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.

*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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You may print and keep a copy of this page for your records.

(REQUIRED) PATIENT AUTHORIZATION FOR DISCLOSURE AND USE OF PERSONAL HEALTH INFORMATION

Please read the following consent carefully and, if you agree, sign and date where indicated in the Patient Information section on page 1.

By signing the PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION section on page 1 of this form, I authorize healthcare providers and staff, my pharmacies, and my health insurers to use and disclose to BridgeBio Pharma, Inc. and its affiliates, business partners, vendors, and other agents (collectively, "BridgeBio") information identifiable to me, including (i) my contact information; (ii) my health information, such as information on my medical condition and treatment; (iii) health insurance and coverage claims; and (iv) prescription fulfillment information (collectively, my "Information"), to facilitate my receipt of benefits from the ForgingBridges Support Program (the "Program"). I further authorize BridgeBio to communicate with my healthcare providers, pharmacies, and insurers about my Information and to use my Information to enroll me in support programs, provide services, and conduct quality assurance and other administrative activities, and to contact me by mail, telephone, email, and, if I check the Text Messaging Consent box on page 1, also by text, regarding: i) Program services; ii) information about BridgeBio's products; iii) research studies; iv) my opinion about such information and topics, including in response to market research questions; and v) disease related surveys. I further authorize BridgeBio, if I check the Marketing Consent box on page 1 to use my Information to send me marketing information by mail, telephone, or email, as well as by text message if I also consent to text messaging. I understand that, once my Information has been disclosed to the Program, the HIPAA privacy regulations may no longer protect the Information from further disclosure. However, I also understand BridgeBio intends to use and disclose my Information only for the purposes referenced in this authorization or as otherwise required or permitted by law. I understand the pharmacy that dispenses my medication may receive payment from BridgeBio in exchange for providing my Information to BridgeBio and/or for using my Information to provide support services to me in relation to the Program. I understand I do not have to sign this authorization in order to obtain treatment from my healthcare providers or pharmacies, to be eligible for health insurance benefits, or to obtain BridgeBio's medications, but that if I do not sign the authorization, I will not be able to participate in the Program. I understand that this authorization expires 10 years from the date signed below, or earlier as may be required by state or local law, unless I cancel the authorization before then. I may cancel this authorization at any time by writing to ForgingBridges at 1120 Stevenson Mill Rd., Ste 400, Coraopolis, PA 15108. I understand that cancellation of this authorization will not invalidate any uses and disclosures of my information made in reliance on the authorization before ForgingBridges' receipt of the cancellation. I understand I may request a signed copy of this authorization.

(REQUIRED) PATIENT CONSENT TO SUPPORT PROGRAM TERMS

Please read the following consent carefully and, if you agree, sign and date where indicated in the Patient Information section on page 1.

By signing under SUPPORT PROGRAM on page 1, I am agreeing to the terms and conditions for my enrollment in the ForgingBridges Support Program (the "Program"), as well as the terms of enrollment in the Copay Assistance Program if I am eligible for copay assistance. If I am applying for the Patient Assistance Program, I authorize the Program to obtain a report on my individual income from consumer reporting agencies and to use information provided by me as sources to verify the information on this form to determine if I am eligible for free medication. I understand that, upon my request, the Program will provide me with the name and address of the consumer reporting agency that delivers any such consumer report. I understand I do not have to enroll in the Program, and I can still receive my medication as prescribed by my physician. I may at any time opt out of individual services offered by the Program or opt out of the Program entirely by notifying a Program representative by calling 1-866-893-5436 or by writing to ForgingBridges at 1120 Stevenson Mill Rd., Ste 400, Coraopolis, PA 15108. I understand the Program may be changed or discontinued in whole or in part by BridgeBio at any time.

(OPTIONAL) PATIENT CONSENTS FOR CONTACT BY A PATIENT ACCESS LIAISON (PAL), TEXT MESSAGING, AND MARKETING

Please read the following consent carefully and, if you agree, sign and date where indicated in the Patient Information section on page 1.

PATIENT ACCESS LIAISON (PAL): By signing the Patient Authorization for Disclosure and Use of Personal Health Information and also checking the PATIENT ACCESS LIAISON (PAL) box on page 1, I opt in to being contacted by a Patient Access Liaison (PAL) to receive personalized support to navigate insurance and financial assistance.

TEXT MESSAGING: By signing the Patient Authorization for Disclosure and Use of Personal Health Information and also checking the Text Messaging Consent box on page 1, I consent to receive text messages regarding enrollment updates and alerts from ForgingBridges, and companies working with ForgingBridges, including, PANTHERx Rare at the mobile telephone number that I provided above on this form, and I agree to notify ForgingBridges promptly, by calling 1-866-893-5436 or by writing to ForgingBridges at 1120 Stevenson Mill Rd., Ste 400, Coraopolis, PA 15108, if my number changes. I understand that message frequency varies by user, and my wireless service provider's message and data rates may apply. I understand that I can opt out of future text messages at any time by texting STOP in response to any ForgingBridges or PANTHERx text message. If I do not sign above or check the Text Messaging Consent box on page 1, I understand I will not receive text messages. BridgeBio's complete text messaging terms are available at BridgeBio Global SMS Policy | BridgeBio.

MARKETING: By signing the Patient Authorization for Disclosure and Use of Personal Health Information and also checking the Marketing Consent box on page 1, I agree that BridgeBio, its affiliates, and companies working with BridgeBio or its affiliates (collectively, "BridgeBio") including PANTHERx Rare, may contact me by mail, email, phone (including autodialed or prerecorded), text (including autodialed) if I agree to Text Messaging as described above, or digital media for marketing purposes about BridgeBio products, services, or offers. I understand that I do not need to provide this marketing consent in order to buy or use BridgeBio products or to participate in the ForgingBridges program, and that if I do consent, I may opt out of receiving marketing messages at any time by calling 1-866-893-5436 or by writing to ForgingBridges at 1120 Stevenson Mill Rd., Ste 400, Coraopolis, PA 15108.

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

WEIGHT-BASED DOSING REGIMEN*

Weight >50 kg: 12 g orally twice daily with or without food at approximately the same times each day.	**Weight ≥30 kg and ≤50 kg:** 9 g orally twice daily with or without food at approximately the same times each day.

*See page 1 for prescription information.

Please see full Prescribing Information for Welgemda.

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