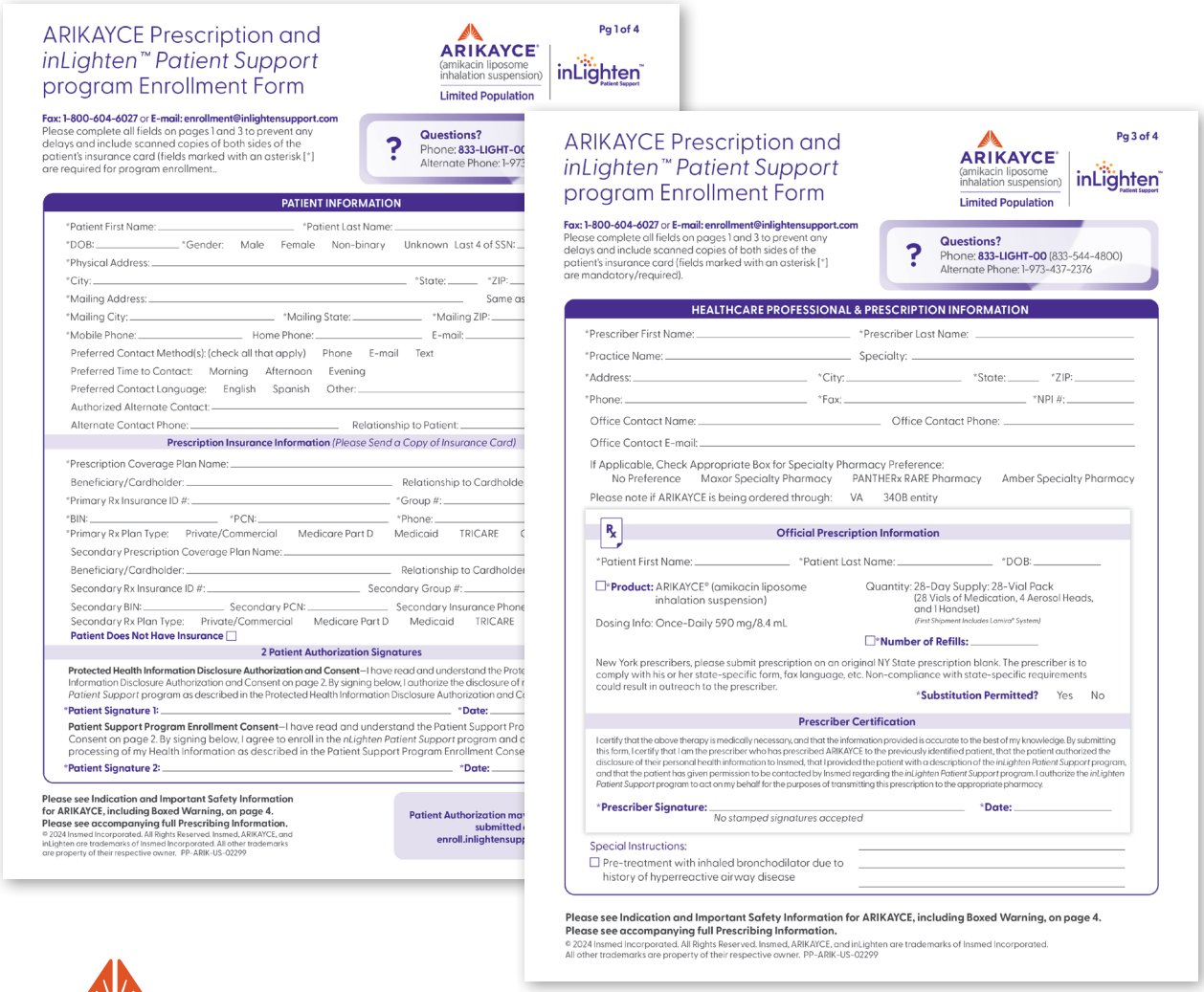
Getting Your Patient Started on ARIKAYCE

inLighten™ Patient Support program Enrollment Form and Patient Information



ARIKAYCE Prescription and *inLighten™ Patient Support* program Enrollment Form

Pg 1 of 4

ARIKAYCE (amikacin liposome inhalation suspension) Limited Population

inLighten Patient Support

Fax: 1-800-604-6027 or E-mail: enrollment@inlightensupport.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 required for program enrollment..

Questions? Phone: 833-LIGHT-00 Alternate Phone: 1-973-

PATIENT INFORMATION

*Patient First Name: *Patient Last Name:
*DOB: *Gender: Male Female Non-binary Unknown Last 4 of SSN:
*Physical Address:
*City: *State: *ZIP:
*Mailing Address: Same as
*Mailing City: *Mailing State: *Mailing 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 Cardholde
*Primary Rx Insurance ID #: *Group #:
*BIN: *PCN: *Phone:
*Primary Rx Plan Type: Private/Commercial Medicare Part D Medicaid TRICARE
Secondary Prescription Coverage Plan Name:
Beneficiary/Cardholder: Relationship to Cardholde
Secondary Rx Insurance ID #: Secondary Group #:
Secondary BIN: Secondary PCN: Secondary Insurance Phone
Secondary Rx Plan Type: Private/Commercial Medicare Part D Medicaid TRICARE
Patient Does Not Have Insurance ☐

2 Patient Authorization Signatures

Protected Health Information Disclosure Authorization and Consent–I have read and understand the Prote Information Disclosure Authorization and Consent on page 2. By signing below, I authorize the disclosure of *Patient Support* program as described in the Protected Health Information Disclosure Authorization and C
*Patient Signature 1: *Date:
Patient Support Program Enrollment Consent–I have read and understand the Patient Support Pro Consent on page 2. By signing below, I agree to enroll in the *nLighten Patient Support* program and processing of my Health Information as described in the Patient Support Program Enrollment Conse
*Patient Signature 2: *Date:

Please see Indication and Important Safety Information for ARIKAYCE, including Boxed Warning, on page 4.
Please see accompanying full Prescribing Information.
© 2024 Insmed Incorporated. All Rights Reserved. Insmed, ARIKAYCE, and inLighten are trademarks of Insmed Incorporated. All other trademarks are property of their respective owner. PP-ARIK-US-02299

Patient Authorization ma submitted enroll.inlightensupp

ARIKAYCE Prescription and *inLighten™ Patient Support* program Enrollment Form

Pg 3 of 4

ARIKAYCE (amikacin liposome inhalation suspension) Limited Population

inLighten Patient Support

Fax: 1-800-604-6027 or E-mail: enrollment@inlightensupport.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: 833-LIGHT-00 (833-544-4800) 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
☐ *Number 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 *inLighten Patient Support* program, and that the patient has given permission to be contacted by Insmed regarding the *inLighten Patient Support* program. I authorize the *inLighten 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

Please see Indication and Important Safety Information for ARIKAYCE, including Boxed Warning, on page 4.
Please see accompanying full Prescribing Information.
© 2024 Insmed Incorporated. All Rights Reserved. Insmed, ARIKAYCE, and inLighten are trademarks of Insmed Incorporated. All other trademarks are property of their respective owner. PP-ARIK-US-02299

ARIKAYCE®
(amikacin liposome inhalation suspension)
Limited Population

inLighten™ Patient Support

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.

inLighten 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.

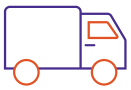
ARIKAYCE® (amikacin liposome inhalation suspension) Limited Population | inLighten™ Patient Support

Program enrollment

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

Payer access education

- A *Field Access Manager* (FAM)* is available to provide the most recent publicly available payer-specific information regarding
  - Payer approval process
  - Prior authorization (PA) and reauthorization requirements
  - Appeal process



Shipment coordination

- *inLighten Coordinator* and specialty pharmacy work with the patient to coordinate the shipment of medication

Device training

- An *inLighten Educator*† can provide voluntary in-home or virtual device training and dedicated support and education throughout your treatment journey

Ongoing patient support

- You'll receive ongoing support. Your *inLighten Coordinator* is available to help answer any questions you may have and can be reached at **833-LIGHT-00 (833-544-4800)** Monday – Friday, 8 AM – 8 PM Eastern Time

Insmed Therapeutic Specialist

inLighten Team

*The role of the *Field Access Manager* is informational only. They cannot fill out or submit any paperwork on behalf of the prescriber, or facilitate the prior authorization process in any way.

†It is not the role of the *inLighten Educator* to provide medical or treatment advice or replace the instructions you receive from your healthcare provider.

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 *inLighten Patient Support* program Enrollment Form

The *inLighten Patient Support* program Enrollment Form is the first step in prescribing ARIKAYCE and enrolling patients in *inLighten*. 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 *inLighten*).

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

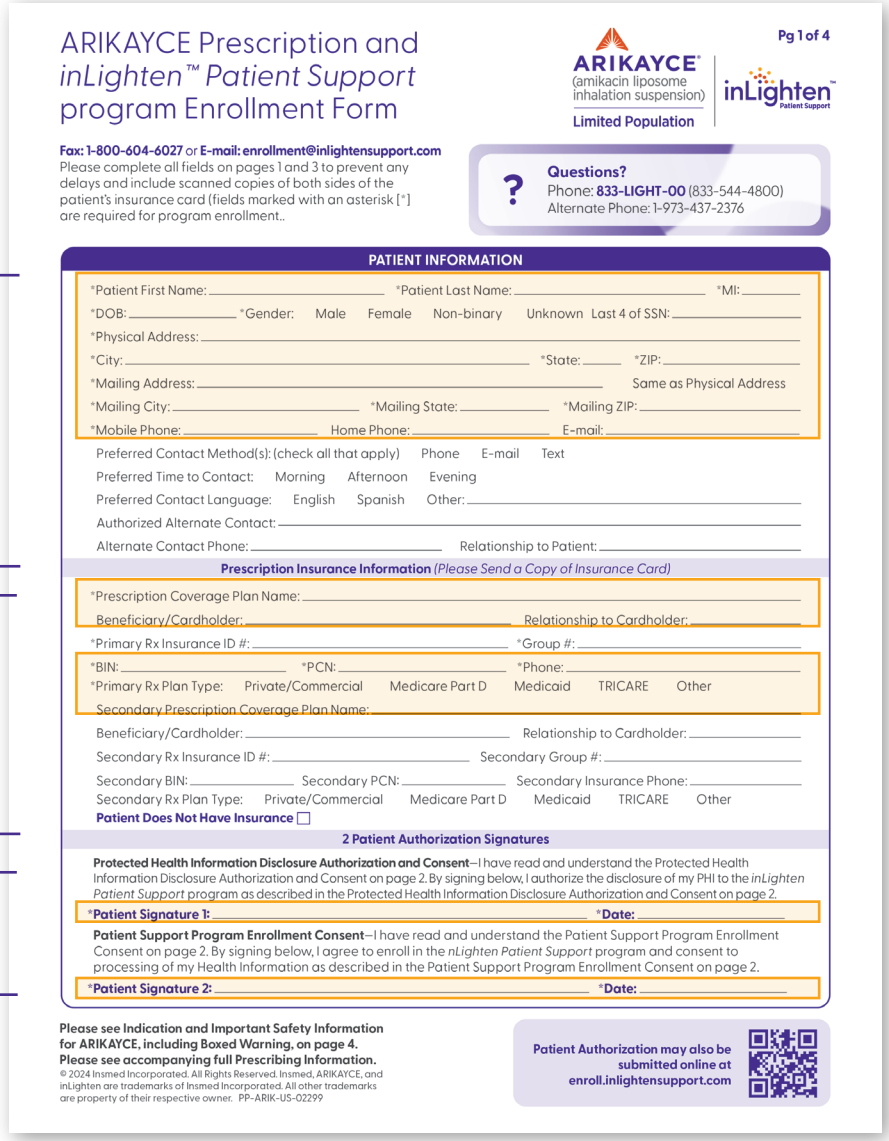
- Ensure patient demographic information is filled out completely

Prescription insurance information

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

Patient signature and date required for enrollment in *inLighten*

- 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 *inLighten™ Patient Support* program Enrollment Form

Pg 1 of 4

ARIKAYCE (amikacin liposome inhalation suspension) Limited Population | inLighten Patient Support

Fax: 1-800-604-6027 or E-mail: enrollment@inlightensupport.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 required for program enrollment..

Questions?
Phone: 833-LIGHT-00 (833-544-4800)
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
*Mailing City: _____ *Mailing State: _____ *Mailing 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 #: _____ Secondary Group #: _____
Secondary BIN: _____ Secondary PCN: _____ Secondary Insurance Phone: _____
Secondary Rx Plan Type: Private/Commercial Medicare Part D Medicaid TRICARE Other
Patient Does Not Have Insurance ☐

2 Patient Authorization Signatures

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 *inLighten Patient Support* program as described in the Protected Health Information Disclosure Authorization and Consent on page 2.
***Patient Signature 1:** _____ ***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 *nLighten 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 2:** _____ ***Date:** _____

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

Patient Authorization may also be submitted online at enroll.inlightensupport.com

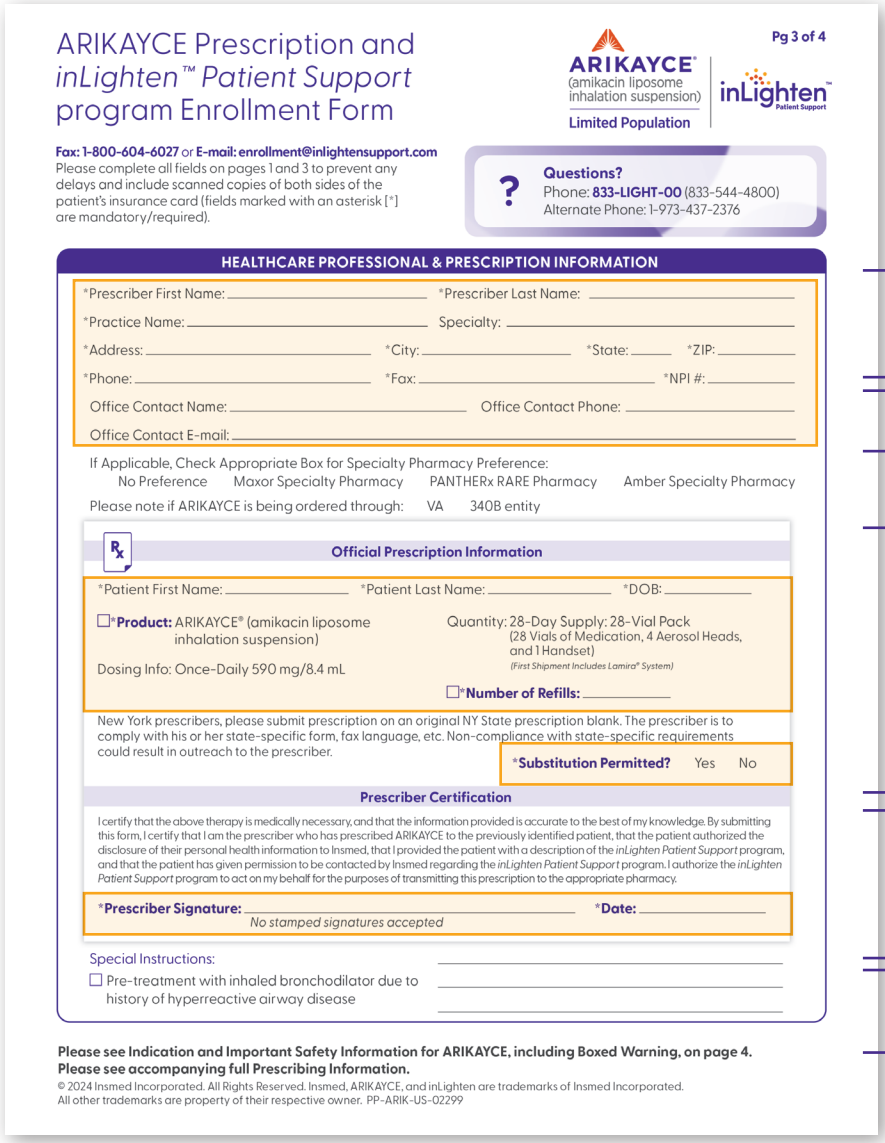
Patient Authorization may also be submitted online at enroll.inLightensupport.com

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

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.

ARIKAYCE® (amikacin liposome inhalation suspension)
Limited Population

inLighten™ Patient Support



ARIKAYCE Prescription and *inLighten™ Patient Support* program Enrollment Form

Pg 3 of 4

ARIKAYCE® (amikacin liposome inhalation suspension) Limited Population | inLighten™ Patient Support

Fax: 1-800-604-6027 or **E-mail: enrollment@inlightensupport.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: **833-LIGHT-00** (833-544-4800)
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)
Dosing Info: Once-Daily 590 mg/8.4 mL

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

☐ ***Number 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 *inLighten Patient Support* program, and that the patient has given permission to be contacted by Insmed regarding the *inLighten Patient Support* program. I authorize the *inLighten 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 _____

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

Prescribing physician contact information

- Please list accurate fax numbers for future communications

Office contact

- Staff member in your office who will communicate with an *inLighten 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.

ARIKAYCE®
(amikacin liposome
inhalation suspension)
Limited Population

inLighten™
Patient Support