Makana Health

Patient Enrollment Form

https://qr.md/merx

TO BE COMPLETED BY PATIENT

1. PATIENT INFORMATION

BOTH PATIENT AND PRESCRIBER SIGNATURES ARE REQUIRED TO AUTHORIZE THIS FORM.

First Name _____ Last Name _____

DOB (MM/DD/YYYY) _____ Male ☐ Female ☐

SSN _____ Email _____

Address _____

City _____ State _____ ZIP _____

Mobile Phone _____ Home Phone _____

Special Precautions (eg, allergies) _____

Caregiver _____

Relationship to Patient _____ Phone _____

By providing the names of my other Care Team Members on this form (healthcare providers other than the MAKANA prescribing physician), I am authorizing any employees of the Companies to follow up with these Care Team Members to provide education and information about MAKANA.

HCP Care Team Member* _____

Care Team Role _____ Phone _____

☐ **I would like to opt in to marketing communications.**

Patient Authorization

I have read, understand, and agree to the release of my protected health information, as described on Page 2, Section 6 of this form.

X _____ _____

Patient signature/legal representative signature (indicate relationship) Date

Makana Patient Support Program and Communications Enrollment

I have read, understand, and agree to the use of my personal information for the purposes described on Page 2, Section 7 of this form.

X _____ _____

Patient signature/legal representative signature (indicate relationship) Date

2. INSURANCE INFORMATION

REQUIRED: Include copies of both sides of the patient's medical and prescription insurance card(s) ☐ **Check if the patient does not have insurance**

Primary Insurance _____ Insurance Phone _____

Policy ID # _____ Group _____

Policy Holder Name (First Last) _____

DOB (MM/DD/YYYY) _____ Relationship to Patient _____

Secondary Insurance _____ Insurance Phone _____

Policy ID # _____ Group _____

Policy Holder Name (First Last) _____

DOB (MM/DD/YYYY) _____ Relationship to Patient _____

Pharmacy Plan _____ Policy ID # _____ Group # _____

Pharmacy Plan Name _____ Rx Bin # _____ Rx PCN # _____

TO BE COMPLETED BY OFFICE/PHYSICIAN

3. PRESCRIBING PHYSICIAN INFO

First Name _____ Last Name _____ NPI # _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Email _____

Title _____

State License Number _____

4. TREATMENT CENTER FACILITY INFO

Treatment Center Facility Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Email _____

Title at Facility _____

Office Loacation at Facility _____

5. PRESCRIPTION

The prescriber must comply with state-specific prescription requirements such as state-specific prescription form, e-prescribing, etc.

STEP 1: Select patient drug program (check one box below)

☐ zCARTA ☐ zPapyrus ☐ zCharta

STEP 2: Select drug delivery mechanism & dosage (check one box below)

☐ Prefilled syringe and pen
- ☐ 125 mg/mL ☐ 250 mg/mL ☐ 300 mg/mL

☐ Single-dose vial for intravenous infusion
- ☐ 300 mg/10 mL ☐ 550 mg/10 mL ☐ 700 mg/10 mL

☐ Single-dose prefilled cartridge with on-body injector
- ☐ 150 mg/1 mL ☐ 175 mg/1.5 mL ☐ 200 mg/2 mL
- ☐ 400 mg/4.0 mL ☐ 650 mg/5.5 mL

STEP 3: Choose # of kits needed

If dose is more than 300 mg/day, two 30-vial kits are recommended†

- ☐ **One (1) 30-Vial Kit** / NDC # 1234-123-12
- ☐ **Two (2) 30-Vial Kits** / NDC # 2345-234-23
- ☐ **One (1) Prefilled syringe and pen** / NDC # 5234-123-12
- ☐ **Two (2) Prefilled syringe and pen** / NDC # 5345-234-23
- ☐ **One (1) prefilled cartridge w/ on-body injector** / NDC # 6234-123-12
- ☐ **Two (2) prefilled cartridge w/ on-body injector** / NDC # 6345-234-23

By signing this form, I certify that therapy with MAKANA (a fictious company) is medically necessary for the patient identified in this application ("Patient", a fictious patient). I (a fictious provider/prescriber) have reviewed the current MAKANA (a fictious company) Prescribing Information and will be supervising Patient's treatment. I have received from Patient, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state law regulations, referenced medical and/or other patient information relating to MAKANA therapy to MAKANA Pharmaceuticals Inc., including its agents or contractors (the "Company"), for the purpose of seeking information related to coverage and/or assisting in initiating or continuing MAKANA therapy.

X _____ _____

Prescriber Signature (Stamps not acceptable; dispense as written) Date