PRODUCT ENROLLMENT FORM

CrinetiCARE

Please fax completed form to: **844-CRN-FAXX (844-276-3299)**
Call CrinetiCARE® Monday – Friday 8am to 8pm EST at
844-CRN-HELP (844-276-4357)

Palsonify® (paltusotine) tablets

PATIENT INFORMATION

(* Required Field)

First Name* _____ Last Name* _____ DOB* (mm/dd/yyyy)

Sex: ☐ Male ☐ Female Street Address* _____ City*_____ State* ____ Zip*_____

Primary Phone #* _____ Alt Phone # _____ Email Address*_____

Alt Contact Person _____ Alt Contact Phone # _____ Prior surgery: ☐ Yes ☐ Surgery Not An Option

PATIENT INSURANCE AND PHARMACY PREFERENCE

Please copy both sides of the patient's insurance card(s) and include with fax.

Primary Health Insurance

Plan Name _____
Phone # _____
Policy ID # _____
Group # _____

_____
Policy Holder Name (if other than patient)

Prescription Drug Insurance

Plan Name _____
Phone # _____
Policy ID # _____
Group # _____
Rx BIN _____
PCN _____

Secondary Insurance

Plan Name _____
Phone # _____
Policy ID # _____
Group # _____

PRESCRIBER INFORMATION & PRESCRIPTION

Prescriber Name*_____
Practice Name*_____
Phone*_____ Fax* _____
Email*_____
NPI #*_____ Best Time to Contact _____
Supervisory Prescriber's Name _____

City*_____ State*_____ Zip*_____
State License # _____
Supervisory Prescriber's NPI # _____
HCP Prior Authorization contact's name_____
HCP Prior Authorization contact's email _____
Faxing clinical notes with this form? ☐YES ☐NO

PREVIOUS MEDICATIONS USED*

☐None ☐cabergoline ☐lanreotide acetate ☐Mycapssa ☐octreotide acetate ☐Sandostatin ☐Sandostatin LAR ☐Signifor ☐Signifor LAR ☐Somatuline Depot ☐Somavert

Dose:_____ Dose:_____ Dose:_____ Dose:_____ Dose:_____ Dose:_____ Dose:_____ Dose:_____ Dose:_____ Dose:_____

PATIENT DOSAGE FOR PALSONIFY™ (paltusotine) TABLETS* - SELECT ONE OR MULTIPLE DOSES

☐ PALSONIFY® 20mg tablets
Dose: 40mg (20mg Tablets x2)
Directions: Take 2 (two) tablets by mouth once daily, as directed.
QUANTITY: _____ REFILLS: _____

☐ PALSONIFY® 30mg tablets
Dose: 60mg (30mg Tablets x2)
Directions: Take 2 (two) tablets by mouth once daily, as directed.
QUANTITY: _____ REFILLS: _____

☐ PALSONIFY® tablets (alternate)
Dose: _____
Directions:_____
QUANTITY: _____ REFILLS: _____

ICD-10 Code: ☐ E22.0 (Acromegaly & Pituitary Gigantism) ☐ Other ICD-10: _____

Pharmacy Preference: ☐ Biologics ☐ Orsini ☐ Institutional Pharmacy _____

Quick Start Supply ☐ YES ☐ NO The "Quick Start Program" is a free supply of PALSONIFY® that allows eligible patients to begin therapy while insurance is verified.

By signing below, I, as the treating healthcare practitioner, state: (i) This prescription is medically appropriate for this patient and I will be supervising this patient's treatment; (ii) all information supplied to Crinetics or its agents ("Crinetics") relating to this enrollment form is accurate, and has been obtained pursuant to a separate, valid patient authorization that allows Crinetics to contact this patient to provide services relating to (1) treatment and (2) benefit verification and/or pre-authorization. Further, I understand that: (a) any free product provided is for the use of this patient only and shall not be sold or transferred to anyone else, or returned for credit; (b) free product may not be counted toward Medicare Part D out-of-pocket costs, free product may not be claimed for reimbursement from any third-party payer; and (c) Crinetics may revise, change, or terminate this or any other program at any time without notice. I authorize the Specialty Pharmacy to initiate any medical authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not related to seeking reimbursement, credit or other prohibited activities related to the free product..

Please Sign*

Prescriber Signature: _____ **Date:*** / /

No Substitution / Dispense as Written / DAW / Brand Name Medically Necessary / Do Not Substitute

(Stamps & Electronic Signatures Not Allowed)

Prescriber Signature: _____ **Date:** / /

Substitution Permissible / Product Selection Permitted

CA, MA, NC & PR:*
Interchange is mandated unless Prescriber writes the words 'No Substitution' _____

Attention: *New York & Iowa providers, please submit an electronic prescription per state prescribing laws & regulations. Send an electronic RX via by searching for: AllCare Plus Pharmacy (NPI: 1902167596)*

(* Required Field)

Please visit www.palsonify.com for Full Prescribing Information.

First Name _____ Last Name _____ DOB _____

Dear patient, we want to support you! Please read the following, then sign and date. Thank you.

PERSONAL INFORMATION FOR PATIENT SUPPORT

- I authorize my healthcare providers, pharmacies, health insurers, employer, and their representatives and vendors ("Providers") to disclose and re-disclose to Crinetics Pharmaceuticals, Inc., its affiliates, business partners, contractors, and vendors ("Crietics") the health and related personal information needed to support my participation in CrinetiCARE® and related Crinetics patient support programs. This information includes my and my caregiver's contact and demographic information; medical, treatment, diagnosis, medication, care-management, and medical-record information; insurance, benefits, coverage, reimbursement, and appeal information; and other information relevant to my condition, treatment, or program participation (collectively, "Health Data").

- Crinetics may use and disclose my Health Data to evaluate eligibility for, enroll me in, manage, and provide CrinetiCARE® and related patient support services, including reimbursement and coverage support, co-pay assistance, nurse educator, adherence, disease-management, care-coordination, and product-delivery support; to communicate with me and, with my permission, my healthcare team; to respond to my requests; and to administer, evaluate, improve, tailor, and develop Crinetics patient support programs, products, services, materials, and operations related to my condition or treatment. For these purposes, Crinetics may combine my information with information from its programs, websites, services, and other data sources, including third-party healthcare data, and may use limited information to verify my information and enable privacy-protective matching. Crinetics will not sell my Health Data or use it for marketing except as permitted by law and separately authorized by me where required.

- I understand my Health Data may include protected health information ("PHI"). Once disclosed under this Authorization, it may no longer be protected by certain federal or state privacy laws and may be re-disclosed, but it will continue to be protected where required by applicable law. Providers may receive financial remuneration from Crinetics for using or disclosing Health Data as described. Email and cell-phone communications may not be secure. Program assistance is subject to eligibility criteria, and Crinetics programs may change or end at any time. I may refuse to sign this Authorization. Refusal will not affect my treatment from Providers or my enrollment or eligibility for health insurance benefits, but I may not be able to participate in CrinetiCARE® or related Crinetics patient support programs because the Health Data described is needed to provide those services.

- This Authorization expires five (5) years from the date signed or when my participation in the applicable Crinetics program ends, whichever occurs first, unless a shorter period is required by state law. I may request a copy of this signed Authorization and may revoke it at any time by calling **844-CRN-HELP (844-276-4357)** or writing to CrinetiCARE®, 6055 Lusk Blvd, San Diego, CA 92121. Revocation will not affect Health Data already used or disclosed in reliance on this Authorization.

I HAVE READ THIS AUTHORIZATION AND AGREE TO ITS TERMS. PATIENT'S AUTHORIZATION AND SIGNATURE:

Patient Name (print)	DOB (mm/dd/yyyy)	Representative Name (print, if applicable)
Patient or Representative Signature	Date (mm/dd/yyyy)	Relation to Patient

Please have patient sign above and check the box to confirm approval for cell phone use below. If the patient is not in office, please send this form to CrinetiCARE® without the patient's signature and we will obtain patient consent and signature.

OPTIONAL COMMUNICATION CONSENTS

☐ I agree Crinetics and its representatives may contact me by phone or text at the number(s) I provide with promotional communications about Crinetics products, educational materials, programs, services, and events that may be relevant to me. Message and data rates may apply. I can reply STOP to any text to opt out.

☐ I authorize voicemail messages to be left at the phone number(s) I provide.

Please visit www.palsonify.com for Full Prescribing Information.

CrinetiCARE®