ENROLLMENT FORM

Adbry® (tralokinumab-ldrm) Injection 150 mg/mL

INSTRUCTIONS FOR HEALTHCARE PROFESSIONALS

1 Complete all required fields with asterisk (*)
2 Have your patient complete and sign the Patient Information section (page 1) and read and sign the Patient Authorization (page 3)
3 Sign the Prescriber Certification section (page 2)
4 Fax this completed form (pages 1, 2, and 3) and copies of the front and back of the patient's insurance card to the selected in-network Specialty Pharmacy (Specialty Pharmacy details can be found in the accompanying Adbry® in-network Specialty Pharmacy Guide)

Select one of the two options below*:

◯ **Option 1:** CHECK HERE if you have **not** sent an Adbry® prescription to a Specialty Pharmacy and select one of the LEO Pharma in-network Specialty Pharmacies below:

- ◉ AcariaHealth
- ◯ Accredo
- ◯ BioPlus
- ◯ Blue Sky
- ◯ CenterWell
- ◯ CVS
- ◯ Fairview
- ◯ Gentry
- ◯ Intermountain
- ◯ Kroger
- ◯ Lumicera
- ◯ Meijer
- ◯ Optum
- ◯ Parkway
- ◯ Prime
- ◯ Publix
- ◯ Senderra
- ◯ Walgreens
- ◯ Windsor
- ◯ Other in-network Specialty Pharmacy: _____

Please refer to the Adbry® in-network Specialty Pharmacy Guide for the latest list of in-network Specialty Pharmacies

◯ **Option 2:** CHECK HERE if you have already sent or intend to send an Adbry® prescription to an in-network Specialty Pharmacy and provide their information below:

Specialty Pharmacy _____ Phone _____ Fax _____

01 PATIENT INFORMATION (To be completed by the patient)

Patient Name* (First, MI, Last) _____ **Date of Birth*** (MM/DD/YYYY) _____ **Gender*** ◯ Male ◯ Female

Address* _____ **City*** _____ **State*** _____ **Zip*** _____

Phone* _____ ◯ Cell ◯ Home Alternate Phone _____ Permission to leave voicemail? ◯ Yes ◯ No

Communication Preference ◯ Call ◯ Email ◯ Text Best Time to Call ◯ Morning ◯ Afternoon ◯ Evening

Preferred Language ◯ English ◯ Spanish ◯ Other _____ Email _____

◯ I agree to receive Program-related calls and text messages about savings and support programs, the administration of those programs I am enrolled in, my prescription medicine from LEO Pharma, and treatment, health and lifestyle tips, product and program-related information.

◯ FOR Patient Assistance Program (PAP) Only – I agree this is written authorization for LEO Pharma and its vendors under FCRA, to obtain information from my credit profile or other information from the vendor, solely for the purpose of determining financial qualifications for PAP administered by LEO Pharma. I understand that I must affirmatively agree to these terms to proceed with the financial screening process which is a condition of participation in PAP.

By enrolling in the Adbry® Advocate™ Program, I agree to the Program Terms and Conditions located at adbry.com/support, by calling 844-MY-ADBRY, or scanning the QR code

Scan for Full Terms, Conditions, and Eligibility Criteria.

Capitalized terms not otherwise defined in this Enrollment Form have the meanings defined in the Program Terms and Conditions.

SIGN HERE **Patient Signature*** _____ **Date*** _____

If signed by a legal representative or guardian, please indicate below the authority to act on behalf of the patient:

◯ Court-appointed guardian ◯ Power of Attorney, including authority to make healthcare decisions

◯ Other (explain) _____

02 INSURANCE INFORMATION

◯ Copies of patient's insurance card(s) are attached ◯ No insurance

Primary Pharmacy Insurance* _____

Policyholder Name* _____ **Rx BIN*** _____

Rx PCN #* _____ **Group #*** _____

Rx Member ID* _____ **Phone Number*** _____

Primary Medical Insurance* _____

Policyholder Name* _____ **Medical ID #*** _____

Group #* _____

Phone Number* _____

◯ Check here if a Prior Authorization has been submitted

03 CLINICAL INFORMATION

Patient Diagnosis* ◯ Atopic Dermatitis, unspecified (L20.9) ◯ Other ICD-10 Code _____ Date of Diagnosis _____

It is the responsibility of each prescriber to exercise independent clinical judgement in selecting codes to submit claims that accurately reflect the diagnosis of each patient.

Prior Therapies _____

Current Therapies _____ Medication Allergies _____ ◯ No Known Allergies

◯ Check here if patient has initiated therapy of Adbry with Samples Date Samples Provided to Patient _____

Adbry® (tralokinumab-ldrm) Injection 150 mg/mL

Patient Name (First, MI, Last)* _____ **Date of Birth*** _____

04 PRESCRIBER INFORMATION

Prescriber Name* (First, Last) _____ **NPI #*** _____ **State License #** _____

Office Name _____ **Office Phone*** _____ **Office Fax*** _____

Address* _____ **City*** _____ **State*** _____ **Zip Code*** _____

Office Contact Name _____ **Office Contact Email** _____

05 ADBRY® ADVOCATE™ PROGRAM

Adbry® advocate™

PHONE: 844-MY-ADBRY (844-692-3279)
FAX: 1-855-423-0011

What support service(s) does your patient need? Check all that apply

◯ Copay Support Program ◯ Adbry® Rapid Access™ Program† ◯ Adbry® Bridge Care™ Program** ◯ Ancillary Supplies ◯ Virtual Injection Training

†Adbry® Rapid Access™ Program provides eligible patients with commercial insurance a free initial dose to be delivered in as little as 48 hours. Refer to full Terms and Conditions located at https://www.adbry.com/terms-conditions.
**Adbry® Bridge Care™ Program provides free drug to eligible patients with commercial insurance who are experiencing a coverage delay (>7 business days post-PA submission) or coverage denial. Refer to full Terms and Conditions located at https://www.adbry.com/terms-conditions.

06 PRESCRIPTION SECTION

In-Network Specialty Pharmacy Prescriptions	Drug Name	Drug Strength	SIG	Quantity	Refill
◯ Adult Initial Dose	ADBRY 150 mg/mL	600 mg	Inject 4 (150 mg/mL) injections subcutaneously on Day 1	4 Prefilled Syringes	0
◯ Adult Maintenance Dose	ADBRY 150 mg/mL	300 mg	Inject 2 (150 mg/mL) injections subcutaneously every 2 weeks, starting on Day 15	4 Prefilled Syringes	_____
◯ Pediatric Initial Dose (12-17 years old)	ADBRY 150 mg/mL	300 mg	Inject 2 (150 mg/mL) injections subcutaneously on Day 1	2 Prefilled Syringes	0
◯ Pediatric Maintenance Dose (12-17 years old)	ADBRY 150 mg/mL	150 mg	Inject 1 (150 mg/mL) injections subcutaneously every other week starting on Day 15	2 Prefilled Syringes	_____
Adbry® Rapid Access™ Program Prescriptions	**Drug Name**	**Drug Strength**	**SIG**	**Quantity**	**Refill**
◯ Adult Initial Dose	ADBRY 150 mg/mL	600 mg	Inject 4 (150 mg/mL) injections subcutaneously on Day 1	4 Prefilled Syringes	0
◯ Pediatric Initial Dose (12-17 years old)	ADBRY 150 mg/mL	300 mg	Inject 2 (150 mg/mL) injections subcutaneously on Day 1	2 Prefilled Syringes	0
Adbry® Bridge Care™ Program Prescriptions	**Drug Name**	**Drug Strength**	**SIG**	**Quantity**	**Refill**
◯ Adult Maintenance Dose	ADBRY 150 mg/mL	300 mg	Inject 2 (150 mg/mL) injections subcutaneously every 2 weeks, starting on Day 15	4 Prefilled Syringes	_____
◯ Pediatric Maintenance Dose (12-17 years old)	ADBRY 150 mg/mL	150 mg	Inject 1 (150 mg/mL) injections subcutaneously every 2 weeks starting on Day 15	2 Prefilled Syringes	_____

07 PRESCRIBER CERTIFICATION

ATTENTION PRESCRIBERS: Please follow your state's prescribing guidelines for electronic prescribing (if applicable)

By signing and dating below, I certify this therapy is medically necessary and this information is complete and accurate to the best of my knowledge. I certify that I am the prescriber who has prescribed Adbry to the identified patient above for an FDA-approved indication. For the purposes of transmitting this prescription, I authorize LEO Pharma Inc., its affiliates, business partners, agents and service providers, including patient support program service providers (collectively, "LEO Pharma") to forward for these limited purposes this prescription electronically, by facsimile, or by mail to the appropriate dispensing pharmacies. I authorize for my commercially insured patient one or more months of temporary shipments of Adbry during a benefits determination delay or during the appeal process after an initial coverage delay for Adbry for the above identified patient. I agree to assist in efforts to secure access to Adbry for my commercially insured patient. I will not attempt to seek reimbursement for any free product provided under the Adbry® Advocate™ Program and no medication may be returned for credit. I certify that any medication received will be used only for the patient named on this form and will not be offered for sale, trade, or barter. I acknowledge that this program is exclusively for purposes of patient care and not for remuneration of any sort. I further understand that any free product provided is not contingent on any purchase obligations. I understand that LEO Pharma may revise, change, or terminate the Program at any time without notice. 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 LEO Pharma and its affiliates, business partners, and agents for purposes relating to LEO Pharma patient support programs, including, assisting the patient with benefits verification, prior authorization/appeals assistance, financial assistance resources and information, such as copy support or free drug programs, for which the patient may be eligible, and other support for Adbry.

_____ _____
Prescriber's Signature (No Stamps)* – DISPENSE AS WRITTEN Date* (MM/DD/YYY)

_____ _____
Prescriber's Signature (No Stamps) – MAY SUBSTITUTE Date (MM/DD/YYY)

PATIENT AUTHORIZATION

Adbry®
(tralokinumab-ldrm)
Injection 150 mg/mL

Please read the following carefully, then sign and date where indicated below.

I hereby authorize my healthcare providers, pharmacies and health insurers, and their service providers ("Providers") to use, release, or disclose information relating to my insurance benefits, medical condition, treatment, and prescription details ("Personal Information") to LEO Pharma Inc., its affiliates, business partners, agents, and service providers, including patient support program service providers (collectively, "LEO Pharma"), in order to receive or be eligible to receive the following LEO Pharma services (the "Services"):

- Assistance coordinating insurance coverage for, access to, or receipt of my prescription medication from LEO Pharma or with training on proper and safe use of prescription medication from LEO Pharma
- Communications through phone, text, or email about possible access, savings and support services, including, for example, LEO Pharma patient support programs, and, if I am enrolled, assistance administering my participation in those programs
- Communications through phone, text, or email about my prescription medication from LEO Pharma and treatment, including, for example, reminders, health and lifestyle tips, product, and program-related information. Communications may be customized based on Personal Information obtained from my Providers
- Participation in quality assurance activities such as surveys and feedback related to the Services or my treatment

In delivering the Services, LEO Pharma may release or disclose my Personal Information (including the personal health information set forth therein) to my Providers and certain financial assistance programs that may assist with my prescription medication payments. I understand and acknowledge LEO Pharma and Providers may combine my records and information with information and data collected from other sources and use that aggregated information to administer the Services listed above. I understand and acknowledge LEO Pharma may be required to share my records and information with law enforcement authorities or other government officials, or when required by law, statute, regulation, or a judicial or administrative order. I understand and acknowledge that my Providers may receive payment from LEO Pharma for providing certain aspects of the Services, such as medication or refill reminders, based on my enrollment or participation.

I understand and acknowledge that my medical records may contain information about psychiatric disorders, human immunodeficiency virus (HIV) test results, acquired immunodeficiency syndrome (AIDS), AIDS-related conditions, alcohol dependence, drug dependence or abuse, and/or a substance use disorder. Once I authorize the release of my records and information, I understand and acknowledge it may be re-disclosed by the recipient and it may no longer be protected by federal or state health privacy laws or other applicable data protection laws or regulations.

I understand that this Authorization is voluntary and that I do not have to sign it in order to get treatment or payment of, eligibility in or enrollment benefits from my insurers.

I understand that I can revoke this Authorization at any time by calling 1-844-692-3279 or by emailing info@Adbry-advocate.com or writing to:

Adbry® Advocate™ Program
PO Box 1587
Jeffersonville, IN 47131

OR

LEO Pharma Support Services
7 Giralda Farms
Madison, NJ 07940

This Authorization will expire 5 years after I sign it, or earlier if required by law, unless I revoke it sooner. If the Authorization expires or is revoked, I understand and acknowledge that I may no longer qualify for Services from LEO Pharma, but it will not impact my Providers' treatment or my insurance benefits. I also understand and acknowledge that if a Provider is disclosing my records and personal health information to LEO Pharma on an authorized, ongoing basis, my revocation of this Authorization will be effective with respect to that Provider as soon as that Provider receives notice of my revocation and such revocation will not affect prior uses or disclosures of my records and personal health information. I understand that I will be able to keep a copy of this Authorization and may, at any time, request a copy of this Authorization. My information may be de-identified and aggregated by LEO Pharma. I am able to learn more about privacy rights within the LEO Pharma Inc. privacy policy, located at https://www.leo-pharma.us/Home/Privacy.aspx. I understand that my information will be used by LEO Pharma in accordance with the LEO Pharma Inc. privacy policy, located at https://www.leo-pharma.us/Home/Privacy.aspx.

I have read and agree to this Patient Authorization.

Patient Name (Print) _____

Patient DOB (MM/DD/YYYY) _____

Legal Rep Name (Print) _____

SIGN HERE

○ **PATIENT or** ○ **LEGAL REPRESENTATIVE SIGNATURE**

_____

Today's Date _____