REBYOTA® (fecal microbiota, live-jslm) suspension, for rectal use

REBYOTA Connect Enrollment Form

Access Coverage Support and Financial Assistance

For assistance call: 1-877-REBYOTA, Monday-Friday 8 a.m. – 8 p.m. EST

Please complete form and fax to 1-877-778-7167

☐ ***Check here to request a benefits investigation ONLY. If checked, Sections 3 and 7 do not need to be completed, and patient will NOT be screened for any financial assistance program eligibility. For financial assistance eligibility screening, complete sections 3 & 7 and have patient sign on pages 3 & 4.***

1. PATIENT INFORMATION (required)

Patient Name (full):	DOB: / /	Gender: ◯ M ◯ F ◯ Other
Street Address:		Apt #:
City:	State:	Zip Code:
Mobile Phone: - -	Home Phone: - -	
Preferred Phone: ◯ Mobile ◯ Home	Best Time to Call: ◯ AM ◯ PM	Email:
Alternate Caregiver/Contact:	Relationship:	
Phone: - -	Email:	Preferred Language:

Voice Message: ◯ Y ◯ N By checking "Y", I am indicating that I allow voice mail messages to disclose to myself or caregiver that I am on a Ferring medicine within the voice mail left for me related to the Program.

2. INSURANCE INFORMATION (required) ☐ CHECK IF UNINSURED (If checked, skip to Section 3)

Include a copy of the front and back of all medical insurance cards and prescription benefit insurance cards OR complete information below.

Insurance	Primary Medical	Secondary Medical (e.g.: MediGap coverage)	Prescription
Name & Type			
Phone Number			
Policy ID #			
Group #			
Policy Holder Name			
Policy Holder DOB	/ /	/ /	/ /
Relationship to Patient			
			PCN #:
			BIN #:

3. PATIENT ASSISTANCE PROGRAM (PAP) (OPTIONAL: If patient wants to be screened for eligibility)

The REBYOTA Patient Assistance Program (PAP) provides REBYOTA at no cost to eligible patients. Assistance will be provided in the form of free product shipped to site of administration or reimbursement for the purchase price of the product if eligibility is verified after product has been administered. Participation in the PAP is free. Ferring does not collect any fees from people seeking assistance through the PAP. To be considered for PAP, please complete the sections below. PAP only covers the cost of the product and not administration or other services.

Annual gross household income (income before taxes): $	**Number of people in household (including patient):**

4. HEALTHCARE PROVIDER INFORMATION (required by treating healthcare provider)

Name (full):			Prescriber NPI #:
Specialty:			State License #:
Practice Name:			Tax ID #:
Street Address:			Suite #:
City:	State:	Zip Code:	**1. How will you access REBYOTA?** (check if not using REBYOTA at home option) ◯ Buy & Bill via medical benefit (order through specialty distributor) ◯ Specialty Pharmacy (via pharmacy and medical benefit) ***OR*** **2. Select option below** (if choosing this option please do not check above) ◯ Verify the REBYOTA Home Administration option for this patient
Office Phone: - -	Ext.:		
Office Fax: - -			
Contact Name (full):			
Contact Email:			

Patient Name (full): _____ Date of Birth: ____ / ____ / ____

5. CLINICAL INFORMATION (required by treating healthcare provider)

Diagnosis code (ICD-10 Code):
◯ **A04.71** (Enterocolitis due to Clostridium difficile, **recurrent**)
◯ Other: ◯ **A04.72** (Enterocolitis due to Clostridium difficile, **not specified as recurrent**)

Antibiotic treatment (if known): Start date: / / Days of therapy:

Expected date for administering REBYOTA® to patient: / /

Treatment location (billing as): ◯ 11: Physician Office ◯ 19/22: Outpatient Center ◯ 24: Ambulatory Surgery Center ◯ 12: Home (REBYOTA@Home)

Address for Product Shipment (if administered in an alternate location provided in Section 4 above). **NOTE:** Cannot be shipped directly to the patient. Leave blank if using REBYOTA@Home.

Facility Name:	Contact Name:	
Facility Phone: - - Ext.:	Facility Fax: - -	
Street Address:		Suite #:
City:	State:	Zip Code:

6. PRESCRIPTION (required for patients serviced by a Specialty Pharmacy if chosen in Section 4 above, do not leave any boxes blank)

Date: / /		REBYOTA: 150 mL suspension for rectal use	Directions for use: Administered rectally by a healthcare provider	Special instructions:
Qty.:	Refills:			
List or attach current medications:			List any medication allergies: ◯ No known drug allergies	

I verify that the patient and healthcare provider information on this enrollment form was completed by me or at my direction and I have discussed with my patient and informed patient of the REBYOTA Connect ("Program") enrollment. The information contained herein is complete and accurate to the best of my knowledge. I understand that I must comply with my practicing state's specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements may result in the dispensing pharmacy reaching out to me.

By signing below, I certify that: (1) I am prescribing REBYOTA (fecal microbiota, live-jslm) ("Product") for the patient identified in Section 1 above, this prescription is medically necessary for the patient and that it will be used as directed; I will be supervising the patient's treatment, and that the information I have provided above is complete and accurate to the best of my knowledge; (2) I have received the appropriate permission and consent from the patient to comply with applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and applicable state laws needed to release to Ferring and its designated agents and service providers the patient-related information on this form for the purposes of verifying the patient's insurance coverage for Product, confirming prior authorization requirements for the Product, if needed, providing information on appeals of denials of claims, assisting with financial assistance resources and information, such as co-pay support or free drug patient assistance programs for which the patient may be eligible, coordinating delivery of Product, contacting the patient with educational materials about the patient's prescription medication or to evaluate the effectiveness of the Program; and providing my patient with other education and support available through the Program associated with the Product; and (3) If applicable, I authorize the above prescription to be forwarded to the specialty pharmacy or home health agency affiliated with patient's insurance plan or chosen by the named patient or by my office on the named patient's behalf.

If my patient is eligible for the REBYOTA Patient Assistance Program ("PAP") and enrolls in the PAP, I further agree to the following: (1) The assistance will be provided in the form of free product that will be shipped to my office prior to product administration or in the form of reimbursement for the purchase price of the product if processed after product administration; (2) If product is shipped to my office, I will receive and secure my patient's medication at my office until it is administered to my patient; (3) (a) any medications supplied by Ferring as a result of enrollment in the PAP are for the use of the named patient only and will not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (such as Medicare, Medicaid, or other benefit provider) for reimbursement, and (b) If the assistance is in the form of reimbursement, the reimbursement will be provided to my patient, or, if authorized by my patient, directly to me if product was obtained via standard buy and bill process, or to the specialty pharmacy if the product was obtained through assignment of benefits to a specialty pharmacy; (4) the Product will be provided only to the eligible patient at no charge of any kind; (5) Ferring may change or cancel the PAP at any time and Ferring reserves the right to terminate my patient's enrollment in the PAP at any time; (6) I will notify Ferring immediately if the Product is no longer medically necessary for this patient's treatment or if my patient's insurance or financial status changes.

SIGN HERE

_____ **Prescriber signature (Dispense as written/Do not substitute)**

_____ **Prescriber signature (Substitute allowed)**

_____ / _____ / _____ **Date**

7. PATIENT TERMS OF PARTICIPATION, FINANCIAL ELIGIBILITY AND PATIENT PRIVACY NOTICE

Authorization to Disclose Protected Health Information

I, or my authorized representative, authorize my healthcare team and staff, my pharmacies, and my insurance provider, to use and disclose information regarding my medical condition, prescription for REBYOTA® (fecal microbiota, live-jslm) ("Product"), financial information and insurance coverage (the "Authorized Information") to Ferring, Ferring's third-party service providers that assist with administering Program (defined below), and any other authorized parties ("Recipients"), as follows: I understand that my Authorized Information will be used to: (1) Enroll me or initiate my enrollment in REBYOTA Connect ("Program"); (2) Establish my benefit eligibility and potential out-of-pocket costs for Product and to provide me with related services, including directing me to separate private or public payer programs, reimbursement services, services to ship my medication, and other support services including patient education and financial assistance (if and to the extent applicable); (3) Determine my eligibility for and help me access any applicable co-pay support or free drug programs; (4) Perform research and data analytics to develop and evaluate products, services, materials, and treatments, and improve the Program; (5) Communicate with my healthcare providers and health plans about my treatment plan; (6) Contact me for reasons related to the Program and all support services, to obtain further information or clarification regarding any adverse event that I may experience, or to solicit my opinions regarding any drug administered under Program, and Ferring's products and services; (7) Administer and maintain the quality of the Program, including but not limited to case review, compliance checks, audit review and accounting purposes; and (8) Help get Product shipped to my healthcare providers.

I understand that once my Authorized Information has been disclosed to Ferring, it may no longer be protected by federal privacy law and could be re-disclosed to others but that Ferring intends to use and disclose my Authorized Information received pursuant to this authorization only for the purposes described above or as required by law.

I understand the Pharmacy that is dispensing my Product may receive financial remuneration from Ferring for disclosing my Authorized Information to Ferring and for providing support services to me, including sending communications to me, for purposes of my participation in the program detailed in this authorization. I understand that I can withdraw this authorization by calling REBYOTA Connect at 1-877-REBYOTA or mailing a letter with my notice of revocation to 680 Century Point, Lake Mary, FL 32746. I understand that if I do revoke the authorization, it will thereafter be invalid, but that uses and disclosures made in reliance on the authorization prior to its revocation will not be invalidated. I understand that I may refuse to sign this form and, if I do so, I will not be able to participate in Program, but such refusal will not affect my eligibility to obtain medical treatment, or to be prescribed the Product, if applicable, or eligibility for insurance coverage, or other benefits. This authorization expires 3 years after the date I sign it below, unless a shorter period is mandated by state law. I understand that I am entitled to receive a copy of this authorization.

My signature below certifies that I have read, understood, and agree to the release of my protected health information pursuant to the Authorization to Disclose Protected Health Information above.

Signature required for all Financial Assistance & Reimbursement Support (not needed if only benefits investigation provided)

Patient Name (printed):	DOB: ____/____/____
Patient Representative Name (printed, if applicable):	
Relationship to Patient (printed, if applicable):	
SIGN HERE Signature of Patient or Representative:	Date: ____/____/____

7. PATIENT TERMS OF PARTICIPATION, FINANCIAL ELIGIBILITY AND PATIENT PRIVACY NOTICE (CONTINUED)

PAP Notice

I understand that if I have opted to be screened by REBYOTA® Patient Assistance Program ("PAP") and participate in the Program, I acknowledge and authorize Ferring and/or its third party service providers to record all communications with PAP representatives for the purposes set forth herein. I further understand and acknowledge that such recordings may contain Authorized Information.

I understand that if I have opted to be screened for PAP that I am consenting to having the PAP perform an electronic verification of my financial information to verify my eligibility and process my application. By signing here, I consent to have my income electronically verified and that I understand I am providing "written instructions" under the Fair Credit Reporting Act ("FCRA") authorizing the PAP to obtain information from my credit profile, solely for the purpose of determining financial qualifications for the PAP. I understand that this authorization allows the PAP to perform this process as needed for the duration of my participation in the PAP.

If I qualify for and enroll in the PAP I acknowledge that the program will provide Product at no cost to me in the form of free product sent to my healthcare provider prior to product administration or in the form of reimbursement for the purchase price of the product if processed after product administration. If the assistance is provided in the form of reimbursement, I authorize payment to be sent directly to my healthcare provider or Specialty Pharmacy. Participation in the PAP is free; Ferring does not collect any fees from people seeking Ferring assistance. Assistance is dependent on my ability to meet the eligibility criteria for the PAP. The PAP does not have any obligation to provide the program services to me and is not liable in the provision of these services. The PAP may be changed or discontinued without notice. I will not seek reimbursement for any assistance provided under the PAP. I will notify the PAP if my insurance or financial situation changes. If I am a member of a Medicare plan including a Medicare Prescription Drug plan and am qualified for the PAP assistance, I will: (1) be eligible to obtain the medication from the PAP for a calendar year term (2) not purchase this medication under my Medicare plan while enrolled in the PAP; (3) if applicable, not submit claims nor seek true out-of-pocket (TrOOP) credit for the medication provided during my enrollment; (4) allow the PAP to provide written notification to my Medicare plan, if applicable, that I am receiving Product at no cost outside of the Medicare Part D benefit.

Privacy and Marketing Notice:

In connection with the Program and PAP, Ferring is collecting the following categories of personal information:

- Personal identifiers, including your name, address, email address and phone number;
- Characteristics of protected classifications, including your gender;
- Demographic information, including your gender and date of birth;
- Audio and visual information, including your voice recordings (when you participate in the Program or PAP)
- Sensitive Personal Information, including your state license identification number, health condition information, prescription information, and other categories of health related information.

Ferring collects this information for purposes described above in this Section 7, in connection with the Program and PAP. Ferring may also use your information to send you communications via mail or email, which may include disease state educational material and information about Ferring and its Products. You can unsubscribe from this use at anytime.

Ferring will keep each category of your personal information listed above for as long as is needed to carry out the purposes described above and in its privacy policy available at https://ferringusa.com/privacy/, or as otherwise required by law to satisfy Ferring's legal obligations.

Ferring does not knowingly "sell" the information collected from this form, however, Ferring may share your information with trusted third parties in limited circumstances as described in this Section 7 and in its privacy policy, which you can access by visiting https://ferringusa.com/privacy/. If you decide you would like to exercise any of your privacy rights, including the right to access, delete or correct your information collected via this form, or to limit the sharing of your information with third-parties collected via this form, you may advise us at any time by calling the toll free number 1-888-FERRING (1-888-337-7464) or submitting a Data Subject Contact Form. A link to the Data Subject Contact Form can be found by visiting the Ferring privacy policy at https://ferringusa.com/privacy/.

My signature below certifies that I have provided accurate and complete information, that I have read, understood, and agree to the terms of the PAP, Privacy and Marketing Notices above.

Signature required for all Financial Assistance & Reimbursement Support (not needed if only benefits investigation provided)

	Patient Name (printed):	DOB: ____/____/____
	Patient Representative Name (printed, if applicable):	
	Relationship to Patient (printed, if applicable):	
SIGN HERE	Signature of Patient or Representative:	Date: ____/____/____

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PRINT FORM
Then sign with pen