Sarepta Gene Therapy Enrollment Form

The Sarepta Gene Therapy Enrollment Form is required to determine patient eligibility and initiate the process to receive therapy. This form **must be completed and submitted by the physician/qualified healthcare professional**.

SECTION 1 General Information (page 1)

- This section **must always be completed when submitting the Sarepta Gene Therapy Enrollment Form**. Be sure to provide the Patient Information and Physician Information in this section

SECTION 2 Sarepta-endorsed AAVrh74 Antibody Test (page 1)

- This section **must be completed to order the Sarepta-endorsed AAVrh74 Antibody Test** to determine the patient's eligibility for therapy
- **Note:** Instruct the patient to carry a copy of the **completed and signed Sarepta Gene Therapy Enrollment Form and the Athena-Sarepta Serum Collection Kit** with them to get their blood drawn at your institution's phlebotomy lab, Quest Patient Service Center (PSC), or at home. A physical copy of the completed and signed Enrollment Form should be sent, along with the test kit that includes the patient's sample, to Quest Diagnostics

SECTION 3 Genetic Test Report (page 2)

- This section **must be completed to support the patient's eligibility for therapy**
- A copy of the **patient's Genetic Test Report from a CLIA-certified lab must be sent to SareptAssist** along with the Sarepta Gene Therapy Enrollment Form

SECTION 4 Insurance, Treatment, and Infusion Site Information (page 2)

- This section **must be completed by the treating physician intending to infuse the patient**

SECTION 5 Physician Declaration (page 2)

- This section **must always be completed and signed by the physician**
- **Note:** Physician consent is limited to the sections completed in the Sarepta Gene Therapy Enrollment Form

SECTION 6 Patient Authorization for SareptAssist (page 3)

- This section **must be completed and signed by the patient's caregiver/legal guardian** and submitted along with the Enrollment Form. **A signed authorization by the patient's parent/legal guardian is required** to receive support through the SareptAssist program

Instructions for Submitting the Sarepta Gene Therapy Enrollment Form

1. Fax the following documents to **SareptAssist at 1-800-621-5203** or via email at **SareptAssist@Sarepta.com**
   - ☐ Completed and signed Sarepta Gene Therapy Enrollment Form (pages 1 and 2)
   - ☐ All pages of the patient's Genetic Test Report from a CLIA-certified lab
   - ☐ Completed and signed Patient Authorization for SareptAssist (page 3)
   - ☐ Both sides of the patient's medical and pharmacy insurance card(s)
2. If the physician is ordering the Sarepta-endorsed AAVrh74 Antibody Test, send a physical copy of the completed and signed Sarepta Gene Therapy Enrollment Form (pages 1 and 2), along with the test kit that includes the patient's blood sample, to **Quest Diagnostics**.

Sarepta Gene Therapy Enrollment Form

Be sure to submit the following documents to the indicated recipients:

Fax the following documents to SareptAssist at 1-800-621-5203 or email to SareptAssist@Sarepta.com

- ☐ Sarepta Gene Therapy Enrollment Form (pages 1 and 2)
- ☐ All pages of the patient's Genetic Test Report from a CLIA-certified lab
- ☐ Patient Authorization (page 3)
- ☐ A copy of both sides of the patient's medical and pharmacy insurance card(s)

Send a physical copy of the following document, along with the test kit that includes the patient's blood sample, to Quest Diagnostics:

- ☐ Sarepta Gene Therapy Enrollment Form (pages 1 and 2)

Section 1: General Information

Patient Information

First Name:	Last Name:		Middle Initial:
Address:	City:	State:	ZIP:
Date of Birth:	Patient Weight (lbs.):	Date Weight Taken:	Gender: ☐ M ☐ F
Primary Contact:		Ambulation Status: ☐ Ambulatory ☐ Non-Ambulatory	
Relationship to Patient:		Primary Phone:	
Best Time to Call: ☐ AM ☐ PM OK to Leave Message: ☐ Y ☐ N		Secondary Phone:	
Language, other than English:		Email Address:	

Physician Information

Physician First Name:	Physician Last Name:	Physician Affiliation:	
Address:	City:	State:	ZIP:
Office Contact:	Phone:	Fax:	
Email:			
NPI #:	Tax ID #:		
For Referred Patients			
Referrer First Name:	Referrer Last Name:	Referrer NPI #:	

Section 2: Sarepta-endorsed AAVrh74 Antibody Test

Test Code ☐ 1185 Adeno-associated virus AAVrh74 Antibody Test (please check the box to order)

Athena Account Number (if assigned):

Patient's blood sample may be collected[1] at any one of the below locations:

- Institution's phlebotomy lab[2] (local lab at your clinic/institution)
- Quest Patient Service Center (PSC) (questdiagnostics.com/locations/search)
- Home phlebotomy (call SareptAssist at 1-888-727-3782)

1. **Note:** In addition to faxing the documents to SareptAssist (see instructions page), instruct the patient to **carry a physical copy of the completed and signed Enrollment Form and the Athena-Sarepta Serum Collection Kit** with them to get their blood drawn at your institution's phlebotomy lab, Quest PSC, or at home. A physical copy of the completed and signed Enrollment Form should be sent along with the patient's sample to Quest Diagnostics.
2. **Note:** Sample collection charges are subject to clinic/institution billing practices and insurance coverage.

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Section 3: Genetic Test Report

☐ All pages of the patient's Genetic Test Report from a CLIA-certified lab

Section 4: Insurance, Treatment, and Infusion Site Information

Insurance Information

☐ **Confirm you have attached a copy of the patient's insurance cards (front & back)**

Primary:	Primary ID #:
Primary Group #:	Phone:
Primary Policy Holder:	Relationship to Patient:
Secondary:	Secondary ID #:
Secondary Group #:	Phone:
Secondary Policy Holder:	Relationship to Patient:

Treatment and Infusion Site Information

Infusion Site Name:		
NPI #:		
Address:		
City:	State:	ZIP:
Select Billing Method: ☐ Buy & Bill ☐ Specialty Pharmacy		
Product Receipt Contact		
Name:		
Phone:	Fax:	
Email:		

Section 5: Physician Declaration

Physician's signature is required for SareptAssist to perform a benefits verification

For the sections I have completed, I certify that by signing below:

1. The therapy is medically necessary and in the best interest of the patient identified above;
2. The patient is appropriately indicated for the therapy; and
3. I have obtained and provided any consent required under federal and state law for the release and use of the patient's information on this form to Sarepta Therapeutics ("Sarepta") and its agents, including its commercial and field-based teams, for purposes of benefits verification, eligibility verification, and coordination of dispensing the therapy.

Print Physician Name

Physician Signature

Date (MM/DD/YYYY)

Section 6: Patient Authorization for the SareptAssist Program

Patient Name:	Date of Birth:

I authorize my healthcare providers (eg, physicians, pharmacies, clinical laboratories) and my insurance company to disclose personal health information about me, including information related to my medical condition and treatment, my health insurance coverage, and my address, email address, and telephone number (collectively, my "PHI") to Sarepta Therapeutics, its agents, including its commercial and field-based teams, and the SareptAssist Program (collectively "Sarepta") so that Sarepta may use the information for purposes of:

(1) verifying, investigating, assisting with, and coordinating my coverage for the therapy with my health insurers; (2) assessing my eligibility for co-pay assistance or free drug or referring me to other programs or sources of funding and financial support; (3) coordinating delivery of the therapy to me or my healthcare providers; (4) providing education, information on Sarepta products and services, and ongoing support services to me related to the therapy; (5) gathering feedback on my therapy, medical condition, and/or disease state; (6) coordinating assessment of AAVrh74 antibodies with third-party diagnostic service providers; (7) contacting me by mail, email, phone, text, or fax for any of the above purposes; and (8) creating information that does not identify me personally for use for other legitimate purposes. I understand that my healthcare providers (eg, physicians, pharmacies, clinical laboratories) may receive remuneration for making such disclosures. I also authorize Sarepta and my healthcare providers and my insurance company to use my PHI to communicate with me about Sarepta products and services. I understand that my healthcare providers and my insurance company may receive remuneration in connection with providing the communications and or in exchange for data or providing PHI in connection with the authorization. I understand that once disclosed pursuant to this authorization, my PHI may no longer be protected under federal or state law and could be disclosed by Sarepta to others, but I also understand that Sarepta will make reasonable efforts to keep my PHI private and to disclose it only for purposes set forth in this authorization.

I understand that I do not have to sign this authorization to obtain healthcare treatment or benefits; however, in order to receive the services and communications described above, I must sign the authorization. I understand that I may cancel my authorization at any time by contacting SareptAssist by fax at 1-800-621-5203, or by mail at 215 First Street, Cambridge, MA 02142. My cancellation of this authorization will be effective for Sarepta upon receipt and will be effective for each of my healthcare providers and insurance companies when they are notified of it, but the cancellation will not affect prior uses or disclosures of PHI.

I understand that I have a right to receive a copy of this authorization.

This authorization expires 5 years after the date I sign it as shown below, or such earlier date as may be required by the state in which I reside, unless I cancel it before then.

Patient or Legal Guardian Signature	Date (MM/DD/YYYY)
Printed Name of Patient or Personal Representative	Date (MM/DD/YYYY)
If signed by Personal Representative, state relationship to Patient	

SAREPTA THERAPEUTICS