WAINUA™ (eplontersen) ENROLLMENT FORM

This resource highlights important sections of the WAINUA Enrollment Form that offices and healthcare providers should note when enrolling their patients into the AstraZeneca Access 360™ program and requesting select patient access services. Use the callouts below and on the next page to review key sections and additional instructions for some of the form fields.

Download the WAINUA Enrollment Form from MyAccess360.com

Patient Authorization
Page 2 of the form details the authorization of the patient to release specific personal information to Access 360 and states that the WAINUA Support Program is available to help patients cover drug costs if they meet certain eligibility criteria. This page does not need to be faxed.

Patient Information
All fields in Section 1 need to be completed.

Checking "Yes" under the "OK to contact patient?" prompt will allow Access 360 to reach out to the patient if more information is needed.

Patient Signature
The patient's (or their LAR's) signature in this section authorizes Access 360 to follow up on the patient's behalf with the insurance company and Specialty Pharmacy.

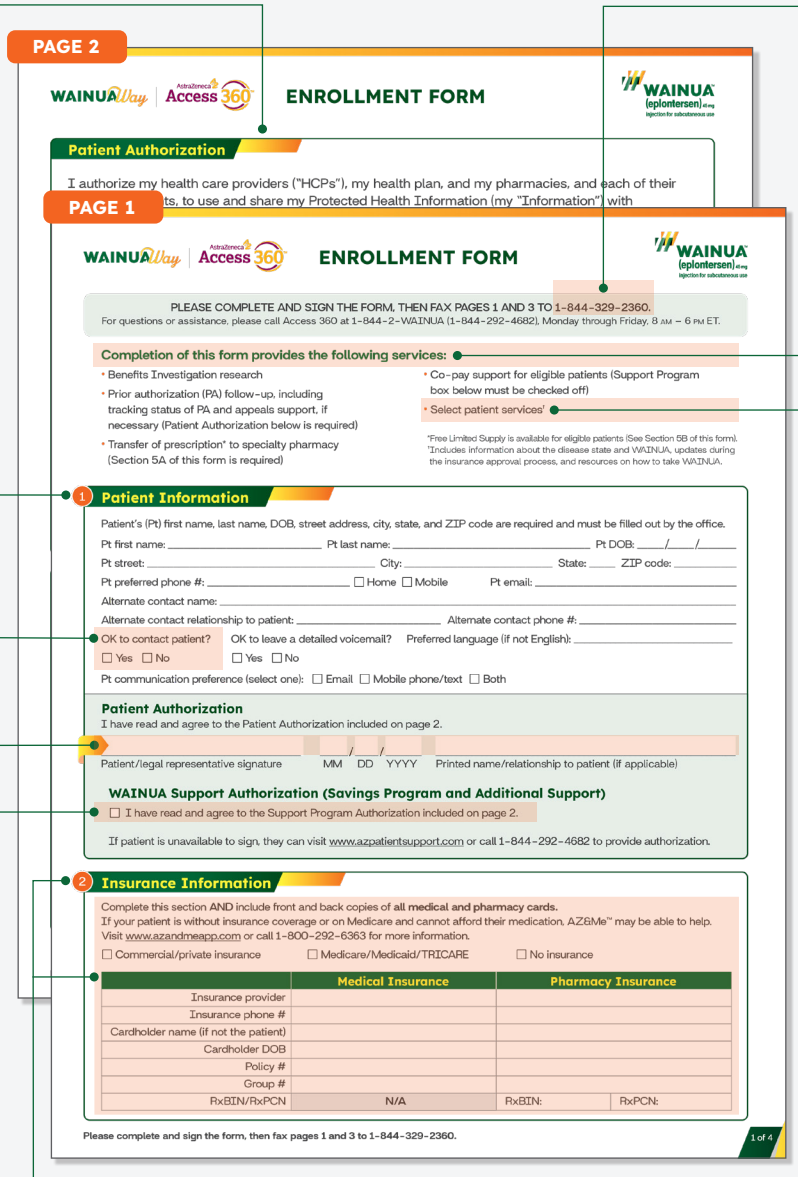
This signature also enables:

1) an FRM to work with the office on patient-specific issues, such as PA and affordability challenges;

2) a PEM to provide support to the patient, if desired; and

3) the office to obtain assistance with appeals and denials

The checkbox in this section allows Access 360 to enroll the patient into the WAINUA Savings Program (eligibility rules apply) and to send the patient additional resources.



Form Instructions
Fax only pages 1 and 3 of the form to this number. Be sure to send all relevant communication or letters from the payer, including any denial or approval letters.

Services Provided by Access 360
Completion of this form allows you to enroll a patient into Access 360 and the appropriate support program.

Completion of the form may provide the following services, if needed: Benefits investigation research; PA follow-up, including tracking status of PA and appeals support; transfer of prescription to Specialty Pharmacy if Section 5A is completed; co-pay support for eligible patients; and select patient services.

Patient Education Managers
If only Patient Education Manager (PEM) services are desired, complete Sections 1, 2, 3, and 4 of this form.

PEMs do not provide medical advice or medical consultation. Patients are directed to speak with their healthcare provider regarding medical issues.

Please contact your Field Reimbursement Manager (FRM) if you have any questions about PEM services.

Patient Insurance Information
Complete all of Section 2 (including the table) AND include front and back copies of all medical and pharmacy cards. Pharmacy insurance is especially important to submit, as most WAINUA coverage falls under the pharmacy benefit.

Proper submission of the patient's insurance information may help ensure quicker processing and fewer phone calls for your office.

FRM=Field Reimbursement Manager; LAR=legally authorized representative; PA=prior authorization.

For additional information, please visit www.MyAccess360.com or call 1-844-2-WAINUA (1-844-292-4682).

WAINUA™ (eplontersen) ENROLLMENT FORM (cont'd)

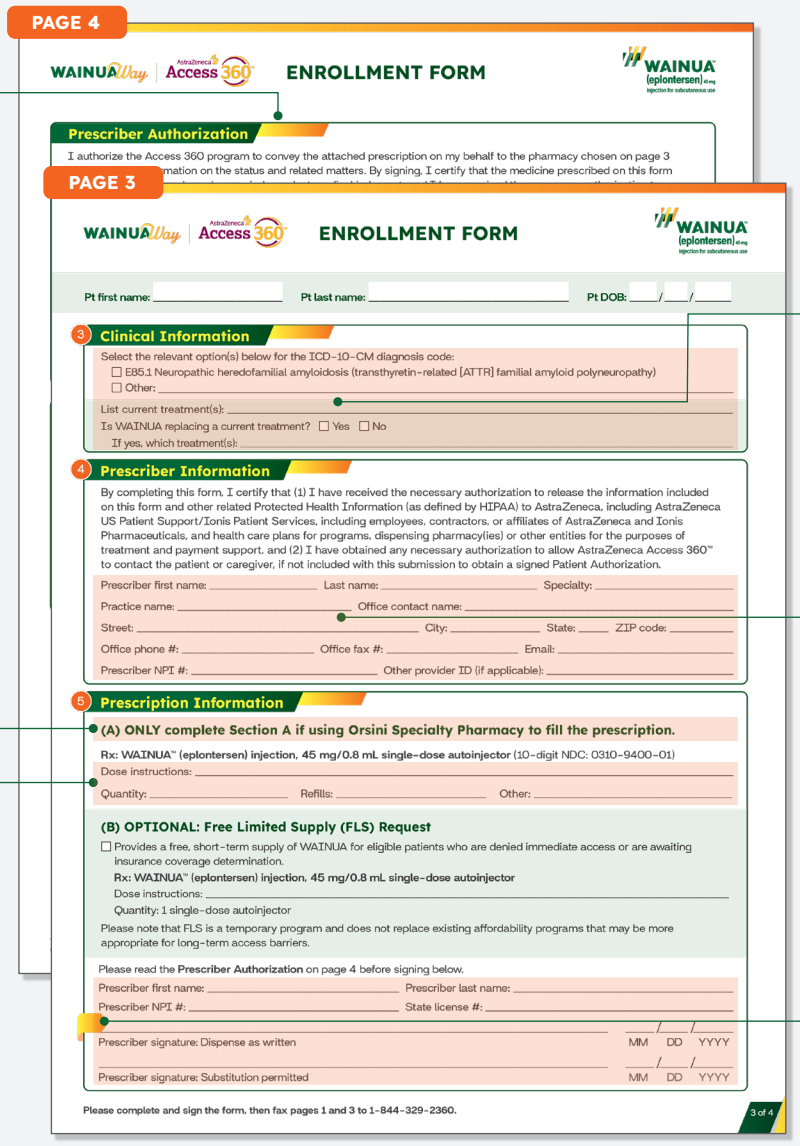
Download the WAINUA Enrollment Form from MyAccess360.com

Prescriber Authorization
Page 4 of this form details the authorization of the prescriber to release specific personal information to Access 360 and provides consent to use that information for Free Limited Supply specifically.

Prescription Information
Completion of Section 5A implies that the prescription for WAINUA will be filled by Orsini Specialty Pharmacy.

Leaving Section 5A blank implies that the prescription will be filled by the health system's pharmacy or that the healthcare provider will be e-prescribing directly to the Specialty Pharmacy.

Only complete these fields if using Orsini Specialty Pharmacy to fill the prescription for WAINUA. Ensure that proper dosage instructions, including autoinjector quantity and number of refills, are recorded here.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WAINUAWay | Access 360 ENROLLMENT FORM

WAINUA (eplontersen) 45 mg injection for subcutaneous use

Prescriber Authorization

I authorize the Access 360 program to convey the attached prescription on my behalf to the pharmacy chosen on page 3 mation on the status and related matters. By signing, I certify that the medicine prescribed on this form

PAGE 3

WAINUAWay | Access 360 ENROLLMENT FORM

WAINUA (eplontersen) 45 mg injection for subcutaneous use

Pt first name: _____ Pt last name: _____ Pt DOB: ___/___/____

3 Clinical Information

Select the relevant option(s) below for the ICD-10-CM diagnosis code:
☐ E85.1 Neuropathic heredofamilial amyloidosis (transthyretin-related [ATTR] familial amyloid polyneuropathy)
☐ Other: _____

List current treatment(s): _____
Is WAINUA replacing a current treatment? ☐ Yes ☐ No
If yes, which treatment(s): _____

4 Prescriber Information

By completing this form, I certify that (1) I have received the necessary authorization to release the information included on this form and other related Protected Health Information (as defined by HIPAA) to AstraZeneca, including AstraZeneca US Patient Support/Ionis Patient Services, including employees, contractors, or affiliates of AstraZeneca and Ionis Pharmaceuticals, and health care plans for programs, dispensing pharmacy(ies) or other entities for the purposes of treatment and payment support, and (2) I have obtained any necessary authorization to allow AstraZeneca Access 360™ to contact the patient or caregiver, if not included with this submission to obtain a signed Patient Authorization.

Prescriber first name: _____ Last name: _____ Specialty: _____
Practice name: _____ Office contact name: _____
Street: _____ City: _____ State: ____ ZIP code: _____
Office phone #: _____ Office fax #: _____ Email: _____
Prescriber NPI #: _____ Other provider ID (if applicable): _____

5 Prescription Information

(A) ONLY complete Section A if using Orsini Specialty Pharmacy to fill the prescription.

Rx: WAINUA™ (eplontersen) injection, 45 mg/0.8 mL single-dose autoinjector (10-digit NDC: 0310-9400-01)
Dose instructions: _____
Quantity: _____ Refills: _____ Other: _____

(B) OPTIONAL: Free Limited Supply (FLS) Request

☐ Provides a free, short-term supply of WAINUA for eligible patients who are denied immediate access or are awaiting insurance coverage determination.
Rx: WAINUA™ (eplontersen) injection, 45 mg/0.8 mL single-dose autoinjector
Dose instructions: _____
Quantity: 1 single-dose autoinjector
Please note that FLS is a temporary program and does not replace existing affordability programs that may be more appropriate for long-term access barriers.

Please read the Prescriber Authorization on page 4 before signing below.
Prescriber first name: _____ Prescriber last name: _____
Prescriber NPI #: _____ State license #: _____
_____ ___/___/____
Prescriber signature: Dispense as written MM DD YYYY
_____ ___/___/____
Prescriber signature: Substitution permitted MM DD YYYY

Please complete and sign the form, then fax pages 1 and 3 to 1-844-329-2360.

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Clinical Information
Accurate and current clinical data are essential when filling out this form. This section requires you to select or fill in a diagnosis code. It is optional to list any relevant treatment(s) the patient is currently receiving and identify whether WAINUA will be replacing one of those current treatments.

Office Contact Information
Section 4 is a critical section that facilitates communication between the office and Access 360.

This section requires the prescribing provider's name and NPI # as well as contact information for the office. The phone number, fax number, and email can refer directly to the office contact who will be responsible for managing the patient's access to therapy.

Prescriber Signature
This part of Section 5 requires the prescribing healthcare provider's information and MUST be signed by that specific individual if this form is being used to fill a prescription for WAINUA via Orsini Specialty Pharmacy.

This is the only section that requires the prescriber's signature. It also requires the prescriber's name, NPI #, and state license #.

For more information, please contact AstraZeneca Access 360™ at 1-844-2-WAINUA, Monday through Friday, 8 AM – 6 PM ET.

1-844-2-WAINUA (1-844-292-4682)
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