**Healthcare Providers:** Please fax this completed and signed form to CRESEMBA Support Solutions℠. Remember to ensure the prescription drug information is completed.
**Patient MUST read and sign Patient Authorization Statement on pages 3 and 4.**

**Please note – All fields denoted with an asterisk (*) are required fields.**

**Phone:** 1-800-477-6472 **Fax:** 1-866-317-6235
**Hours:** Monday–Friday, 9 AM–8 PM ET
**Website:** www.CRESEMBASupportSolutions.com

CRESEMBA® (isavuconazonium sulfate) 372 mg for injection • 186 mg capsules
SUPPORT SOLUTIONS℠

## 1. PATIENT INFORMATION

Name*:_____ Date of Birth*:_____
Sex*: ☐ Male ☐ Female Phone: _____ Phone Type: ☐ Home ☐ Work ☐ Mobile
Home Address*:_____
City*:_____ State*:_____ ZIP*:_____
E-mail: _____
Alternate Contact Name:_____ Relationship:_____ Phone: _____
Permission to contact patient: ☐ Yes ☐ No Best time to contact: _____

## 2. CURRENT INSURANCE INFORMATION*

☐ **Patient has no insurance**
☐ **Patient has insurance pending with** (name of insurer): _____
Patient Insurance Plan:
☐ Medicare Part D ☐ Medicaid ☐ Private/Commercial ☐ Medicare Advantage
Insurer Name:_____ Insurer Phone:_____
Subscriber Name:_____ Policy ID: _____ Group No.: _____
Prescription Insurer Name:_____
PBM Subscriber ID: _____ PBM Phone No.: _____
PBM BIN No.: _____ PBM Group No.: _____

## 3. FINANCIAL INFORMATION*

Financial information and proof of income are required to assess eligibility for the Astellas Access Program℠ or for assistance with out-of-pocket expenses.
Size of Household (including patient): _____ Annual Household Income: _____

## 4. SHIPPING INFORMATION

**Please note: Product cannot be shipped to P.O. boxes**
Ship to patient home address indicated above in Section 1* ☐ Yes ☐ No–if No, ship to the address below

Shipping Location: ☐ Patient ☐ Facility Site Name (if applicable):_____
Contact Person Name: _____
Address: _____
City: _____ State: _____ ZIP: _____

## 5. DISCHARGE INFORMATION*

Discharge Planner (or facility contact): _____
Phone: _____ Fax: _____
Post-Discharge Physician: _____ Phone: _____
Estimated Discharge Date: _____ Discharge Location: _____
Product Formulation Post-Discharge: _____ Product Need-By Date: _____
Direct Ship to Patient: ☐ Yes ☐ No Preferred Pharmacy: _____
Pharmacy Address: _____
City: _____ State: _____ ZIP: _____

## 6. PRESCRIBER INFORMATION

Prescriber Name (First, Last)*: _____
Practice Name*: _____ Specialty*: _____
Office Contact:_____
(If different from discharge planner/facility contact in section 5)
Address*:_____
City*:_____ State*: _____ ZIP*:_____
Phone*: _____ Fax*: _____
Medicaid/Medicare Provider No.*:_____ Tax ID No.*:_____
State License No.*: _____ UPIN/NPI*: _____

## 7. PRESCRIPTION FOR CRESEMBA® (isavuconazonium sulfate) capsules*

**In order for us to send medication to your patient, the prescription information must be complete and accurate.**
**Patient Name:** _____ **Date of Birth:** _____
**Diagnosis Code:** _____
**Reason for Medical Necessity:** _____
Product Name: CRESEMBA (isavuconazonium sulfate) 186 mg capsules
☐ Maintenance Dose
Instructions: Take _____ 186 mg capsule(s) orally per _____ hours for _____ days
Dispense:_____ day supply Refills:_____
☐ Loading Dose (If not previously administered) Instructions: Take 2 capsules (372 mg) orally every 8 hours for 6 doses (48 hours)

Doctor/Prescriber Signature X _____ **Date:** _____

**Dispense as Written** – Stamped signatures cannot be accepted
**Prescriber Certification: My signature below certifies that I have read, understand, and agree to the Prescriber Certification Statement on page 4.**

Prescriber Signature X _____ **Date:** _____
(This form cannot be processed without an original signature)

## 8. (OPTIONAL) PRESCRIPTION FOR CRESEMBA QUICK START+® PROGRAM ONE-TIME SUPPLY

Complete this additional (optional) prescription for CRESEMBA Quick Start+® Program One-Time Supply in order for patient (if applicable) to receive a free one-time 7-day supply (limit of 14 pills)‡ of **CRESEMBA** in the event that the Prior Authorization request is delayed by the Payer. The shipment will be made to the address designated in Section 4.
Patient Name: _____ Date of Birth: _____
Product Name: CRESEMBA (isavuconazonium sulfate) 186 mg capsules
☐ Maintenance Dose
Instructions: Take _____ 186 mg capsule(s) orally per _____ hours for _____ days
Dispense: 7-day supply Refills: 0
☐ Loading Dose (If not previously administered) Instructions: Take 2 capsules (372 mg) orally every 8 hours for 6 doses (48 hours)

Prescriber Signature X _____ Date*: _____
(Stamps not accepted)

‡If loading dose required, patient will also receive a 2-day supply of 12 capsules.

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CRESEMBA® (isavuconazonium sulfate) 372 mg for injection • 186 mg capsules
SUPPORT℠ SOLUTIONS

## SERVICES

Astellas ("Company"), through CRESEMBA Support Solutions℠†, has developed an integrated approach of customized access and reimbursement services to help patients minimize potential barriers to accessing CRESEMBA® (hereinafter referred to as "Services"). These Services are designed to help providers and patients evaluate a patient's coverage and reimbursement options for CRESEMBA. The prescriber and patient signatures on page 1 and page 4 authorize the Service Providers (defined on page 3) to perform any or all of the following necessary Service(s) to assist with patient access to CRESEMBA.

- Benefits Verification/Prior Authorization information (if PA is required by payor)
- Referral to pharmacy
- Benefits Appeal assistance
- Referral to third party for assistance with out-of-pocket expenses
- Free Drug Program through Astellas Access Program℠
- Educational services

Benefits Verification/Prior Authorization (PA) Information (if PA is required by payor) – A Benefits Verification allows a Service Provider to call a patient's insurance plan to investigate specific coverage for CRESEMBA. During the call, a Service Provider may inquire about patient eligibility for benefits, coverage restrictions, deductible, copayment or coinsurance, and benefit maximum amounts, and any other payor requirements. A Service Provider may provide the healthcare provider and/or payor with a summary of the Benefits Verification research.

If PA is required, a Service Provider will use reasonable efforts to provide the healthcare provider information on what to submit to the payor, the submission process, and an estimation of how long it will take the payor to make a determination.

Referral to Pharmacy – This service allows Service Providers to call a patient's insurance plan to confirm in-network pharmacy options and forward the prescription directly to the appropriate pharmacy. If applicable, Service Providers will provide the healthcare provider a summary of the prescription referral to such Pharmacy or third party.

Benefits Appeal Assistance – If a payor denies coverage for CRESEMBA, Service Providers may assist the healthcare provider with appealing the payor's decision. This means that a Service Provider may use reasonable efforts to provide the healthcare provider and/or the pharmacy provider information on what to submit to the payor, the submission process, and an estimation of how long it will take the payor to make a determination.

Referral to Third Party for Assistance With Out-of-Pocket Expenses – Subject to meeting eligibility requirements, patients may receive support with their out-of-pocket expenses for CRESEMBA. A Service Provider may obtain information from patients, such as insurance status, state of residence, and income in order to determine eligibility for alternate resources and help the patient apply for such assistance.

Free Drug Program Through the Astellas Access Program – The Astellas Access Program was established to provide certain Astellas medications at no cost for uninsured patients. A Service Provider may obtain information from patients, such as insurance status and income in order to determine eligibility. If a patient is approved, a Service Provider will notify both the healthcare provider and patient and schedule a 28-day shipment of CRESEMBA for delivery to the patient.

Educational Services – The Service Providers and the Company may provide educational and other information on CRESEMBA via mail, e-mail, phone, or other methods of communication. This may include activities like sending educational and/or other materials, or offering a nurse support program or other similar programs to promote patient education and medication adherence on CRESEMBA.

astellas
Astellas Pharma US, Inc.

## 9. PATIENT AUTHORIZATION FOR CRESEMBA SUPPORT SOLUTIONS[†]

### Patient Authorization Statement

My signature authorizes my doctor(s), my healthcare providers, my discharge planners, my health plan or payor, and my pharmacy to disclose to Astellas ("Company") and its third-party suppliers, vendors, and other service providers supporting CRESEMBA Support Solutions[SM] (collectively, the "Service Providers") information about me (for example, my name, Social Security number, address, insurance policy number and income) and my medical condition (for example, my diagnosis or medications) (together, "Personally Identifiable Information"). This information can include spoken or written facts about my health and insurance benefits that I may have. It can include copies of records from my healthcare providers or health plans about my health or healthcare. I understand that my healthcare providers and my pharmacy may receive remuneration for disclosing my information pursuant to this Authorization. I understand that CRESEMBA Support Solutions is a component of Astellas Pharma Support Solutions[SM], and that the Service Providers may be compensated by Astellas. The Service Providers will use and give out my information to (i) assist in my enrollment in CRESEMBA Support Solutions and to contact me and/or the person legally authorized to sign on my behalf; (ii) provide me and/or the person legally authorized to sign on my behalf with educational and other materials, information, and services related to CRESEMBA Support Solutions; (iii) verify, investigate, assist with, and coordinate my coverage for CRESEMBA with my payor; (iv) coordinate prescription fulfillment; (v) assess my eligibility for patient assistance and/or benefits, if necessary; (vi) make referrals to other programs, foundations, or alternate sources of funding or coverage that may be available to provide assistance to me with the costs of my CRESEMBA, or as otherwise required or allowed under the law; and (vii) assist with analyses of the efficiencies and performance of Services provided by Service Providers. In some instances the Service Providers may de-identify my information and use or disclose the de-identified information (in individual or aggregated form) for any legitimate business purposes. I understand that the Service Providers will make reasonable efforts to keep my information private; however, I understand that once my information has been disclosed to the Service Providers, how the Service Providers further disclose my information may no longer be protected under federal and state privacy laws.

This authorization will last for three (3) years from the date on page 4 or until I am no longer receiving CRESEMBA or enrolled in CRESEMBA Support Solutions, whichever is later. I do not have to sign this authorization, but if I do not, I will not be able to have my insurance coverage verified, have alternate sources of funding or coverage researched, or access other services provided by or on behalf of CRESEMBA Support Solutions. My choice as to whether to sign this form will not change the way my doctors, healthcare providers, or payors treat me. If I no longer wish to participate in CRESEMBA Support Solutions, I shall inform my healthcare providers and/or the administrators of CRESEMBA Support Solutions in writing that I do not want them to share any more information with the Service Providers, but it will not change any actions that took place before I told them. I have the right to revoke this authorization, in writing, at any time by providing written notice to my healthcare providers and/or the administrators of CRESEMBA Support Solutions. Revocation of this authorization will be valid when received by my healthcare providers or the administrators of CRESEMBA Support Solutions. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization. I know I have a right to see or copy the information my healthcare providers or payors have given to the Service Providers.

[†] A component of Astellas Pharma Support Solutions[SM]

## 9. PATIENT AUTHORIZATION FOR CRESEMBA SUPPORT SOLUTIONS† (cont.)

If applying for assistance from the Astellas Access Program℠, I certify that I correctly checked the box in Section 2 on page 1 that I do not have insurance and am not eligible for other public health insurance programs. I agree to notify my physician if I become aware in the future of changes that would affect my eligibility, including but not limited to changes in health insurance status or coverage, financial status, and United States residing status.

This Authorization Statement is governed by and interpreted in accordance with the laws of the state of Illinois, excluding Illinois conflict of law rules, and applicable federal law.

**My signature below certifies I have read and understand the Patient Authorization Statement.**

Patient Name (please print)*: _____ Date: _____

Patient (or Representative) Signature* X _____ Date: _____

If signed by a representative, please describe the representative's authority to act on behalf of the patient:

_____

Representative Signature* X _____ Date: _____

I am acting for another person and I hereby affirm that I have the legal right to do so, that I am the parent or legal guardian of the patient, or otherwise have a valid power of attorney to act on behalf of the patient.

## PRESCRIBER CERTIFICATION STATEMENT

By signing on page 1, I hereby attest that I am the prescribing healthcare provider and I agree to submit requests to CRESEMBA Support Solutions because I have determined that CRESEMBA (isavuconazonium sulfate) capsules is medically appropriate and I have explained such to my patient. I certify that I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act [HIPAA] of 1996) to the Service Providers for the purpose of providing access and reimbursement support, assisting in initiating or continuing therapy, and/or the evaluation of the patient's eligibility for support. I authorize Service Providers, as designated agents and on behalf of my patients, to forward a prescription for CRESEMBA, by fax or other mode of delivery, to a pharmacy. For the state of New York, copies of all prescriptions should be on Official New York State Prescription forms.

If applying for the Astellas Access Program, I certify that this patient has no insurance and is not eligible for other public health insurance programs. I agree to notify the Service Providers if I become aware at any time in the future of changes in my patient's circumstances that would affect his or her eligibility, including but not limited to changes in health insurance status or coverage, financial status, United States residency status, or the indication for which CRESEMBA has been prescribed for this patient. I understand that Astellas reserves the right to change or terminate the Astellas Access Program at any time or refuse to provide CRESEMBA under the Astellas Access Program to any patient.

If my patient obtains CRESEMBA via the Astellas Access Program I understand that (a) no third party or patient can be charged for CRESEMBA provided under such program and (b) that no free product should be sold, traded, or distributed for sale. I also understand that provision of free drug as part of the Astellas Access Program is not contingent upon future purchase or prescribing of CRESEMBA.

I certify that a copy of the Patient Authorization Statement has been given to the patient named on page 1 and his/her representative and that I have provided my patient with a description of CRESEMBA Support Solutions.