Biogen REACH Start Form—INSTRUCTIONS

SKYCLARYS® (omaveloxolone) capsules, 50 mg each

Phone: 1-844-98-REACH (1-844-987-3224) Fax: 1-844-806-1718

Biogen REACH is a centralized resource for patients and healthcare providers to receive information on insurance requirements and affordability options for SKYCLARYS.

THE COMPLETED AND SIGNED FORM MUST BE SUBMITTED BY A HEALTHCARE PROVIDER VIA

Fax: 1-844-806-1718

OR

Email: StartForm@biogen.com

Instructions for Healthcare Provider

Please complete all sections on page 3, including:

- Patient information
- Insurance information
- Prescriber information
- Diagnosis
- Prescription information

A completed Start Form provides the required patient consent to allow Biogen REACH to discuss relevant healthcare information and affordability options for SKYCLARYS with a patient's healthcare provider, insurer, and Biologics, the exclusive specialty pharmacy for SKYCLARYS.

To be eligible for all Biogen REACH services, your patient or their caregiver/authorized representative must complete and sign the patient consent section on page 2. Your patient is not required to enroll in Biogen REACH before you prescribe SKYCLARYS. However, their signed consent is required to access all program support services.

If the patient is not in the office while you are completing the Start Form, you may submit the form without patient signature. The Biogen REACH program will contact the patient to obtain consent via DocuSign or by mail.

QUESTIONS?

Visit www.SKYCLARYS.com or call 1-844-98-REACH (1-844-987-3224)

Biogen REACH Care Navigators are available

8:30am to 8pm ET, Monday–Friday (except holidays)

PRESCRIBER AUTHORIZATION

I certify that (i) I am prescribing SKYCLARYS® for the patient identified above and that the medication is medically necessary; (ii) I have provided the patient with a description of the Biogen REACH program ("Program") and the patient has elected to participate; and (iii) the information provided herein is accurate to the best of my knowledge. I authorize Biologics Specialty Pharmacy as my designated agent and on behalf of my patient to forward the above statement of medical necessity and furnish any information on this form to the insurer of the above-named patient. I understand that (i) participation in the Program is not a guarantee of insurance coverage or reimbursement; and (ii) the Program reserves the right, at any time and without notice, to rescind, revoke, or amend the Program.

**Signature stamps not permitted. Please attach all prescriptions on Official State Prescription form if mandated by individual state laws.

PATIENT CONSENT: PLEASE READ, SIGN, AND DATE

Patient Full Name (Print):

Caregiver/Authorized Representative Full Name (Print): Relationship to Patient:

I. Authorization to Share Health Information

I understand that I have certain rights related to the collection, use, and disclosure of my/my child's medical and health information. This information is called "protected health information" (PHI) and includes demographic information (such as sex, race, date of birth, etc.), the results of physical examinations, clinical tests, blood tests, X-rays, and other diagnostic medical procedures that may be included in my/my child's medical records. Biogen will not use my/my child's PHI without my consent.

By signing this Authorization, I authorize my/my child's healthcare provider, my/my child's health insurance company and my/my child's pharmacy providers ("Healthcare Entities") to disclose to Biogen, and companies working with Biogen (collectively, "Biogen"), health information relating to my/my child's medical condition, treatment, and insurance coverage for Biogen to (i) provide me/my child with support services (and related information and materials) related to any of Biogen's products, including but not limited to, online support, financial assistance services, compliance and persistency and other therapy support services, and (ii) conduct data analysis, market research and other necessary internal business activities, and (iii) provide me with information about Biogen's products, services, and programs for educational or other purposes. I understand that once I sign this Authorization, and my/my child's medical and health information is disclosed to Biogen by the Healthcare Entities, the Health Insurance Portability and Accountability Act (HIPAA) will no longer protect my information because Biogen is not covered by HIPAA. However, Biogen agrees to protect my/my child's health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. I understand that my/my child's pharmacy provider may receive remuneration from Biogen in exchange for the health information and/or for any therapy support services provided to me/my child.

I understand that I may refuse to sign this Authorization. I further understand that my/my child's treatment (including with a Biogen product), payment for treatment, insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization; but if I do not sign it or later cancel it, I/my child will not be able to receive Biogen's therapy support services.

I may cancel this Authorization at any time by mailing a letter to: [Biogen, ATTN: Patient Services, 5000 Davis Drive, PO Box 13919, Research Triangle Park, NC, 27709] or by emailing privacy@biogen.com. Canceling this Authorization will end consent to further disclosure of my/my child's health information to Biogen by my/my child's Healthcare Entities after they are notified of my cancellation but will not affect previous disclosures by them pursuant to this Authorization. Canceling this authorization will not affect my/my child's ability to receive treatment, payment for treatment, or my/my child's eligibility for health insurance.

This Authorization expires ten (10) years, or such shorter timeframe required by applicable law, from the day I sign it as indicated by the date next to my signature unless otherwise canceled earlier as set forth above.

I have read and understand the Authorization to Share Health Information and agree to the terms.

X Signature of patient or patient representative (if under 18): **Date:**

If signed by patient representative, please explain authority to act on behalf of the patient:

II. Patient Services Authorization

By signing this Authorization, I authorize Biogen, and companies working with Biogen, to provide me/my child with support services related to any of Biogen's products, including but not limited to: online support, financial assistance services, compliance and persistency and other therapy support services, as well as any information or materials related to such services. I understand and agree that personnel, including but not limited to nurses, providing such support services on behalf of Biogen are not employed by my/my child's healthcare professional. I authorize Biogen, and companies working with Biogen, to contact me to provide such services and information by mail, email, fax, telephone call, text message (including calls and text messages made with an automatic telephone dialing system or a prerecorded voice), chat, push notifications and other forms of electronic messaging.

I also authorize Biogen, and companies working with Biogen, to use and disclose my/my child's medical and health information in connection with providing the services, including but not limited to, disclosing my/my child's information to vendors, processors, and service providers for business purposes associated with providing the services, sharing such information with my/my child's healthcare provider, insurance provider, or pharmacy, or disclosing my/my child's information where required by applicable laws or regulations. I further authorize Biogen to use my personal information to access my credit profile, including but not limited to, information from a consumer reporting agency (credit bureau) and information derived from public and other sources to estimate my income as part of the determination of eligibility for financial assistance. I also authorize the disclosure of my/my child's health information to specific individuals that I have designated.

I have read and understand the Patient Services Authorization and agree to the terms.

X Signature of patient or patient representative (if under 18): **Date:**

III. Marketing Authorization

By signing this Authorization, I authorize Biogen, and companies working with Biogen, to contact me by mobile or online digital media, mail, email, fax, telephone call, and text message (including autodialed and prerecorded calls and messages) for marketing purposes or otherwise provide me with information about Biogen's products, services, and programs or other topics of interest, conduct market research or otherwise ask me about my/my child's experience with or thoughts about such topics. I understand and agree that any information that I provide may be used by Biogen for marketing, including targeted online marketing, as well as to develop new products, services, and programs. I understand that Biogen will not sell or transfer my/my child's personal data to any unrelated third party for marketing purposes without my express permission. I understand that my consent is not required as a condition of purchasing or receiving any goods or services from Biogen. I understand that I may revoke this authorization and choose not to receive information from Biogen by using the link provided in emails I receive from Biogen, sending an email with the subject "Unsubscribe" to privacy@biogen.com, or mailing a letter to Biogen, 5000 Davis Drive, PO Box 13919, Research Triangle Park, NC 27709. For more information visit biogen.com/privacy.

I have read and understand the Marketing Authorization and agree to the terms.

X Signature of patient or patient representative (if under 18): **Date:**

Residents of certain US States (including but not limited to California) may have additional rights regarding the collection, use, maintenance, disclosure, and deletion of your personal information. To understand or exercise those rights California residents please visit https://www.biogen.com/privacy-center/california-policy.html. For more information, visit https://www.biogen.com/privacy-center.html.

I understand that I have the right to receive a copy of the terms and conditions of my agreement with Biogen, and that I may request that copy at the time of signing or at a later date by contacting Biogen at: Biogen, ATTN: Patient Services, 5000 Davis Drive, PO Box 13919, Research Triangle Park, NC, 27709 or emailing privacy@biogen.com.

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PATIENT INFORMATION

* Indicates a required field

*Patient First Name: *Last Name: Middle Initial:

*Patient Street Address: *Apt/Suite:

*City: *State: *ZIP Code: *Gender: *DOB:

*Patient Primary Phone (Mobile ☐): Voicemail Allowed: ☐ Yes ☐ No

Check Y/N: I authorize Biogen REACH to leave information regarding my prescription and insurance coverage on voicemail of number(s) provided

Secondary Phone (Mobile ☐):

Patient Email: Preferred Language:

Caregiver/Authorized Representative (Please complete this section ONLY if someone other than the patient will be interacting with Biogen REACH on program services)

I authorize the disclosure of my health information to the following designated individual(s) (optional)

Full Name of Caregiver/Authorized Representative: Relationship to Patient:

Caregiver/Authorized Rep Primary Phone: Caregiver/Authorized Rep Email:

INSURANCE INFORMATION

Include a copy of front and back of patient's medical and prescription benefit insurance cards, copy of insurance information from EMR, or complete the information below

Primary Insurance Name: ☐ No Insurance ☐ Medicare Part D

Member ID: Group #:

Policy Holder Name: DOB: Relationship to Patient:

Prescription Benefit Insurance Name: Phone #:

Member ID: Rx BIN: Rx PCN: Rx Group:

PRESCRIBER INFORMATION

*Prescriber Name: *Specialty:

*Practice Name:

*Street Address: *Suite/Apt: *Office Phone #:

*City: *State: *ZIP Code: Office Fax #:

*NPI #: *State License #:

Office Contact: Office Contact Phone #: Office Contact Email:

DIAGNOSIS

ICD-10 Code: ☐ G11.11 Friedreich's Ataxia ☐ Other (list ICD-10):

SKYCLARYS® PRESCRIPTION INFORMATION

☐ SKYCLARYS® (omaveloxolone) 50-mg capsules x 30-day supply (90 capsules) ☐ Other (please specify):

*Refills Authorized: ☐ 11 ☐ Other (please specify):

Directions for use: ☐ Take 3 (50-mg) capsules by mouth once daily ☐ Other (please specify):

Prescriber Full Name:

X Prescriber Signature: **Date:**

By providing my signature I agree to the Prescriber Authorization language at the top of page 2.

SKYCLARYS® BRIDGE PRESCRIPTION INFORMATION *(Optional, at no cost to patient)*

If your patient's insurance has not yet authorized coverage of SKYCLARYS, the Bridge Program offers a temporary supply of SKYCLARYS to your patient at no cost to provide initial access to therapy while we work with you to secure authorization and access through the patient's insurance plan.

The SKYCLARYS Bridge Program is limited to an initial 30-day supply of medication. Should additional doses be needed, the patient must meet additional criteria to ensure eligibility for an additional 30 days of product through the Program. If coverage is not obtained, your patient will be assessed for other manufacturer support offerings. If no offerings are available, your patient will not continue to receive no-cost medication beyond the 60-day supply.

The offer of this Program is not in any way intended to influence or result in any future purchase obligation. Additionally, you are not permitted and hereby attest that you shall not seek reimbursement for any free doses provided to the patient under the Program. The terms and conditions of the Program will be sent to the patient if/when the first Program shipment is sent.

☐ SKYCLARYS® (omaveloxolone) 50-mg capsules x 30-day supply (90 capsules) ☐ Other (please specify):

*Refills Authorized: ☐ 1 ☐ 0

Directions for use: ☐ Take 3 (50-mg) capsules by mouth once daily ☐ Other (please specify):

Prescriber Full Name:

X Prescriber Signature: **Date:**

By providing my signature I agree to the Prescriber Authorization language at the top of page 2.