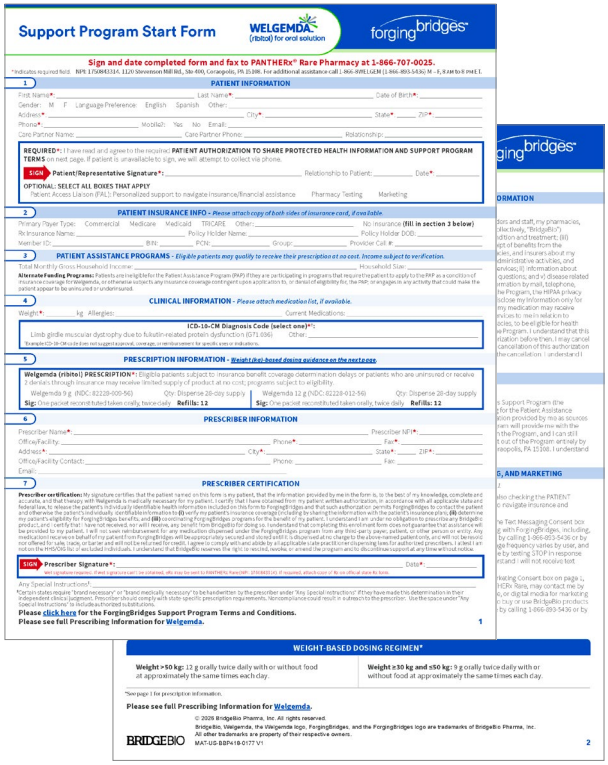
How to complete the Welgemda™ (ribitol) Support Program Start Form

forging bridges™ | WELGEMDA™ (ribitol) for oral solution

Welgemda Support Program Start Form


Support Program Start Form

WELGEMDA (ribitol) for oral solution

forging bridges

Sign and date completed form and fax to PANTHERx® Rare Pharmacy at 1-866-707-0025.

PATIENT INFORMATION

PATIENT INSURANCE INFO - Please attach copy of both sides of insurance card, if available.

PATIENT ASSISTANCE PROGRAMS - Eligible patients may qualify to receive their prescription at no cost. Income subject to verification.

CLINICAL INFORMATION - Please attach medication list, if available.

ICD-10-CM Diagnosis Code (select one)*:

PRESCRIPTION INFORMATION - Weight (kg)-based dosing guidance on the next page.

PRESCRIBER INFORMATION

PRESCRIBER CERTIFICATION

WEIGHT-BASED DOSING REGIMEN*

Please see full Prescribing Information for Welgemda.

BRIDGEBIO

This guide provides clear, step-by-step instructions for completing the Welgemda Support Program Start Form. Follow this guide to streamline enrollment, help patients start Welgemda, and connect them to the comprehensive support from ForgingBridges®.

The Start Form serves 2 purposes:

- Prescribes Welgemda to patients
- Enrolls patients in ForgingBridges, a support program for Welgemda

Who completes this form:

- The prescribing physician (or office staff)
- The patient or their representative

Steps to complete:

- Review all sections of the Start Form
- Complete and sign where indicated on page 1 (for both patient and prescriber)
- Fax the completed form to PANTHERx® Rare Pharmacy at 1-866-707-0025

After the completed form is received:

- You will receive a receipt of enrollment, and PANTHERx will contact the patient within 1-2 days

Download the Start Form

Questions?

Contact your dedicated Field Reimbursement Manager (FRM)

Scan or click the QR code to find a local FRM who is ready to provide guidance

Patient sections

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1 Patient information

Complete all marked fields with the patient's current legal information. Accurate information helps prevent processing delays and ensures the patient can be reached with important program updates.

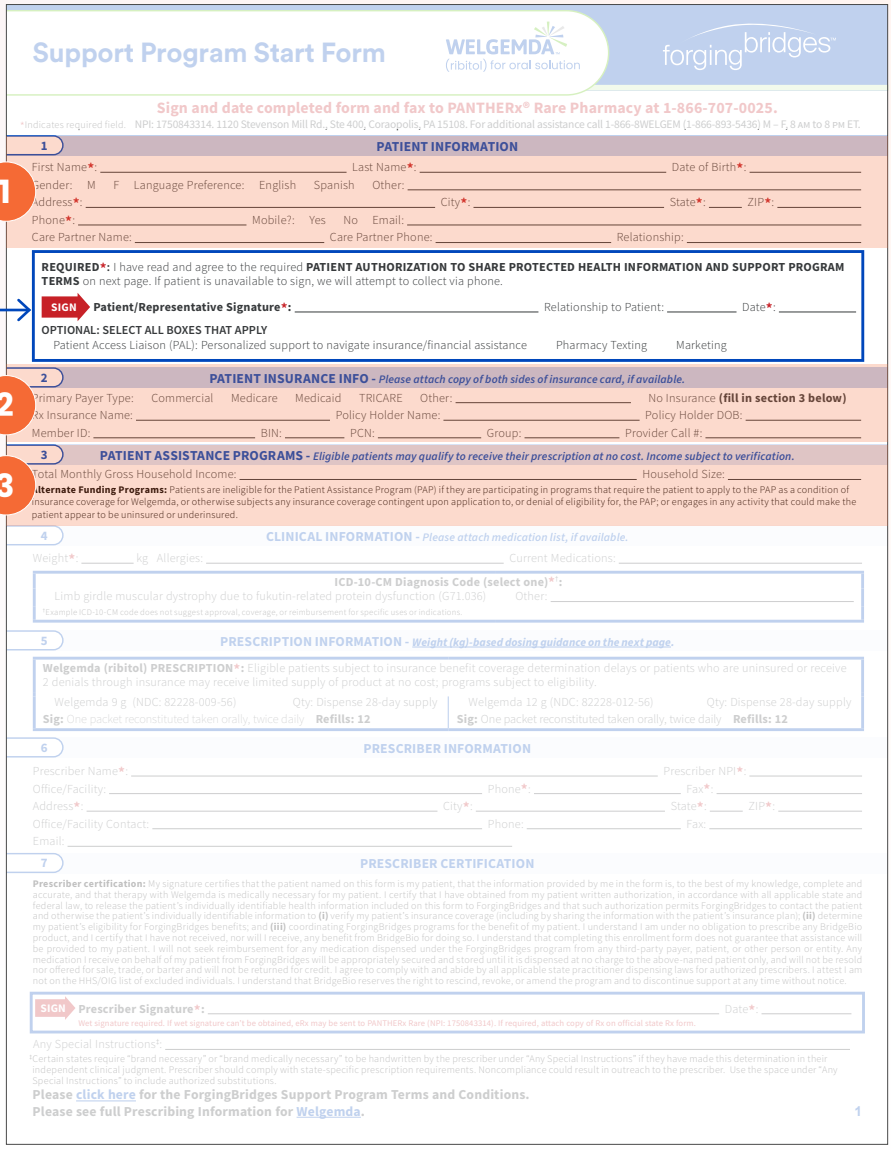
Patient signature required

Ensure the patient or their representative reads page 2 of the Start Form and understands that signing here authorizes BridgeBio to access the patient's protected health information in order to provide support and confirms enrollment in the program's full suite of services.†

If possible, please have the patient sign the form in person. If the patient is unavailable to sign, PANTHERx will attempt to collect their consent via phone.

The patient may also check optional boxes below the signature line for additional services they would like to receive.

PAGE 1



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Sign and date completed form and fax to PANTHERx® Rare Pharmacy at 1-866-707-0025.

*Indicates required field. NPI: 1750843314. 1120 Stevenson Mill Rd., Ste 400, Coraopolis, PA 15108. For additional assistance call 1-866-8WELGEM (1-866-893-5436) M – F, 8 AM to 8 PM ET.

1 PATIENT INFORMATION

First Name*: _____ Last Name*: _____ Date of Birth*: _____

Gender: M F Language Preference: English Spanish Other: _____

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

Phone*: _____ Mobile?: Yes No Email: _____

Care Partner Name: _____ Care Partner Phone: _____ Relationship: _____

REQUIRED*: I have read and agree to the required **PATIENT AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION AND SUPPORT PROGRAM TERMS** on next page. If patient is unavailable to sign, we will attempt to collect via phone.

SIGN **Patient/Representative Signature*:** _____ Relationship to Patient: _____ Date*: _____

OPTIONAL: SELECT ALL BOXES THAT APPLY

Patient Access Liaison (PAL): Personalized support to navigate insurance/financial assistance Pharmacy Texting Marketing

2 PATIENT INSURANCE INFO - *Please attach copy of both sides of insurance card, if available.*

Primary Payer Type: Commercial Medicare Medicaid TRICARE Other: _____ No Insurance **(fill in section 3 below)**

Rx Insurance Name: _____ Policy Holder Name: _____ Policy Holder DOB: _____

Member ID: _____ BIN: _____ PCN: _____ Group: _____ Provider Call #: _____

3 PATIENT ASSISTANCE PROGRAMS - *Eligible patients may qualify to receive their prescription at no cost. Income subject to verification.*

Total Monthly Gross Household Income: _____ Household Size: _____

Alternate Funding Programs: Patients are ineligible for the Patient Assistance Program (PAP) if they are participating in programs that require the patient to apply to the PAP as a condition of insurance coverage for Welgemda, or otherwise subjects any insurance coverage contingent upon application to, or denial of eligibility for, the PAP; or engages in any activity that could make the patient appear to be uninsured or underinsured.

4 CLINICAL INFORMATION - *Please attach medication list, if available.*

Weight*: _____ kg Allergies: _____ Current Medications: _____

ICD-10-CM Diagnosis Code (select one)*†:

Limb girdle muscular dystrophy due to fukutin-related protein dysfunction (G71.036) Other: _____

†Example ICD-10-CM code does not suggest approval, coverage, or reimbursement for specific uses or indications.

5 PRESCRIPTION INFORMATION - *Weight (kg)-based dosing guidance on the next page.*

Welgemda (ribitol) PRESCRIPTION*: Eligible patients subject to insurance benefit coverage determination delays or patients who are uninsured or receive 2 denials through insurance may receive limited supply of product at no cost; programs subject to eligibility.

Welgemda 9 g (NDC: 82228-009-56) Qty: Dispense 28-day supply **Sig:** One packet reconstituted taken orally, twice daily **Refills: 12**

Welgemda 12 g (NDC: 82228-012-56) Qty: Dispense 28-day supply **Sig:** One packet reconstituted taken orally, twice daily **Refills: 12**

6 PRESCRIBER INFORMATION

Prescriber Name*: _____ Prescriber NPI*: _____

Office/Facility: _____ Phone*: _____ Fax*: _____

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

Office/Facility Contact: _____ Phone: _____ Fax: _____

Email: _____

7 PRESCRIBER CERTIFICATION

Prescriber certification: My signature certifies that the patient named on this form is my patient, that the information provided by me in the form is, to the best of my knowledge, complete and accurate, and that therapy with Welgemda is medically necessary for my patient. I certify that I have obtained from my patient written authorization, in accordance with all applicable state and federal law, to release the patient's individually identifiable health information included on this form to ForgingBridges and that such authorization permits ForgingBridges to contact the patient and otherwise the patient's individually identifiable information to **(i)** verify my patient's insurance coverage (including by sharing the information with the patient's insurance plan); **(ii)** determine my patient's eligibility for ForgingBridges benefits; and **(iii)** coordinating ForgingBridges programs for the benefit of my patient. I understand I am under no obligation to prescribe any BridgeBio product, and I certify that I have not received, nor will I receive, any benefit from BridgeBio for doing so. I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. I will not seek reimbursement for any medication dispensed under the ForgingBridges program from any third-party payer, patient, or other person or entity. Any medication I receive on behalf of my patient from ForgingBridges will be appropriately secured and stored until it is dispensed at no charge to the above-named patient only, and will not be resold nor offered for sale, trade, or barter and will not be returned for credit. I agree to comply with and abide by all applicable state practitioner dispensing laws for authorized prescribers. I attest I am not on the HHS/OIG list of excluded individuals. I understand that BridgeBio reserves the right to rescind, revoke, or amend the program and to discontinue support at any time without notice.

SIGN **Prescriber Signature*:** _____ Date*: _____

Wet signature required. If wet signature can't be obtained, eRx may be sent to PANTHERx Rare (NPI: 1750843314). If required, attach copy of Rx on official state Rx form.

Any Special Instructions†: _____

†Certain states require "brand necessary" or "brand medically necessary" to be handwritten by the prescriber under "Any Special Instructions" if they have made this determination in their independent clinical judgment. Prescriber should comply with state-specific prescription requirements. Noncompliance could result in outreach to the prescriber. Use the space under "Any Special Instructions" to include authorized substitutions.

Please click here for the ForgingBridges Support Program Terms and Conditions.

Please see full Prescribing Information for Welgemda.

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2 Patient insurance info

If the patient has insurance, complete this section in its entirety. Complete information helps to speed up processing and determine coverage options.

Attach a copy of the front and back of the patient's insurance card.

If they do not have insurance, check the box and complete Section 3.

3 Patient Assistance programs

For patients who do not have insurance, please complete this section completely. This section helps connect eligible patients with financial assistance.†

For insured patients, this information can be provided to have on file in the event insurance denies and the patient needs to be screened for assistance.

*** indicates required field and must be completed for timely processing.**

†Eligibility criteria and Terms and Conditions apply. To learn more, visit Welgemda.Forgingbridges.com/HCP/Terms-Conditions.

Prescriber sections

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4 Clinical information

Complete weight, allergies, and current medications. Confirm the ICD-10-CM diagnosis code. The diagnosis code is essential for PANTHERx to conduct a benefits investigation and process the prescription request. Attaching a medication list supports clinical assessment and helps ensure medication safety.

5 Prescription information

Select the appropriate Welgemda dose based on patient weight using the weight-based dosing guidance on the bottom of page 2.

Verify the dosing frequency (twice daily) and confirm the 28-day supply with 12 refills. For any changes to dosing instructions or refills, use the Any Special Instructions field under the Prescriber Signature.

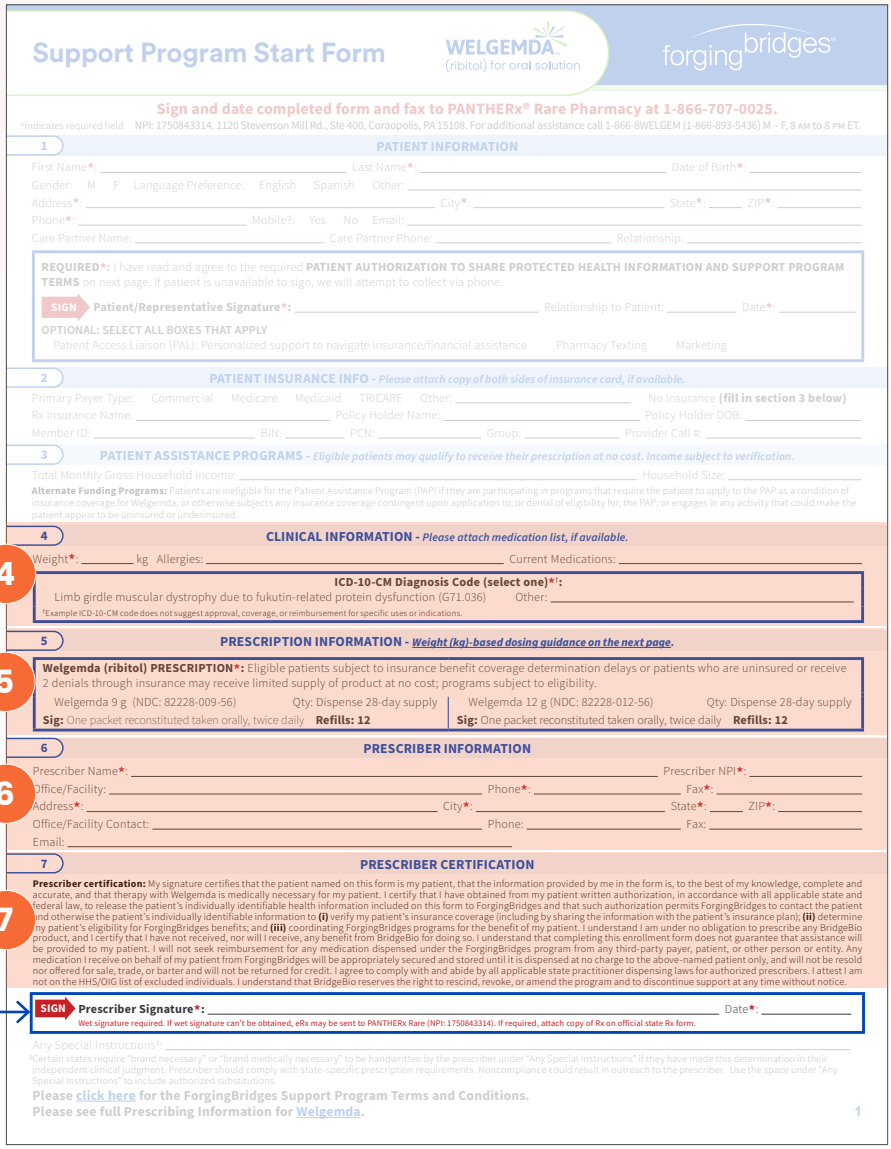
6 Prescriber information

Complete all prescriber fields with accurate contact information. PANTHERx may contact your office regarding the benefits investigation or prescription processing.

7 Prescriber certification

By signing here, the prescriber certifies that: 1) they are the prescriber of record, 2) they have reviewed this form, and 3) Welgemda is medically appropriate for this patient.

PAGE 1



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Gender: M F Language Preference: English Spanish Other:

Address*: City*: State*: ZIP*:

Phone*: Mobile?: Yes No Email:

Care Partner Name: Care Partner Phone: Relationship:

REQUIRED*: I have read and agree to the required PATIENT AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION AND SUPPORT PROGRAM TERMS on next page. If patient is unavailable to sign, we will attempt to collect via phone.

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Office/Facility: Phone*: Fax*:

Address*: City*: State*: ZIP*:

Office/Facility Contact: Phone: Fax:

Email:

7 PRESCRIBER CERTIFICATION

Prescriber certification: My signature certifies that the patient named on this form is my patient, that the information provided by me in the form is, to the best of my knowledge, complete and accurate, and that therapy with Welgemda is medically necessary for my patient. I certify that I have obtained from my patient written authorization, in accordance with all applicable state and federal law, to release the patient's individually identifiable health information included on this form to ForgingBridges and that such authorization permits ForgingBridges to contact the patient and otherwise the patient's individually identifiable information to **(i)** verify my patient's insurance coverage (including by sharing the information with the patient's insurance plan); **(ii)** determine my patient's eligibility for ForgingBridges benefits; and **(iii)** coordinating ForgingBridges programs for the benefit of my patient. I understand I am under no obligation to prescribe any BridgeBio product, and I certify that I have not received, nor will I receive, any benefit from BridgeBio for doing so. I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. I will not seek reimbursement for any medication dispensed under the ForgingBridges program from any third-party payer, patient, or other person or entity. Any medication I receive on behalf of my patient from ForgingBridges will be appropriately secured and stored until it is dispensed at no charge to the above-named patient only, and will not be resold nor offered for sale, trade, or barter and will not be returned for credit. I agree to comply with and abide by all applicable state practitioner dispensing laws for authorized prescribers. I attest I am not on the HHS/OIG list of excluded individuals. I understand that BridgeBio reserves the right to rescind, revoke, or amend the program and to discontinue support at any time without notice.

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Please see full Prescribing Information for Welgemda.

1

Prescriber signature required

A wet signature is required. If a wet signature cannot be obtained, an eRx may be sent to PANTHERx (NPI: 1750843314). If required, attach a copy of the prescription on an official state prescription form.

Use the Any Special Instructions field for state-required markings (eg, "brand medically necessary"). Ensure compliance with state prescription requirements.

*** indicates required field and must be completed for timely processing.**

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Get dedicated support

ForgingBridges® is a patient support program for Welgemda.

The program offers:

- A dedicated team ready to support patients and healthcare providers throughout the Welgemda treatment journey
- A range of financial support programs designed to help eligible patients access and make Welgemda more affordable

For more information about ForgingBridges for Welgemda, visit Welgemda.ForgingBridges.com/HCP

For patient-specific access and logistics support, call PANTHERx at 1-866-8WELGEM (1-866-893-5436) Mon – Fri, 8 AM to 8 PM ET.

BRIDGEBIO

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