Getting Your Patient Started on ARIKAYCE

Arikares® Support Program Enrollment Form and Patient Information

Please see the accompanying full Prescribing Information for ARIKAYCE for information about Limited Population. Please see Indication and Important Safety Information for ARIKAYCE enclosed, including Boxed Warning.

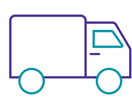
The *Arikares Support Program* is designed to help your patients **get started on ARIKAYCE (amikacin liposome inhalation suspension)**, **become familiar with taking it**, and **receive support** during their treatment journey.

PROGRAM ENROLLMENT

- Complete the *Arikares* Enrollment Form **enclosed** or **download an interactive form** by visiting ArikaresEnrollmentForm.com
    - Submit all pages via fax (1-800-604-6027) or e-mail (enrollment@arikares.com)
- Patient signature on the *Arikares* enrollment form is required to receive full benefits of the program

PAYER ACCESS EDUCATION

- *Patient Access Lead* is available to provide the most recent publicly available payer-specific information regarding
    - Payer approval process
    - Prior authorization and reauthorization
    - Appeal process



SHIPMENT COORDINATION

- *Arikares Coordinator* and specialty pharmacy work with the patient to coordinate the shipment of medication
- Specialty pharmacy reviews financial support options with patient

DEVICE TRAINING

- *Arikares Trainer* can provide one in-office or virtual train-the-trainer to healthcare provider and staff
- *Trainer* conducts voluntary in-home or virtual device training for patient and caregiver(s)

ONGOING PATIENT SUPPORT

- *Arikares Coordinator* provides office with patient updates and answers patients' device-related questions

Insmed Therapeutic Specialist

Arikares Team

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QUESTIONS?

Call the *Arikares Support Program* at 1-833-ARIKARE (1-833-274-5273) or 1-973-437-2376.

The *Arikares Support Program* Enrollment Form

The *Arikares Support Program* Enrollment Form is the first step in prescribing ARIKAYCE and enrolling patients in *Arikares*. To begin, you need to gather all the relevant information from each of your patients.

To avoid delays, please **complete all the mandatory fields** in the Enrollment Form (fields marked with an asterisk [*] are required if your patient would like to enroll in *Arikares*).

Below you can find an annotated example highlighting what's required from the patient and physician sections.

Remember to include copies of each patient's insurance card(s) when submitting the Enrollment Form and Prescription (Rx).

Patient information

- Ensure patient demographic information is filled out completely

Prescription insurance information

- Provide policy and phone numbers
- Include separate prescription plan (if applicable)

Patient signature and date required for enrollment in the *Arikares Support Program*

- Ensure patients sign both signature areas on their Enrollment Form prior to leaving the office. Patient signatures are required to receive full benefits of the program
- ***Patients must read and understand page 2 of the Enrollment Form prior to signing***

ARIKAYCE Prescription and *Arikares® Support Program* Enrollment Form

ARIKAYCE® (amikacin liposome inhalation suspension) Limited Population | Arikares® Support Program

Fax: 1-800-604-6027 or **E-mail:** enrollment@arikares.com

Please complete all fields on pages 1 and 3 to prevent any delays and include scanned copies of both sides of the patient's insurance card (fields marked with an asterisk [*] are mandatory/required).

Questions? Phone: **1-833-ARIKARE** (1-833-274-5273) Alternate Phone: 1-973-437-2376

PATIENT INFORMATION

*Patient First Name: ______ *Patient Last Name: ______ *MI: ______
*DOB: ______ *Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Unknown Last 4 of SSN: ______
*Physical Address: ______
*City: ______ *State: ______ *ZIP: ______
*Mailing Address: ______ ☐ Same as Physical Address
*City: ______ *State: ______ *ZIP: ______
*Mobile Phone: ______ Home Phone: ______ E-mail: ______
Preferred Contact Method(s): (check all that apply) ☐ Phone ☐ E-mail ☐ Text
Preferred Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening
Preferred Contact Language: ☐ English ☐ Spanish ☐ Other: ______
Authorized Alternate Contact: ______
Alternate Contact Phone: ______ Relationship to Patient: ______

Prescription Insurance Information *(Please Send a Copy of Insurance Card)*

*Prescription Coverage Plan Name: ______
Beneficiary/Cardholder: ______ Relationship to Cardholder: ______
*Primary Rx Insurance ID #: ______ *Group #: ______
*BIN: ______ *PCN: ______ *Phone: ______
*Primary Rx Plan Type: ☐ Private/Commercial ☐ Medicare Part D ☐ Medicaid ☐ TRICARE ☐ Other
Secondary Prescription Coverage Plan Name: ______
Beneficiary/Cardholder: ______ Relationship to Cardholder: ______
Secondary Rx Insurance ID #: ______ Group #: ______
BIN: ______ PCN: ______ Phone: ______
Secondary Rx Plan Type: ☐ Private/Commercial ☐ Medicare Part D ☐ Medicaid ☐ TRICARE ☐ Other
Patient Does Not Have Insurance ☐

Patient Authorization Signature

Protected Health Information Disclosure Authorization and Consent—I have read and understand the Protected Health Information Disclosure Authorization and Consent on page 2. By signing below, I authorize the disclosure of my PHI to the Insmed Patient Support Team as described in the Protected Health Information Disclosure Authorization and Consent on page 2.

***Patient Signature:** ______ ***Date:** ______

Patient Support Program Enrollment Consent—I have read and understand the Patient Support Program Enrollment Consent on page 2. By signing below, I agree to enroll in the Insmed Patient Support Program and consent to processing of my Health Information as described in the Patient Support Program Enrollment Consent on page 2.

***Patient Signature:** ______ ***Date:** ______

Please see Indication and Important Safety Information for ARIKAYCE, including Boxed Warning, on page 4. Please see accompanying full Prescribing Information.

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Patient Authorization may also be submitted online at ENROLL.ARIKARES.COM

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ENROLL.ARIKARES.COM

Mandatory/required fields are highlighted here in **yellow** for reference only.

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ARIKAYCE Prescription and *Arikares® Support Program* Enrollment Form

ARIKAYCE (amikacin liposome inhalation suspension) Limited Population | Arikares® Support Program

Fax: 1-800-604-6027 or **E-mail:** enrollment@arikares.com

Please complete all fields on pages 1 and 3 to prevent any delays and include scanned copies of both sides of the patient's insurance card (fields marked with an asterisk [*] are mandatory/required).

Questions?
Phone: **1-833-ARIKARE** (1-833-274-5273)
Alternate Phone: 1-973-437-2376

HEALTHCARE PROFESSIONAL & PRESCRIPTION INFORMATION

*Prescriber First Name: ____ *Prescriber Last Name: ____
*Practice Name: ____ Specialty: ____
*Address: ____ *City: ____ *State: ____ *ZIP: ____
*Phone: ____ *Fax: ____ *NPI #: ____
Office Contact Name: ____ Office Contact Phone: ____
Office Contact E-mail: ____

If Applicable, Check Appropriate Box for Specialty Pharmacy Preference:
☐ No Preference ☐ Maxor Specialty Pharmacy ☐ PANTHERx RARE Pharmacy ☐ Amber Specialty Pharmacy

Please note if ARIKAYCE is being ordered through: ☐ VA ☐ 340B entity

Official Prescription Information

*Patient First Name: ____ *Patient Last Name: ____ *DOB: ____

☐ ***Product:** ARIKAYCE® (amikacin liposome inhalation suspension)

Quantity: 28-Day Supply: 28-Vial Pack (28 Vials of Medication, 4 Aerosol Heads, and 1 Handset) *(First Shipment Includes Lamira® System)*

Dosing Info: Once-Daily 590 mg/8.4 mL

☐ ***# of Refills:** ____

New York prescribers, please submit prescription on an original NY State prescription blank. The prescriber is to comply with his or her state-specific form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

***Substitution Permitted?** ☐ Yes ☐ No

Prescriber Certification

I certify that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. By submitting this form, I certify that I am the prescriber who has prescribed ARIKAYCE to the previously identified patient, that the patient authorized the disclosure of their personal health information to Insmed, that I provided the patient with a description of the Insmed Patient Support Program, and that the patient has given permission to be contacted by Insmed regarding the Insmed Patient Support Program. I authorize the Insmed Patient Support Program to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

***Prescriber Signature:** ____ ***Date:** ____
No stamped signatures accepted

Special Instructions:
☐ Pre-treatment with inhaled bronchodilator due to history of hyperreactive airway disease

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Prescribing physician contact information

- Please list accurate fax numbers for future communications

Office contact

- Staff member in your office who will communicate with an *Arikares Coordinator* regarding patient enrollment, their insurance coverage, and their progress

Prescription information

- **Complete entire section, including number of refills**

Prescriber signature and date

- Required; no stamped signatures accepted

Special instructions

- Include any applicable special instructions (optional)

Mandatory/required fields are highlighted here in **yellow** for reference only.

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