

The Sentynl Cares program

Provided by Sentynl Therapeutics to help bring NULIBRY to those who need it.

Instructions for Prescribers



Discuss the Sentynl Cares program with your patient's parents or caregivers

Once enrolled in the program the patient is evaluated for access options based on individual needs



Fill out practice information, including:

- NPI number
- Primary facility contact information
- NICU/PICU information if applicable

Indicate prescription information and sign, including:

- ICD-10 codes and other relative information

Sign, where applicable, for all program opportunities



Fax completed form to Sentynl Cares: 877-977-0011, including:

- All completed and signed pages (8)
- Medical coverage information

Instructions for Parents/Caregivers



Discuss the Sentynl Cares application with your healthcare provider

Sentynl Cares offers programs that provide a high level of support during every step of the treatment journey



Read and sign to give consent for access to Sentynl Cares

- Insurance benefits verification and appeals support
- Patient affordability programs, which can help qualified patients get NULIBRY



Provide insurance information, including:

- Primary and secondary insurance information
- Medical and pharmacy information
- Preferred method of contact

Please call 1-888-251-2800 with any questions



NULIBRY enrollment form

In order to obtain your prescription for NULIBRY, you must enroll in the Sentyln Cares | NULIBRY Patient Access and Support Program. Print and fax completed enrollment forms to 877-977-0011. All pages must be received to process enrollment.

Phone: 1-888-251-2800
Fax: 877-977-0011
Web: NULIBRY.com/sentylncares

SUPPORT OFFERED TO PATIENT AND/OR THEIR CAREGIVER

In addition to dispensing your medication, the Sentyln Cares | NULIBRY Patient Access and Support Program is your source to help you feel supported on your child's path with NULIBRY.

Based on your selections below, your child will be enrolled in the Sentyln Cares | NULIBRY Patient Access and Support Program (the "Program").

Sentyln Therapeutics, Inc. has designed this Program to help you learn more about your child's condition and treatment, and to help your child get started on their NULIBRY treatment journey.

Please complete the form and let us know which features of the Program you would like to be enrolled in by checking the relevant box(es) and signing below:

- ☐ **By checking this box, the patient will be evaluated for all features of the Program listed below and is opting in to receive program-related communications (e.g., phone, text, email, mail) as specified by your selections below. Otherwise, please check the program features below that you are interested in being evaluated for.**
- ☐ **Insurance Support and Financial Assistance**
May include benefits verification, prior authorization, appeals support, and potential financial assistance options. Additional information may be required to determine eligibility.
- ☐ **NULIBRY Copay Assistance Program**
Helps patients manage out-of-pocket copay coinsurance costs for those with commercial insurance or private prescription drug coverage. This offer is not valid for prescriptions reimbursed under Medicaid, a Medicare drug benefit plan, or other federal or state programs (such as medical assistance programs).
- ☐ **Nurse and Educational Support**
Sentyln Cares clinical staff may provide educational information on your child's condition and information on NULIBRY.

Please check your preferred method(s) of contact and list your contact information below:

- ☐ Mail Preferred Mailing Address: _____
- ☐ Email Preferred Email Address: _____
- ☐ Telephone Preferred Telephone Number: _____

PATIENT/CAREGIVER CONSENT TO ENROLL IN SENTYNL CARES | NULIBRY PATIENT ACCESS AND SUPPORT PROGRAM

By signing below, I agree to enroll in the features of the Program specified by my selection(s) above. I hereby agree to receive any Program-related communications necessary to fulfill the requirements of the program, as specified above.

SIGN HERE

Parent/Caregiver or Legal Representative

Print Name

Date

PATIENT & CAREGIVER AUTHORIZATION TO SHARE HEALTH INFORMATION

By signing below, I authorize my healthcare providers, insurers, and pharmacies ("Healthcare team") to disclose information often referred to as protected health information ("Health Information") to Biologics, Inc and its agents (the "Parties"). Health Information includes information such as: (1) name, address, telephone, and other personal and contact information, (2) health insurance coverage-related information, and (3) treatment-related information. In addition to my Health Information, I authorize my Healthcare team to disclose to the Parties any financial information necessary for my enrollment in the Sentynl Cares | NULIBRY Patient Access and Support Program.

The Parties agree to use and disclose my Health Information and financial information (together "Information") only as allowed by me in this Authorization or as otherwise allowed by law. Once my Information has been disclosed to the Parties, I understand that federal privacy laws may no longer protect it from further disclosure.

I authorize the Parties to use my Information for the following purposes:

- Enrolling me in the Sentynl Cares | NULIBRY Patient Access and Support Program (the "Program")
- Providing me with educational information, nursing educational calls (if selected), and other treatment-related educational support
- Verifying, investigating, assisting, and helping with coordinating my health insurance coverage for NULIBRY
- Assessing my initial and continued eligibility for various financial assistance programs
- Coordinating prescription fulfillment
- Contacting me regarding the Program
- Assisting with analyses related to the use of NULIBRY

I understand that I may refuse to sign this Authorization, that I may refuse to disclose all or some of my Information, and that a refusal to sign will not affect my ability to obtain medical care, insurance coverage, or access to health benefits. However, if I do not sign this Authorization, I understand I will not be able to participate in the Program. Unless I cancel this Authorization sooner or unless otherwise required by state or local law, this Authorization will expire on ____ / ____ / 20____, or ten (10) years from the date of signature on this Authorization, whichever occurs first.
(month/day/year)

I may cancel this Authorization at any time by writing to Sentynl Cares | NULIBRY at 11800 Weston Parkway, Cary, NC 27513, or by sending an email to NULIBRY@mckesson.com. I understand that canceling this Authorization will end my participation in the Program and will not affect any use or disclosure of the Information made before my request is received.

I understand that I have a right to receive a copy of this Authorization when it is signed.

SIGN HERE

Parent/Caregiver or Legal Representative

Print Name

Date

OPTIONAL PATIENT/CAREGIVER AUTHORIZATION TO RECEIVE COMMUNICATIONS FROM SENTYNL THERAPEUTICS, INC. REGARDING SENTYNL PROGRAMS AND INITIATIVES

Sentynl Therapeutics, Inc. ("Sentynl" or "we"), the manufacturer of NULIBRY, would like to reach out to you regarding Sentynl programs and initiatives, such as sharing your personal health journey, disease-state awareness/educational materials, patient advocacy opportunities, and other topics of interest.

We will not sell or share any personal information you disclose pursuant to this authorization ("Personal Information") to any third party, except for (1) Sentynl Affiliates (as defined below) or (2) regulatory authorities, as appropriate, without your express permission. We may contact you to ask about your experience with Sentynl and/or its products.

The Personal Information we collect may include your name, contact details, your relationship to the patient, and information about your experience as a patient or caregiver of a patient with MoCD Type A and/or Sentynl's products or services. We will use this information to contact you to send you communications regarding disease-state awareness or patient advocacy opportunities, to discuss your experience as a patient or caregiver of a patient with MoCD Type A and/or Sentynl's products or services, and/or to manage and document our communications with you.

I authorize Sentynl and companies contracted or affiliated with Sentynl ("Affiliates") to contact me by mail, email, and/or telephone to provide me with the information I requested or discuss my personal health journey, story, or experience as a patient or caregiver of a patient with MoCD Type A ("Personal Health Journey"), as specified by my selections below. I understand that I am not required to provide this consent as a condition of purchasing any property, goods, or services from Sentynl. I also understand that I may participate in the Sentynl Cares | NULIBRY Patient Access and Support Program if I do not sign this optional authorization. To learn more about how your information is used or if you decide that you no longer wish to receive information about Sentynl programs and initiatives, please visit our privacy statement at Sentynl.com. I understand that withdrawing my consent will not affect any use of my information that has already occurred, but Sentynl will not use my information for new outreach after my withdrawal.

Check all that apply:

- ☐ Check here if you are interested in sharing your Personal Health Journey with others. By checking this box, I understand that a representative from Sentynl may contact me to discuss my Personal Health Journey at my preferred method(s) of contact listed below.
- ☐ Check here if you are interested in receiving communications from Sentynl regarding disease-state awareness and other educational materials. By checking this box, I understand that a representative from Sentynl may contact me regarding disease-state awareness or other related educational materials at my preferred method(s) of contact listed below.
- ☐ Check here if you are interested in receiving communications from Sentynl regarding patient advocacy opportunities. By checking this box, I understand that a representative from Sentynl may contact me to discuss patient advocacy opportunities at my preferred method(s) of contact listed below.

Please check your preferred method(s) of contact and list your contact information below:

- ☐ Mail Preferred Mailing Address: _____
- ☐ Email Preferred Email Address: _____
- ☐ Telephone Preferred Telephone Number: _____

SIGN HERE

Parent/Caregiver or Legal Representative

Print Name

Date

PATIENT INFORMATION

Name: _____ (First, MI, Last) DOB: _____ (mm/dd/yyyy)
 Street: _____
 City: _____ State: _____ ZIP: _____
 Gender: ☐ Male ☐ Female Today's Date: _____ Current Weight: _____

PARENT/CAREGIVER INFORMATION (PARTY RESPONSIBLE FOR PATIENT)

Parent/Caregiver Name: _____ (First, MI, Last)
 Relationship to Patient: _____
 Primary Phone: _____ Primary Email: _____
 I consent to allow Sentyln Cares to leave me a voicemail about access information.: ☐ Yes ☐ No

Primary Email: _____
 Street: _____
 City: _____ State: _____ ZIP: _____
 DOB: _____ (mm/dd/yyyy) Gender: ☐ Male ☐ Female Preferred Language (If Not English): _____

Additional Contact Permitted to Receive Patient Information

Name: _____
 Email: _____
 Relationship to Patient: _____
 Phone: _____

PRIMARY INSURANCE INFORMATION

Please attach copies (front and back) of all available insurance and prescriptions cards.

No Insurance? ☐

Primary Medical Insurance Name: _____	Primary Rx Insurance Name (If Different): _____
Insurance Phone: _____	Rx Insurance Phone: _____
Policy ID #: _____	Policy ID #: _____
Group #: _____	Group #: _____

Policy Holder Name: _____ (First, MI, Last)
 Relationship to Patient: _____ Rx BIN #: _____ Rx PCN #: _____
 Street: _____
 City: _____ State: _____ ZIP: _____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Please attach copies (front and back) of all available insurance and prescriptions cards.

Secondary Medical Insurance Name: _____	Secondary Rx Insurance Name (If Different): _____
_____	_____
Insurance Phone: _____	Rx Insurance Phone: _____
Policy ID #: _____	Policy ID #: _____
Group #: _____	Group #: _____
Policy Holder Name: _____	
(First, MI, Last)	
Relationship to Patient: _____	Rx BIN #: _____ Rx PCN #: _____
Street: _____	
City: _____	State: _____ ZIP: _____

PRESCRIBER INFORMATION (PRESCRIBER TO FILL OUT)

Prescriber Name: _____ Group Tax ID (NPI #): _____

Prescriber Facility Name: _____

Specialty: _____ Primary Facility Contact Email: _____

Street: _____ Primary Contact Phone: _____

City: _____ State: _____ ZIP: _____ Primary Facility Contact Fax: _____

Hospital Admission Date (if different from DOB): _____

Complete below if the patient is currently hospitalized:

Hospital Name: _____

Hospital Contact Name: _____ Hospital Contact Email: _____

Street: _____

City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____

NICU/PICU INFORMATIONNICU ☐ PICU ☐

NICU/PICU Contact Name: _____

NICU/PICU Contact Email: _____

Phone: _____ Fax: _____

Best Time to Contact: _____

DIAGNOSIS AND ICD-10 CODE

Diagnosis: _____

ICD-10 Code: _____

TREATMENT AND PRESCRIPTION INFORMATION*Fill out this section to write your patient's prescription. Please submit a separate prescription if required by state law (New York prescribers).***Prescription for NULIBRY**

Date: _____

An infusion pump and supplies are required for adequate administration of NULIBRY. Please see the full Prescribing Information for details, specifically the Instructions for Use section.☐ Confirmed or presumptive diagnosis: molybdenum cofactor deficiency Type A (MoCD Type A)

Patient Name: _____

DOB: _____
(mm/dd/yyyy)

Current Weight: _____

NULIBRY for injection 9.5 mg fosdenopterin hydrobromide per vial:

Dosage: _____ Quantity: _____ Refills: _____

SIGN HERE_____
Prescriber Signature Required – No Stamps_____
Print Name_____
Date

HEALTHCARE PROFESSIONAL CONSENT

I certify that (1) the prescribed medicine is medically necessary for this patient and the treatment decision was based solely on my independent medical judgment; (2) services provided by Sentynl Therapeutics, Inc. ("Sentynl") on behalf of any patient are not made in exchange for any express or implied agreement or understanding that I will recommend, prescribe, or use any Sentynl product or service; (3) the patient provided me with an authorization to release their personal health information to Biologics Specialty Pharmacy (together with its affiliates, including but not limited to its third-party business partners, vendors, and other agents) for purposes of enrollment in the Sentynl Cares | NULIBRY Patient Access and Support Program and receipt of patient support services; and

If my patient is eligible for free product, I understand that receiving free product is not contingent on any purchase obligations. I also understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; nor should it be sold, traded, or distributed for sale. I will notify Biologics immediately if NULIBRY is no longer medically necessary for this patient's treatment or if my patient's insurance status changes. I agree to comply with my state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. I understand that noncompliance with state-specific requirements could result in outreach to me as the prescriber.

SIGN HERE

Prescriber Signature Required – No Stamps

Print Name

Date