PATIENT ENROLLMENT FORM

Fax completed form to Vertex at (888) 952-5933 | Phone: (877) 752-5933

PATIENT INFORMATION

*First Name: _____ Middle Initial: _____ *Last Name: _____

*Date of Birth (mm/dd/yyyy): _____ Preferred Name and/or Pronouns: _____

For Insurance Verification Purposes: Last 4 digits of SSN: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ *State: _____ ZIP Code: _____

Check Preferred: ☐ Mobile: _____ ☐ Home: _____ OK to Leave Messages? ☐ YES ☐ NO

E-mail: _____ Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

PRIMARY CAREGIVER, LEGAL GUARDIAN OR ADDITIONAL CONTACT

☐ Primary Caregiver ☐ Legal Guardian ☐ Additional Contact Check all that apply.

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name and/or Pronouns: _____ Relationship to Patient: _____

Phone: _____ E-mail: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

INSURANCE INFORMATION *This section is not required if you attached a face sheet or copies of the insurance and prescription cards.*

Prescription Drug Insurance: _____ Rx ID#: _____ Rx Group#: _____

Rx BIN#: _____ Rx PCN#: _____ Phone: _____ Employer Name: _____

Primary Medical Insurance: _____ Phone: _____ Policyholder: _____

ID#: _____ Group#: _____ Policyholder Relationship to Patient: _____

Secondary Insurance: _____ Phone: _____ Policyholder: _____

ID#: _____ Group#: _____ Policyholder Relationship to Patient: _____

Additional Information

Is the patient enrolled in a government-funded healthcare program such as Medicare, Medicaid, VA, DoD, or TRICARE®, a qualified health plan (QHP), or a plan offered on a state or federal marketplace or exchange? ☐ YES ☐ NO

CENTER INFORMATION

Center Name: _____ Center Phone: _____ Center Fax: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Primary Center Contact/Title: _____ Phone: _____ E-mail: _____

*Required field

VERTEX GPS™ GUIDANCE & PATIENT SUPPORT

PATIENT ENROLLMENT FORM

Fax completed form to Vertex at (888) 952-5933 | Phone: (877) 752-5933

*Patient Name: _____ *Date of Birth: _____ (mm/dd/yy)

Patient's Preferred Pharmacy (if any):

- ☐ AcariaHealth, Inc./Foundation Care, LLC
- ☐ Accredo Health Group, Inc.
- ☐ AllianceRx Walgreens Pharmacy
- ☐ Fairview Pharmacy Services, LLC
- ☐ Maxor Specialty Pharmacy
- ☐ Optum Specialty Pharmacy

Prescription already sent: ☐ YES ☐ NO

Please include a face sheet or copies of the insurance and prescription cards.

*CLINICAL INFORMATION AND PRESCRIBER AUTHORIZATION

***Specify the patient's indicated mutation(s):** Mutation 1: _____ Mutation 2: _____

trikafta® (elexacaftor/tezacaftor/ivacaftor and ivacaftor)

- ☐ **TWO tablets (elexacaftor 50 mg/tezacaftor 25 mg/ivacaftor 37.5 mg)** in the morning with fat-containing food
  ONE tablet (ivacaftor 75 mg) in the evening with fat-containing food, approximately 12 hours after morning dose
- ☐ **TWO tablets (elexacaftor 100 mg/tezacaftor 50 mg/ivacaftor 75 mg)** in the morning with fat-containing food
  ONE tablet (ivacaftor 150 mg) in the evening with fat-containing food, approximately 12 hours after morning dose

☐ **28-day supply**
☐ **84-day supply**

symdeko® (tezacaftor/ivacaftor and ivacaftor)

- ☐ **ONE tablet (tezacaftor 50 mg/ivacaftor 75 mg)** in the morning with fat-containing food
  ONE tablet (ivacaftor 75 mg) in the evening with fat-containing food, approximately 12 hours after morning dose
- ☐ **ONE tablet (tezacaftor 100 mg/ivacaftor 150 mg)** in the morning with fat-containing food
  ONE tablet (ivacaftor 150 mg) in the evening with fat-containing food, approximately 12 hours after morning dose

☐ **28-day supply**
☐ **84-day supply**

ORKAMBI® (lumacaftor/ivacaftor)

- ☐ **ONE oral granules packet (75 mg/94 mg)**
- ☐ **ONE oral granules packet (100 mg/125 mg)**
- ☐ **ONE oral granules packet (150 mg/188 mg)**

Every 12 hours mixed with 1 tsp (5 mL) of soft food or liquid and fat-containing food

- ☐ **TWO tablets (100 mg/125 mg)**
- ☐ **TWO tablets (200 mg/125 mg)**

Every 12 hours with fat-containing food

☐ **28-day supply**
☐ **84-day supply**

kalydeco® (ivacaftor)

- ☐ **ONE oral granules packet (25 mg)**
- ☐ **ONE oral granules packet (50 mg)**
- ☐ **ONE oral granules packet (75 mg)**

Every 12 hours mixed with 1 tsp (5 mL) of soft food or liquid and fat-containing food

- ☐ **ONE tablet (150 mg)**

Every 12 hours with fat-containing food

☐ **28-day supply**
☐ **84-day supply**

☐ Refills: _____ ☐ Dispense as written

Special instructions: _____

Has the patient previously taken this medicine? ☐ YES ☐ NO ☐ UNKNOWN

By signing below, I certify that (1) the Vertex Pharmaceuticals Incorporated ("Vertex") therapy I prescribe is medically necessary and is in the best interest of the patient listed above; (2) I have any consent required under federal and state law for the release of the patient's information on this form to Vertex and its contractors and business partners ("Contractors") for benefits verification and coordination of dispensing Vertex medicine; (3) I will comply with state-specific prescription requirements and understand non-compliance with these requirements could result in further outreach by the patient's specialty pharmacy; (4) I understand that information I provide on this form, if signed by the patient, will be used by Vertex and its Contractors as authorized by the patient. I authorize Vertex to forward the above prescription to the applicable pharmacy.

Prescriber Signature & Date (no stamp allowed):

*Signature _____ *Signature Date _____

*Prescriber First Name: _____ *Prescriber Last Name: _____ NPI#: _____

*Required field

PATIENT ENROLLMENT FORM

Fax completed form to Vertex at (888) 952-5933 | Phone: (877) 752-5933

Vertex Guidance and Patient Support program ("Vertex GPS"™) provides product support to appropriate patients who have been prescribed a Vertex medicine. This includes: (1) reimbursement and financial support (such as investigating your insurance coverage, confirming out-of-pocket costs, and reviewing eligibility for financial assistance); (2) working with you and your pharmacy to fill your prescription; and (3) providing you with disease, medication, and adherence-related educational resources and communications ("GPS Support").

*Patient Name: _____ *Date of Birth: _____ (mm/dd/yy)

PRIVACY AUTHORIZATION

By signing below, I authorize my healthcare providers and staff, my health plan, and my pharmacy to use my medical information (such as information about my diagnosis and treatment) and insurance information (my "Information") and disclose my Information to Vertex Pharmaceuticals Incorporated (including Vertex GPS) and its affiliates ("Vertex"), as well as its contractors and business partners ("Contractors"), to enroll me in Vertex GPS, provide the GPS Support, administer the Vertex GPS program, and conduct business activities with my de-identified information as described below under "Enrollment into GPS."

I understand that once my Information is disclosed, my Information may no longer be protected by federal privacy laws and could be re-disclosed; however, Vertex and its Contractors will only use and disclose my Information as described in this form. I understand that my pharmacy will receive payment from Vertex for disclosing my Information to Vertex. I understand that I can refuse to sign this Authorization and that this will not affect my treatment, insurance coverage, or eligibility for benefits or Vertex products. However, if I do not sign this Authorization, I will not be able to receive GPS Support. I understand that I may cancel this Authorization at any time by mailing a letter requesting cancellation to Vertex GPS, 50 Northern Avenue, Boston, MA 02210. I understand my cancellation will not apply to any Information already used or disclosed by my healthcare providers and staff, health plan, or pharmacy based on this Authorization prior to their receipt of the cancellation. This Authorization expires ten (10) years from the date signed below, or as otherwise required by state or local law, unless I cancel it before then. I understand that I am entitled to a signed copy of this Authorization.

*Patient or Legal Guardian Signature: _____ *Relationship to Patient: _____ *Signature Date: _____ (mm/dd/yy)

ENROLLMENT INTO GPS

By signing below, I confirm I would like to enroll in Vertex GPS and authorize Vertex and its Contractors to provide me with the GPS Support. I understand that Vertex GPS is an optional program. I agree that Vertex and its Contractors may use my Information and share it with each other, my healthcare providers and staff, my health plan, my pharmacy, and patient assistance programs in connection with providing the GPS Support, administering the Vertex GPS program, or as otherwise required for Vertex to meet its legal obligations. For example, Vertex and its Contractors may communicate with me (such as by mail, phone, e-mail, and text message†), use my Information to tailor GPS Program-related communications to my needs, and share information with my healthcare providers about dispensing my Vertex medicine to me. I authorize Vertex and its Contractors to send text messages to the phone number(s) I provide. I understand this consent is not a condition of participating in Vertex GPS or purchasing anything from Vertex. I may revoke this authorization and choose not to receive automated calls and text messages by replying STOP to any such text from Vertex or by contacting Vertex in writing at the address above. I understand Vertex and its Contractors may de-identify my Information, combine it with information about other patients, and use the resulting information for Vertex's business purposes.

By signing below, I acknowledge that if I am enrolled in a government-funded healthcare program, I am not eligible for and will not accept any co-pay assistance from Vertex. I understand and agree that if my insurance information changes at any time while I am participating in the GPS Program, I will notify Vertex as soon as possible, and any such change may affect my eligibility for such assistance programs.

For California Residents: By signing below, I acknowledge that I have reviewed and understand Vertex's Privacy Notice, available at: www.vrtx.com/english-privacy-us-residents/#5.

We greatly appreciate your feedback. Please indicate whether you would like to be contacted by Vertex and its Contractors about opportunities for you to provide feedback to us (such as program feedback surveys or market research): ☐ YES ☐ NO

*Patient or Legal Guardian Signature: _____ *Signature Date: _____ (mm/dd/yy)

Please specify any additional contacts with whom Vertex GPS is allowed to discuss your information in addition to the Primary Contact listed on page 1 of this form:

Additional Contact Name: _____ **Relationship to Patient:** _____

†Additional charges may apply. I understand that my telephone provider may charge me fees for calls or texts I receive and I agree that Vertex will not pay those fees.

*Required field

We're With You Along the Way

At Vertex GPS™: Guidance & Patient Support, our focus is to provide you with ongoing, one-on-one support right from the start of your Vertex treatment.

See what Vertex GPS has to offer at **VertexGPS.com**.

We look forward to speaking with you

With Vertex GPS, your dedicated Patient Support Specialist is with you along the way. Once your enrollment form is submitted, you can expect a call from your specialist to welcome you to the program and walk you through the next steps.

Your specialist will be calling from **1-877-752-5933**.

Get personalized support from the day you enroll in Vertex GPS

Your Patient Support Specialist is here to help by:

Verifying insurance coverage

Coordinating coverage with your healthcare provider

Providing financial assistance information

Coordinating your first shipment

Ongoing support: Your specialist will continue to provide support while you are taking your Vertex medicine by offering educational tools, refill reminders, and other helpful resources. They will check in with calls, texts, and e-mails along the way.

The Vertex GPS Connect app

Download the app to see the status of your Vertex product shipments, from prescription to delivery. You can also manage medicine refills and chat with your Patient Support Specialist. **Use your camera to scan the QR code below and download the app.**

Download on the App Store

GET IT ON Google Play

Our Patient Support Specialists are just a phone call away. To speak with a specialist, call or text **1-877-752-5933** (press 2 when calling), Monday through Friday, from 8:30 AM to 7 PM ET.