May 2017

VERTEX GPS™
GUIDANCE & PATIENT SUPPORT

# PATIENT ENROLLMENT FORM

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

## PATIENT INFORMATION

First Name: _____

Last Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Date of Birth (mm/dd/yy): _____ Gender: ☐ Male ☐ Female

Last 4 Digits of SSN (for insurance verification purposes): _____

Primary Contact (if different than the patient): _____

Relationship to Patient: _____

Contact me by: (check primary phone number)

Phone: ☐ Mobile: _____ ☐ Home: _____

☐ Work: _____ OK to leave messages? ☐ Yes ☐ No

E-mail: _____

Patient's Preferred Pharmacy: (if any) ☐ Accredo Health Group, Inc.
☐ BriovaRx ☐ CVS Specialty Pharmacy* ☐ Cystic Fibrosis Services (CFS), Inc.
☐ Diplomat Pharmacy, Inc. ☐ Fairview Pharmacy Services, LLC ☐ Foundation Care, LLC
☐ Kroger Specialty Pharmacy ☐ Maxor Specialty/IV Solutions/Pharmaceutical Specialties (PSI)
☐ Walgreens Specialty Pharmacy

*As of August 1, 2017, CVS Specialty Pharmacy will no longer be in the Vertex Specialty Pharmacy Network.

## INSURANCE INFORMATION

**Please include a copy of both the Prescription and Medical insurance cards (both sides of cards).**

**Primary Insurance:** _____

ID#: _____ Group#: _____

Phone: _____ Policyholder: _____

Relationship to Patient: _____

**Secondary Insurance:** _____

ID#: _____ Group#: _____

Phone: _____ Policyholder: _____

Relationship to Patient: _____

**Prescription Drug Insurance:** _____

BIN#: _____

ID#: _____ Group#: _____

Phone: _____ Employer Name: _____

**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

## PRESCRIBER INFORMATION

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

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

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

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

## CLINICAL INFORMATION AND PRESCRIBER AUTHORIZATION

**1) Does the patient have the indicated mutation for ORKAMBI?** ☐ YES ☐ NO

ORKAMBI® (lumacaftor/ivacaftor) 200 mg • 125 mg + 100 mg • 125 mg tablets

**2) Select Prescribed Dose:**

☐ **Two TABLETS (100 mg/125 mg)** po q12h with fat-containing food

☐ **Two TABLETS (200 mg/125 mg)** po q12h with fat-containing food

**3) Select Days Supply:**

☐ **112 TABLETS (28-day supply)** ☐ **336 TABLETS (84-day supply)**

**1) Specify the patient's indicated mutation for KALYDECO:** _____

kalydeco® (ivacaftor) tablets 150 mg oral granules 50 • 75 mg

**2) Select Prescribed Dose:**

☐ **One TABLET (150 mg)** po q12h with fat-containing food

☐ **ORAL GRANULES (75 mg)** ☐ **ORAL GRANULES (50 mg)**

po q12h mixed with 1 tsp (5 mL) of soft food or liquid with fat-containing food

**3) Select Days Supply:**

☐ **56 TABLETS (28-day supply)**
☐ **168 TABLETS (84-day supply)**
☐ **56 single-dose packets (28-day supply)**
☐ **168 single-dose packets (84-day supply)**

☐ Refills: _____ ☐ Dispense as written Special instructions: _____

Is the patient currently receiving this prescribed therapy? ☐ YES ☐ NO

By signing below, I certify that (1) the above therapy is medically necessary and 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 Pharmaceuticals Incorporated ("Vertex") and its contractors and business partners ("Contractors") for benefits verification and coordination of dispensing of ORKAMBI® (lumacaftor/ivacaftor) or KALYDECO® (ivacaftor); (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 (mm/dd/yy):** _____
(No stamp allowed)

VERTEX GPS™ GUIDANCE & PATIENT SUPPORT

# 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:** _____ **Date of Signature:** _____ (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 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.

**Optional Service:** Please indicate whether you would like to be contacted by Vertex and its Contractors about opportunities for you to provide your feedback to Vertex (such as through market research or disease-related surveys): ☐ YES ☐ NO

**Patient or Legal Guardian Signature:** _____ **Date of Signature:** _____ (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.

VERTEX GPS
GUIDANCE & PATIENT SUPPORT

# We're here to help

**Vertex Guidance & Patient Support (Vertex GPS)** is a comprehensive product support program that helps eligible patients who have been prescribed KALYDECO® (ivacaftor) or ORKAMBI® (lumacaftor/ivacaftor) access their medication and stay on track with treatment.

Our network of expert Case Managers can provide you with one-on-one product support to help answer your questions as you get started on treatment. To help guide you through each step of your treatment, we'll also provide you with helpful educational resources along the way.

Members of the Vertex GPS Case Management Team

## Here's what you can expect from us

After your healthcare provider submits your enrollment form, you will receive a phone call from your dedicated Case Manager welcoming you to Vertex GPS. **Your Case Manager will be calling from (617) 961-1101.**

> "I like the fact that if I have any questions or concerns, I can connect with my Case Manager and get things resolved very quickly."
>
> —Patient Enrolled in Vertex GPS

**From there, your Case Manager will help by:**

1. Reviewing your insurance coverage.
2. Working with your healthcare provider to inform him or her of insurance coverage requirements.
3. Reviewing potential financial assistance options and determining your out-of-pocket costs.
4. Coordinating shipments with your specialty pharmacy and providing monthly refill reminders.
5. Providing educational resources throughout your treatment to help you stay on track with your prescribed medicine.

IF YOU HAVE COMMERCIAL INSURANCE,
**VERTEX MAY BE ABLE TO REDUCE YOUR CO-PAY* TO $15 PER REFILL**

*Limitations apply, and Vertex reserves the right to rescind, revoke, or amend this assistance program at any time.

Our Case Managers are just a phone call away. You can reach them by calling 617-961-1101 or toll free at 877-752-5933 (press 2), Monday through Friday, from 8:30 AM to 7:00 PM, Eastern Standard Time.

VERTEX