VYEPTI CONNECT® ENROLLMENT FORM

Complete all required (*) fields, sign where indicated, and fax to VYEPTI CONNECT at 866-868-7071.
For questions, call 833-4-VYEPTI (833-489-3784), Monday - Friday, 8 AM - 8 PM ET.

vyepti connect®

vyepti® (eptinezumab-jjmr) 100 mg/mL Injection for IV

Patient and Prescriber Information

PATIENT INFORMATION DOB (MM/DD/YYYY)* _____ Sex ◯ M ◯ F

First Name* _____ MI _____

Last Name* _____

Address* _____

City* _____ State* _____ ZIP* _____

Preferred Phone Number _____ ◯ Cell ◯ Home

Alternate Phone Number _____ ◯ Cell ◯ Home

Email _____

Alternate Contact Name _____

Relationship to Patient _____

Alternate Contact Phone _____

PRESCRIBER INFORMATION

First Name* _____ Last Name* _____

Specialty _____ NPI* _____

PTAN _____ Tax ID* _____

Office Name* _____

Office Address* _____

City* _____ State* _____ ZIP* _____

Office Contact Name _____ Title _____

Phone* _____ Fax* _____

Email _____

Preferred Method of Contact ◯ Phone ◯ Fax ◯ Both
(Note: If no option is selected, will default to both. Updates can be made anytime by calling VYEPTI CONNECT)

Insurance Information

Please include front and back copy of insurance card(s) along with this form. If copies of insurance cards are provided, the fields below are not required.

◯ Patient Does Not Have Insurance. (If this is selected, insurance information should be left blank.)

MEDICAL INSURANCE

Primary Insurance* _____ Phone* _____

Member ID* _____ Group ID* _____

Policy Holder Full Name _____

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

Secondary Insurance _____ Phone _____

Member ID _____ Group ID _____

Policy Holder Full Name _____

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

PHARMACY INSURANCE

Insurance Name _____ Policy ID _____ Group ID _____ Rx BIN _____ Rx PCN _____

Infusion Provider

Select Site of Infusion*: ◯ Physician Office ◯ Home Infusion ◯ Infusion Center ◯ Hospital Outpatient

Please complete below, if infusion provider is not the same as the prescriber address information above.

Infusion Provider Name* _____

Address* _____ City* _____ State* _____ ZIP* _____

Contact Name* _____ Phone* _____ Fax* _____ Tax ID* _____

If Rx is included below, it will be sent to the indicated infusion provider.

Clinical

Please fax all clinical documentation and labs to VYEPTI CONNECT for inclusion with the prescription when sending to the dispensing pharmacy or infusion provider.

VYEPTI Dosage*: ◯ 100 mg ◯ 300 mg ◯ Other_____

Primary Diagnosis (ICD-10 Code)* _____ Patient Is New to VYEPTI ◯ Yes ◯ No Date Migraines Started _____

Headache Days Per Month _____ Date of Last Treatment _____ Anticipated Infusion Date _____

Allergies _____

Previous Migraine Medication _____

Prescription

℞ **COMPLETING THE PRESCRIPTION IS ONLY REQUIRED WHEN SENDING TO SPECIALTY PHARMACY OR INFUSION PROVIDER LISTED ABOVE.**

Rx*: ◯ VYEPTI 100 mg/mL Single-Use Vial

Quantity (Vials)* _____ Refills* _____

SIG: Infuse* _____mg over ~30 min once every 3 months.

Please attach a separate prescription if this does not comply with your state's prescription laws.

ADMINISTRATION AND NURSING ORDERS (Select all that may apply.)

◯ **Infusion Instructions:** Withdraw 1 mL of VYEPTI (for 100 mg dose) or 3 mLs (for 300 mg dose) using a sterile needle and syringe and inject into a 100 mL bag of 0.9% Sodium chloride injection, USP. Gently invert the VYEPTI solution to mix completely. Infuse over ~30 minutes. After infusion is complete, flush the line with 20 mL of 0.9% Sodium Chloride Injection, USP.

◯ **Skilled Nursing Visit:** As needed for IV access, administration, and clinical monitoring.

◯ **Supplies:** Provide necessary infusion and flush supplies, such as needles, tubing, etc. Please refer to section 2 of the PI for full instructions.

If using **specialty pharmacy**, indicate preference ◯ Orsini Healthcare ◯ AllianceRx Walgreens Prime

◯ Rx has already been provided to specialty pharmacy or the Infusion Provider listed above.

Prescriber's Signature* (Sign either box **A** or **B** below.) (Physician attests that this is his/her legal signature. **NO STAMPS**.)

A. Dispense as written _____ Date

B. Generic substitution permitted _____ Date

I elect to **OPT-IN** to the following VYEPTI CONNECT options (choose all that apply):

◯ Final Coverage Status (including PA/Appeal Info) ◯ Upcoming Infusion Reminders ◯ Apply these choices for all of the patients I enroll in VYEPTI CONNECT

PRESCRIBER CERTIFICATION AND AUTHORIZATION (Signature and Date Required)

I certify that I have obtained authorization from the patient named above to release their protected health information to Lundbeck LLC and its affiliates, agents and service providers ("Lundbeck"), so Lundbeck may use it to provide patient support through the VYEPTI program(s) indicated on this form ("Programs"), and for the purposes described in the Patient Authorization on page 2 of this form. I certify that the information contained in this form is complete and accurate to the best of my knowledge and I will notify VYEPTI CONNECT if I learn of any updates to the patient's insurance. I have obtained the patient's authorization for Lundbeck to contact the patient regarding the Patient Authorization section on page 2 of this form. Lundbeck may contact me, including via email, fax, and telephone, to seek additional information relating to the Programs, VYEPTI, or the information contained on this form.

I certify that VYEPTI is medically necessary for the patient above, and if completed, I authorize or have obtained authorization for Lundbeck to send the prescription above and all information on this form to the dispensing pharmacy or infusion provider on this form or later selected by the patient or based on the patient's insurance.

SIGN Prescriber Name (Print)* _____ Prescriber Signature* _____ Date* _____

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PATIENT TO COMPLETE ALL REQUIRED FIELDS AND SIGN

Patient Authorization for Use and Disclosure of Personal Health Information
(Signature and Date Required)

By signing below, I authorize my healthcare providers (including pharmacies and infusion providers) and health plans (together, my "Health Team") to disclose my personal health information relevant to my treatment or potential treatment with VYEPTI® (eptinezumab-jjmr), including my contact and other information provided on this enrollment form (my "Information"), to Lundbeck LLC and its affiliates, agents, representatives, and service providers (collectively, "Lundbeck"), so that Lundbeck can determine if I am eligible for the VYEPTI Program(s) I am seeking to participate in (collectively, the "Programs"), enroll me in the Programs if I am eligible, and undertake the activities listed below that involve the use and disclosure of my Information.

I authorize Lundbeck to share my Information with my Health Team to communicate about benefit and coverage status, medical care, and payments for my treatment with VYEPTI and to use and disclose my information as needed to: (1) administer the Programs; (2) provide me with patient support, including facilitating the provision of VYEPTI to me; (3) provide me with informational and promotional materials relating to Lundbeck products and/or my condition or treatment; (4) contact me for Program or research purposes or to provide information about Lundbeck products and services, including by phone, email and/or text message following my preferences indicated on this form, and including through messages that disclose that I take or may take VYEPTI; and (5) allow Lundbeck to analyze the usage patterns and the effectiveness of Lundbeck products, support, and programs and help develop new products, support, and programs, and for other Lundbeck general business and administrative purposes. I understand that Lundbeck may compensate my pharmacy providers for communicating with me about the benefits of Lundbeck products or services, and/or disclosing PHI pursuant to this authorization. I authorize my pharmacy providers to make such communications.

I understand that I am not required to sign this Authorization in order to receive healthcare benefits or treatment, including with Lundbeck products. I also understand that once my Information has been disclosed to Lundbeck, federal privacy laws may no longer restrict its disclosure and it might legally be redisclosed to others.

I understand that I may cancel this authorization at any time by sending a written cancellation notice to 2250 Perimeter Park Drive, Suite 300, Morrisville, North Carolina 27560, attention, Privacy Office. I understand that if I were to cancel the authorization, it would be invalid for further uses and disclosures of my Information, but that my cancellation would not invalidate any uses and disclosures of my Information made prior to the Program's receipt of my notice of withdrawal. I understand that if I do not cancel this authorization, the authorization will expire ten years from the date of signature (or the maximum period allowed by applicable state law, if less than ten years). I understand that I am entitled to receive a copy of this authorization once it has been signed.

PRINT PATIENT NAME*: _____

PATIENT CELL PHONE: _____ **OK TO TEXT:** ○ Yes ○ No

PATIENT EMAIL: _____

SIGN **PATIENT SIGNATURE*:** _____ **DATE*:** _____

IF UTILIZING A PERSONAL REPRESENTATIVE, THE FOLLOWING FIELDS WILL BE REQUIRED INSTEAD OF PATIENT SIGNATURE:

PRINT PERSONAL REPRESENTATIVE (AUTHORIZED TO SIGN FOR PATIENT)*: _____

SIGN **PERSONAL REPRESENTATIVE SIGNATURE*:** _____ **DATE*:** _____

RELATIONSHIP TO PATIENT*: ○ Parent ○ Spouse ○ Power of Attorney ○ Other _____

vyepti® GO

Nursing Support (Included with VYEPTI CONNECT)

Once enrolled in VYEPTI CONNECT, eligible patients will automatically be enrolled to receive VYEPTI GO® nursing support that includes helpful information and resources to help you stay on track while you are taking VYEPTI.

- Registered nurses to help you better understand migraine including education on infusions and VYEPTI
- Text and email communications including appointment reminders (using the contact information and preferences on this form)

○ I prefer not to receive nursing support from VYEPTI GO.

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PATIENT TO COMPLETE THIS PAGE AND SIGN

Commercially Insured Patients Can Enroll Today for VYEPTI CONNECT Copay Assistance

Financial assistance is available for eligible commercially insured patients through the VYEPTI CONNECT Copay Assistance Program. Eligible commercially insured patients may pay as little as $5 for VYEPTI® (eptinezumab-jjmr) every 3 months. Patients are responsible for administration costs; a maximum annual benefit limit and other restrictions may apply. Please see Terms and Conditions below for full details.

To enroll in the VYEPTI CONNECT Copay Assistance Program: 1. Answer the following five questions; 2. Review the Terms and Conditions; 3. Check the authorization button; 4. Sign and date below.

ANSWER

○ YES ○ NO	Has your doctor prescribed VYEPTI for you?
○ YES ○ NO	Are you 17 years of age or older?
○ YES ○ NO	Are you enrolled in a health plan where the federal or state government could pay anything for your prescription, either all of it or part of it? Examples of government programs that pay for medication are Medicare or Medicaid, Medigap, VA, DOD, or TRICARE.
○ YES ○ NO	Are you Medicare-eligible and enrolled in an employer-sponsored retiree health plan or prescription drug benefit program?
○ YES ○ NO	Are you self-pay, meaning you pay the entire cost of the prescription out of your own pocket without any assistance from your insurance plan?

CHECK

○ I have read and agree to the complete Terms and Conditions for the VYEPTI CONNECT Copay Assistance Program ("Program") below. I authorize the Program to provide payment directly to my healthcare provider, and not to me, for my out-of-pocket drug costs for VYEPTI. I authorize my healthcare provider to contact the Program on my behalf to initiate payment for VYEPTI after my infusion has taken place. I understand that I will be responsible for any out-of-pocket expenses for VYEPTI if (1) my healthcare provider does not request payment within 120 days of my date of service, or (2) if the Program determines that I am not eligible to receive copay assistance through the Program. I understand that by participating in the Program, I authorize Lundbeck LLC and its affiliates, agents, representatives, and service providers (together "Lundbeck") to use, disclose, and/or transfer my personal information in order to administer the Program, including contacting me by email, mail, or telephone to request or provide further information about the Program; evaluate the effectiveness of the Program; and provide resources and information related to VYEPTI. If my insurance changes, including becoming eligible to participate in any federal healthcare program such as Medicare or Medicaid, I will call VYEPTI CONNECT so my eligibility can be re-evaluated.

SIGN

PATIENT/AUTHORIZED CONTACT SIGNATURE: _____ **DATE:** _____

Please make sure that you've reviewed and checked the button above.

Terms and Conditions for the VYEPTI CONNECT® Copay Assistance Program (the "Program")

Terms and Conditions: Only commercially insured patients age 17 years and older whose insurance policy provides coverage for VYEPTI® (eptinezumab-jjmr) and whose insurance company does not pay for the entire cost of their prescription, are eligible for copay assistance (the "Offer"). Patients are not eligible for the Offer:

(1) If they are self-pay, meaning the patient pays the entire cost of the prescription out of their own pocket; or

(2) If the patient is enrolled in a health plan in which the federal or state government could pay for their prescription, either all of it or part of it; examples of government programs that pay for medication are Medicare or Medicaid, Medigap, VA, DOD, or TRICARE; or

(3) If they are Medicare-eligible and enrolled in an employer-sponsored retiree health plan or prescription drug benefit program.

The Offer is valid for use only with a valid prescription for VYEPTI at the time the prescription is filled by the pharmacist, or at the time the healthcare provider (or "HCP") administers VYEPTI to the patient. The Offer applies only to prescriptions filled before the Program expires or terminates. The Offer applies to the cost of the product only; any administration costs (e.g., cost of IV infusion) or other fees are the responsibility of the patient. The patient or patient's HCP shall not submit any prescription copays for payment to any public third-party payer, including Medicaid or Medicare, or to any other similar federal or state healthcare program. Patients are responsible for complying with any obligations or requirements imposed by their commercial insurance plans.

The Offer is for the eligible patient and is not transferable to any other person. The selling, purchasing, trading, or counterfeiting of the Offer is prohibited by law. The Offer has no cash value and may not be used in combination with any other discount, coupon, rebate, free trial, or similar offer for the specified VYEPTI prescription.

Lundbeck reserves the right to rescind, revoke, terminate, or amend the Offer at any time without notice. The Offer is intended to comply with all applicable laws and regulations including, without limitation, the federal Anti-Kickback Statute, its implementing regulations, and related guidance interpreting the federal Anti-Kickback Statute. The Offer is not health insurance. The Offer is valid only in the USA where allowed by law. There is no product purchase requirement associated with the Offer. Patients can discontinue participation in the Program at any time and their questions and requests can be directed to 833-4-VYEPTI (833-489-3784) Monday through Friday, 8 AM - 8 PM ET.

Eligible commercially insured patients age 17 years and older with a valid VYEPTI prescription who participate in this Program must pay at least $5 for each VYEPTI treatment. Copay assistance is subject to a per patient maximum benefit of $4,000 per calendar year (the "Cap") for out-of-pocket expenses for VYEPTI, including copays or coinsurances. If the patient's total out-of-pocket bill exceeds the Cap established by Lundbeck, the patient will be responsible for the additional balance. Patients should confirm their out-of-pocket cost with their pharmacy, or with their HCP, prior to treatment.

The Offer will automatically renew each calendar year. If the patient no longer wishes to participate in the Offer, he/she can call and cancel at any time. By participating in the VYEPTI CONNECT Copay Assistance Program, the patient acknowledges and agrees that he/she is eligible to participate pursuant to the rules stated in these VYEPTI CONNECT Copay Assistance Program Terms and Conditions and that he/she understands and agrees to comply with these VYEPTI CONNECT Copay Assistance Program Terms and Conditions.

Please see the Important Safety Information on page 4. For more information, talk with your healthcare provider, and see the Full Prescribing Information and Patient Information, or go to vyepti.com.

INDICATION

VYEPTI® is indicated for the preventive treatment of migraine in adults.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

VYEPTI is contraindicated in patients with serious hypersensitivity to eptinezumab-jjmr or to any of the excipients. Reactions have included anaphylaxis and angioedema.

WARNINGS AND PRECAUTIONS

Hypersensitivity reactions: Hypersensitivity reactions, including angioedema, urticaria, facial flushing, and rash, have occurred with VYEPTI in clinical trials. Most hypersensitivity reactions occurred during infusion and were not serious, but often led to discontinuation or required treatment. Serious hypersensitivity reactions may occur. Cases of anaphylaxis have been reported in the postmarketing setting. If a hypersensitivity reaction occurs, consider discontinuing VYEPTI, and institute appropriate therapy.

ADVERSE REACTIONS

The most common adverse reactions (≥2% and at least 2% or greater than placebo) in the clinical trials for the preventive treatment of migraine were nasopharyngitis and hypersensitivity.

Please see the accompanying Full Prescribing Information, including Patient Information, or go to vyeptihcp.com.