# 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: _____ 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

Email: _____ 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: _____ Pronouns: _____ Relationship to Patient: _____

Phone: _____ Email: _____

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: _____ Email: _____

*Required field

VERTEX GPS™ GUIDANCE & PATIENT SUPPORT

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

**Patient's Pharmacy** (if any):

☐ AcariaHealth, Inc./Foundation Care, LLC
☐ Accredo Health Group, Inc.
☐ AllianceRx Walgreens Pharmacy
☐ Fairview Specialty Pharmacy
☐ 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)

☐ **ONE oral granules packet (elexacaftor 80 mg/tezacaftor 40 mg/ivacaftor 60 mg)** in the morning mixed with 1 tsp (5 mL) of soft food or liquid and with fat-containing food
**ONE oral granules packet (ivacaftor 59.5 mg)** in the evening mixed with 1 tsp (5 mL) of soft food or liquid and with fat-containing food, approximately 12 hours after morning dose

☐ **ONE oral granules packet (elexacaftor 100 mg/tezacaftor 50 mg/ivacaftor 75 mg)** in the morning mixed with 1 tsp (5 mL) of soft food or liquid and with fat-containing food
**ONE oral granules packet (ivacaftor 75 mg)** in the evening mixed with 1 tsp (5 mL) of soft food or liquid and with fat-containing food, approximately 12 hours after morning dose

☐ **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

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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/yyyy)

## 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/yyyy)

## 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 or updating 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, email, and text message†), request feedback or participation in market research, 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.

**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.

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

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

VERTEX GPS™
GUIDANCE & PATIENT SUPPORT

Information for Patients

# WE'RE HERE TO HELP YOU GET THERE

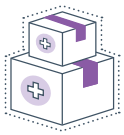
Vertex GPS™: Guidance & Patient Support offers personalized, one-on-one support to help you start and stay on track with your Vertex treatment. Once you're enrolled, you'll be assigned a dedicated GPS Support Specialist who will be with you every step of the way.

## Here are just some of the ways your Support Specialist can help:

**Get you started on treatment** by verifying your coverage and out-of-pocket costs with your insurance company. Your Support Specialist will also connect with your healthcare provider to discuss any requirements or questions your insurance company may have while determining coverage.

**Help you explore financial assistance options**. And if you have commercial insurance, the Vertex GPS Co-pay Assistance Program may be able to lower your co-pay to as little as $0 per fill.*

*Limitations apply. Annual assistance is limited to a maximum of $20,000. Not available to individuals with government-funded insurance such as Medicaid, Medicare, and TRICARE®. Vertex reserves the right to rescind, revoke, or amend this assistance program at any time.



**Keep you on track with your treatment** by coordinating shipments with your specialty pharmacy and reminding you when it's time to refill your Vertex medicine. And if your daily routine changes, your Support Specialist can help you pre-plan refills, ship your medicine to a new address, and share tips to help you stay motivated.

**Meet your everyday needs** with information on nutrition and tips for staying physically active and maintaining a healthy mindset. And if you're caring for someone on a Vertex medicine, your Support Specialist can send educational resources to help you teach your loved one about the importance of their daily treatment routine.

**Plan for what's ahead** as you approach big life changes. Your Support Specialist can help you prepare for your next chapter and give you tips on staying on track with your Vertex treatment. They can also share experiences from others in this community.

Vertex GPS is just a phone call away. To speak with us, call or text **1-877-752-5933 (press 2 when calling)**, Monday through Friday, from 8:30 AM to 7 PM ET.

**Discover more about GPS and the support resources available at VertexGPS.com.**