EPIDIOLEX® (cannabidiol) CV Patient Support Program

Enrollment Form

Epidiolex engage™ by Greenwich Biosciences

EPIDIOLEX Engage™ is a comprehensive patient support program that helps patients who have been prescribed EPIDIOLEX access their medication. Complete the form below to help your patients get started on treatment. All fields are required unless noted as optional. **Since EPIDIOLEX is a controlled substance, the appropriate prescription, in accordance with state-specific requirements, must be submitted separately from this enrollment form.**

SECTION 1: PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____

Physician Practice Name: _____ Office Contact Name: _____

Office Contact Phone: _____ Fax: _____

Office Email: _____

Office Street Address: _____

City: _____ State: _____ ZIP Code: _____

NPI # _____ DEA # _____ State License # _____

SECTION 2: PATIENT INFORMATION

Patient First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female Weight _____ kg

Patient Street Address: _____

City: _____ State: _____ ZIP Code: _____

Is the patient under the age of 18 or under legal guardianship? ☐ Y ☐ N

Legal Guardian First and Last Name: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred method of contact (optional) ☐ Home ☐ Work ☐ Cell

Best time to contact (optional) ☐ Morning ☐ Afternoon ☐ Evening

Diagnosis:

The diagnosis designations below are intended to ensure communication of accurate information to your patient's insurance plan. **EPIDIOLEX is approved to treat seizures associated only with Lennox-Gastaut syndrome or Dravet syndrome in patients 2 years of age and older. Safety and efficacy have not been established in other forms of refractory epilepsy.** See accompanying Prescribing Information.

☐ Seizures associated with Lennox-Gastaut syndrome ☐ Seizures associated with Dravet syndrome

☐ Refractory epilepsy ☐ Other (please specify) _____

If prescribing this medication for a use that is not listed on the FDA-approved label (see above), by signing below and initialing here, I certify that this prescription is medically necessary and appropriate for this patient and, as the treating physician, I will be supervising this patient's treatment with the prescribed medication.

Prescriber's initial _____ **Date** _____

Is the patient experiencing seizures? ☐ Y ☐ N

What antiseizure medications is the patient currently taking? _____

What antiseizure medications has the patient tried and failed? (optional) _____

Note: This information may be needed if a prior authorization is required.

SECTION 3: INSURANCE INFORMATION

Does the patient have prescription drug coverage? ☐ Yes ☐ No

If you answered ***yes*** to having prescription drug coverage, which may be different than the health insurance, **please provide the following information and a copy of the front and back of the prescription drug card**. If you answered ***no***, you may skip this section.

Prescription Drug Insurance Provider Name:

Insurer Name: _____ Insurer Phone: _____

Rx ID Number: _____ Rx PCN: _____

Rx BIN Number: _____ Rx Group Number: _____

Patient's relationship to cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Does the patient have other health insurance? ☐ Y ☐ N

If you answered ***yes*** to having other health insurance, please provide the following information and a copy of the front and back of the insurance card. If you answered ***no***, you may skip this section.

Other Insurance Provider Name: _____

Policy ID Number: _____ Group Number: _____

Insurer Phone: _____ Cardholder Name: _____

Patient's relationship to cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

SECTION 4: PRESCRIBER AUTHORIZATION

I authorize the use or disclosure of the patient's health information contained on this enrollment form to the patient's other healthcare providers (including pharmacies and Greenwich Biosciences, Inc.), health insurers, and their respective agents and contractors, and other designees, that are involved in the patient's treatment, to: (1) determine the patient's insurance benefits for EPIDIOLEX; (2) transmit the prescription and other necessary information, to a pharmacy that will fill the patient's prescription, and to obtain information from the pharmacy regarding delivery of such prescribed medication and related matters; (3) contact the patient to obtain any other necessary signatures, consents or information relating to the patient's treatment; (4) contact the patient in order to ask whether the patient would like to apply for the Greenwich Biosciences Patient Assistance Program, and to request information from the patient or from patient's designees needed to determine eligibility for the program; and (5) to provide other related care coordination services. I certify that I have obtained my patient's authorization as required by HIPAA to use and disclose patient's personally identifiable health information (including diagnosis, treatment, and insurance information, contained in this form), for the purposes permitted under this "Prescriber Authorization" Section. I agree that the patient's providers, insurers, pharmacies and other designees may contact me for additional information as needed relating to the patient's EPIDIOLEX therapy.

I certify that: I am the physician who has prescribed EPIDIOLEX to the identified patient; EPIDIOLEX is medically necessary for this patient; and the information provided on this form is accurate to the best of my knowledge.

Prescriber's Signature _____ **Date** _____

SECTION 5: OPTIONAL HIPAA PATIENT AUTHORIZATION FORM

The attached HIPAA Patient Authorization Form is not necessary to permit the use and disclosure of the patient's health information as stated in the Prescriber Authorization Section, but Prescriber may elect to submit to the patient.

Fax the completed form to the EPIDIOLEX Engage™ Hub, or if the payer's preferred specialty pharmacy provider is known, directly to one of the authorized specialty pharmacies below:

	FAX
EPIDIOLEX Engage Hub	1-855-518-7566

OR

AcariaHealth	1-877-541-1503
Accredo	1-888-302-1028
AllianceRx Walgreens Prime	1-877-231-8302
Amber Pharmacy	1-402-896-3774
CVS Specialty	1-844-691-1343

Before submitting this form, please ensure:

☐ This enrollment form is complete with all required information requested and the prescriber's signature

☐ Copies of the health insurance and prescription drug coverage cards are provided

☐ A separate prescription for EPIDIOLEX is sent via fax or e-prescribed

Please see accompanying full Prescribing Information.

Optional HIPAA Patient Authorization Form

Patient Authorization to Use/Disclose Health Information

By signing this HIPAA Patient Authorization Form ("Authorization"), I hereby request and authorize my physicians, my pharmacists (including any specialty pharmacy that receives my prescription for EPIDIOLEX) and other healthcare providers ("Providers"), and my health insurers ("Insurers") and their respective agents and contractors, to disclose my protected health information, including but not limited to, information related to my medical condition and treatment (including prescription information), my health insurance coverage and policy number, my name, mailing and e-mail address(es), telephone number, date of birth and Social Security Number ("Protected Health Information" or "PHI"), to Greenwich Biosciences, Inc. and its affiliates, and their respective agents and contractors (collectively, "Greenwich Biosciences") for the following purposes: (i) to contact me, my personal representative(s), guardian(s) or designees, my Providers, Insurers or others I have identified, about my disease or treatment (including EPIDIOLEX); (ii) to contact me about enrollment in support programs and/or related market research, including patient surveys; (iii) to provide me with educational materials, information, and services related to EPIDIOLEX, my disease, and ways to help me maintain my prescribed treatment; (iv) to perform analyses or improve or develop products (including EPIDIOLEX), services, programs, or treatment related to my disease; (v) to perform activities related to quality, efficacy, and safety of EPIDIOLEX; (vi) to offer me opportunities to participate in any clinical studies or trials; (vii) to de-identify my PHI or combine it with other data for research or analysis, or for any other purpose permitted by law; (viii) to send marketing communications to me; or (ix) to use and disclose my PHI as required or permitted by law.

I understand that once my PHI has been disclosed to Greenwich Biosciences, my information may be protected by certain state privacy laws but may no longer be protected under federal privacy laws and that my PHI may be subject to re-disclosure. I understand that one or more Providers and/or Insurers may receive payment from Greenwich Biosciences for using or disclosing my Protected Health Information for some or all of the purposes permitted by this Authorization. I understand that Greenwich Biosciences will not sell my name, address, e-mail address, or any other information to another party for their own marketing use. I understand that I am not required to agree to this Authorization. If I do not agree, my treatment (including the receipt of EPIDIOLEX), payment for my treatment, or eligibility for insurance benefits will not be affected, but I may not receive the other services described above.

I understand that I may cancel this Authorization at any time by: mailing a written request to a Greenwich Biosciences representative at PO Box 42485, Cincinnati, OH 45242, faxing my cancellation to 1-855-518-7566, or calling 1-833-GBNGAGE (1-833-426-4243). The Greenwich Biosciences representative shall provide timely notification of my cancellation to the applicable parties. Once they receive and process the notice of cancellation of this Authorization, the applicable parties may no longer share my PHI with Greenwich Biosciences as permitted by this Authorization. However, canceling this Authorization will not affect any action(s) taken by the applicable parties based on this Authorization before receipt of my notice of cancellation. This Authorization will expire in five (5) years from the date this Authorization is signed below, unless a shorter period is required by the law of my state of residence. I understand that I have a right to request and to receive a copy of this Authorization.

By signing below, I am indicating that I have read and understand the information set forth in this Authorization.

Patient Name: _____

Signature of Patient or Guardian, if applicable: _____

Name (if different from Patient):_____ Date: _____

Relationship to Patient:_____

Email Address:_____

For additional assistance, call us at 1-833-GBNGAGE (1-833-426-4243).
Please see accompanying full Prescribing Information.