VOWST Voyage™ Support Program
Enrollment Form and Prescription

Please complete all required fields, sign, and fax to 1-888-234-6987.
For assistance, call VOWST Voyage Support Services at 1-888-356-5444.

PATIENT INFORMATION
*Required field

First name*_____ Middle initial _____ Last name*_____
(Please print)

Date of birth*_____ Gender* ☐ Female ☐ Male ☐ Other Preferred language_____
(mm/dd/yyyy)

Address*_____ City/State/Zip code*_____

Phone (please check preferred)* ☐ Home_____ ☐ Mobile_____

Email address_____

Alternate contact name_____ Phone number_____

INSURANCE INFORMATION
*Required field

Coverage (check all that apply):

☐ Medicare ☐ Medicaid ☐ Commercial/Private ☐ Other ☐ Uninsured

☐ **Copies of insurance cards included**

PRIMARY INSURANCE

Insurance carrier*_____

ID #*_____

Group #*_____

Insurance phone*_____

Policyholder name _____
(If not the patient)

Relationship to patient _____

PHARMACY BENEFIT INSURANCE
Required if patient has separate pharmacy benefit card

Pharmacy Benefit Manager_____

ID #_____

Group #_____

Insurance phone_____

BIN # _____

PCN # _____

SECONDARY INSURANCE

Insurance carrier_____

ID #_____

Group #_____

Insurance phone_____

Policyholder name _____
(If not the patient)

Relationship to patient_____

PHARMACY BENEFIT INSURANCE
Required if patient has separate pharmacy benefit card

Pharmacy Benefit Manager_____

ID #_____

Group #_____

Insurance phone_____

BIN # _____

PCN # _____

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Patient name* _____ **Date of birth*** _____

PATIENT CONSENT

VOWST PATIENT AUTHORIZATION

I hereby authorize my healthcare prescribers, health plans, pharmacies, and their respective contractors and agents ("my healthcare organizations") to share my personal and health information ("my information") related to my Aimmune therapy with Aimmune Therapeutics, Inc., and its affiliates, agents, and contractors, (collectively, "Aimmune") as described below.

I authorize my healthcare organizations to share my information with Aimmune in order for Aimmune to: (1) contact me or my healthcare organizations, or others I have identified, about my disease or treatment; (2) confirm my health plan eligibility and benefits, and determine whether I may be eligible for financial assistance programs; (3) provide me with reimbursement support; (4) engage with me for internal business purposes, including quality control, support-enhancing surveys and market research; (5) send me marketing information, offers, and educational materials related to *Clostridioides difficile* and/or Aimmune therapies, including VOWST Voyage; and (6) use and disclose my information for safety reasons or as required by law. I understand that if I do not sign this form, my treatment and payment for my treatment by my healthcare prescribers and pharmacy will not be affected, but I will not have access to the Aimmune support described above. I understand that my pharmacy providers and/or their contractors may receive financial remuneration from Aimmune for disclosing my information to Aimmune, and for providing support services to me, including sending me communications, pursuant to this authorization.

I understand that once my health information has been disclosed to Aimmune, federal privacy laws may no longer protect it and it may be further redisclosed. I may cancel this authorization at any time by notifying Aimmune at 1-888-356-5444 or by sending written notice to P.O. Box 5490, Louisville, KY 40255 or info@vowstvoyage.com. My cancellation will not be effective until after Aimmune receives it and my healthcare organizations are notified of it by Aimmune, and it will not apply to any of my information disclosed in reliance on this authorization prior to my cancellation. I am entitled to a copy of this signed authorization, which expires at the earlier of ten (10) years or other time period required under the state in which I reside, from the date it is signed by me.

SIGN _____ Date: _____

Signature of patient or patient representative

If signed by a patient representative:

_____

Printed name

_____

Phone number of patient representative

*Required field

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Patient name* _____ **Date of birth*** _____

PATIENT CONSENT (continued)

TELECOMMUNICATIONS OPT-IN (OPTIONAL)

☐ Check here to receive nonmarketing tools and resources via calls/text messages from or on behalf of Aimmune and its affiliates at the telephone number(s) that I provide to help support me on my treatment journey with VOWST. I understand that these communications may be sent using an autodialer or artificial/prerecorded voice at the telephone number(s) that I provide. Message and data rate may apply. Recurring messages; frequency may vary.

SIGN _____ Date: _____

Signature of patient or patient representative

If signed by a patient representative:

_____ Printed name

_____ Phone number of patient representative

PATIENT CONSENT - VOWST PATIENT ASSISTANCE PROGRAM ("PAP"):

Please check each box, fill in the requested information, and sign at the bottom to be considered for the VOWST PAP. Contact VOWST Voyage Support Services with any questions regarding PAP enrollment.

☐ I understand that if my insurance does not cover my VOWST therapy, I may be eligible to participate in the PAP. I grant permission to the program to check my eligibility. I certify that my household income is $_____/year and there are _____ individuals in my household. I recognize that as part of determining my eligibility for PAP, my household income may be subject to verification.

☐ I understand that Aimmune Therapeutics, Inc., and its affiliates, agents, and contractors (Aimmune) may request documentation from me, my employer, my healthcare provider, or my insurance company to verify my financial information. Aimmune may obtain information from my credit profile from TransUnion for the purpose of verifying my income eligibility for PAP. I understand that I am providing "written instructions" to Aimmune under the Fair Credit Reporting Act ("FCRA"), authorizing Aimmune to obtain information from my credit profile or other information from TransUnion solely for the purpose of determining financial qualifications for PAP. I understand that I am entitled to a copy of this Authorization upon request.

☐ I attest that the information I have provided in this form is accurate to the best of my knowledge. I understand that by enrolling in the PAP, I agree to comply with the requirements of the PAP. I understand that Aimmune make no representation or guarantee concerning my eligibility to participate in the PAP. Participation in the PAP does not obligate me to use any specific health care provider, and I am free to change providers at any time. I attest that neither I nor anyone acting on my behalf will seek reimbursement for any product received as part of the PAP program from any government health care program or any other third-party insurer or payer, health savings account, or flexible spending account. I understand that the PAP program reserves the right to request additional documentation from me to determine program eligibility, and may independently verify information provided. I understand that I must inform the PAP if my financial circumstance, insurance, or any other eligibility criteria changes. I understand that Aimmune reserves the right to amend or discontinue the PAP, in whole or in part, at any time and without notice.

SIGN _____ Date: _____

Signature of patient or patient representative

If signed by a patient representative:

_____ Printed name

_____ Phone number of patient representative

*Required field

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Patient name* _____ **Date of birth*** _____

PRESCRIBER INFORMATION
*Required field

First name* _____ Last name* _____
(Please print)

Title _____ Specialty _____

Practice name* _____

Practice address* _____ City* _____

State* _____ Zip code* _____

Prescriber NPI* _____ Group NPI _____

Prescriber tax ID _____

Practice phone* _____ Office fax* _____

Primary contact name* _____ Primary contact phone* _____

Email address _____ Preferred contact method ☐ Phone ☐ Fax ☐ Email

COMPLETE STATEMENT OF MEDICAL NECESSITY AND CONSENT

By my signature, I certify that I am the healthcare professional who has prescribed the therapy identified in this form. I further certify that I have made an independent judgment that the above therapy is medically necessary, and that the information provided in this form is accurate to the best of my knowledge. I authorize Aimmune Therapeutics, Inc. (Aimmune), and its affiliates, agents, representatives, and service providers to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

☐ By checking this box, I certify that I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Aimmune and its employees or agents for purposes relating to Aimmune patient support programs, including, assisting the patient with benefits verification, prior authorization/appeals assistance, financial assistance resources and information, such as co-pay support or free drug programs, for which the patient may be eligible, and other support for VOWST. I certify that I have obtained consent from the patient or the patient's caregiver to be contacted by, VOWST Voyage, and/or parties acting on their behalf using email, text message, a live operator, autodialer, or prerecorded voice at the telephone number(s) provided regarding the purposes described above and for other non-marketing purposes. I also give my permission to receive calls related to these services from Aimmune, VOWST Voyage, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

SIGN

Prescriber signature* (No stamps) _____ Date* (mm/dd/yyyy) _____

Prescriber first and last name* (Please print) _____

Attending physician (If applicable) _____

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Patient name* _____ **Date of birth*** _____

CLINICAL INFORMATION
*Required field

DIAGNOSIS*

☐ **A04.71** Enterocolitis due to *Clostridium difficile*, recurrent

☐ **A04.72** Enterocolitis due to *Clostridium difficile*, not specified as recurrent†

☐ Other _____ (Please fill in)

Please indicate patient's clinical history of rCDI* (with attachments)

☐ Patient chart notes ☐ PCR test ☐ Toxin test

Number of recurrences* ☐ First ☐ Second ☐ Third ☐ Other _____

ANTIBACTERIAL TREATMENT DETAILS

Antibacterial treatment course type* ☐ Fidaxomicin ☐ Oral vancomycin ☐ Other (Please fill in) _____

Antibacterial treatment start date* _____ Day supply* _____

PREFERRED SPECIALTY PHARMACY*

☐ Amber Specialty Pharmacy ☐ Orsini Specialty Pharmacy ☐ No preference

†Is not the initial episode.

PRESCRIPTION & WELCOME KIT
*Required field

VOWST*

VOWST (fecal microbiota spores, live-brpk) capsules Refills: 0

1 dose = 4 capsules; 12 capsules

Directions: Take each dose (4 capsules) on an empty stomach prior to the first meal of the day for 3 days

☐ Dispense as written ☐ Substitutions allowed

_____ Prescriber signature

_____ Date

_____ Prescriber signature

_____ Date

WELCOME KIT

Please select one*

☐ Patient to receive one (1) 10 oz. bottle of magnesium citrate saline laxative oral solution in the Welcome Kit provided at no cost

☐ Patient using an alternative laxative option§

§In clinical studies, participants with impaired kidney function received polyethylene glycol electrolyte solution (250 mL GoLYTELY®, not approved for this use)

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SERES THERAPEUTICS