Patient Consent

Ohtuvayre™ (ensifentrine) Inhalation Suspension 3 mg/2.5 mL

Note: If Patient Authorization and Consent is not completed the patient will not have access to Verona Pathway Plus Support Programs and Services until it is received.

‹ SCAN HERE TO COMPLETE ELECTRONICALLY

Patient Name: _____ **DOB:** ___/___/___ **Patient Cell Phone:** _____

Authorized Representative: _____ **Authorized Representative Phone:** _____

Patient Services Authorization and Release of Health Information Consent Form

By signing this Authorization and Release of Health Information Consent Form ("Authorization"), I authorize my healthcare provider, my health insurance company, and my pharmacy providers ("Healthcare Entities") and each of their respective representatives, employees, and agents (collectively "Providers") to disclose information relating to my insurance benefits, medical condition, treatment, and prescription details (Protected Health Information "PHI") to Verona Pharma, Inc. ("Verona Pharma"), Verona Pathway Plus, its service providers and affiliates (collectively "Verona Pathway Plus") to (i) provide me with support services and related information and materials on any of Verona Pharma products, including, but not limited to, benefit verification, insurance coverage and education, financial assistance services, medication adherence services, (ii) conduct data analytics, market research and other internal business activities including, but not limited to, evaluating the services provided. (iii) enroll me into Verona Pathway Plus Copay Program, if eligible, I understand that Copay Card information will be sent to my specialty pharmacy, along with my prescription. I understand any assistance with my cost-sharing or co-payment for Ohtuvayre™ (ensifentrine) will be made in accordance with the Program Terms and Conditions. For purposes of clarification, "Verona Pharma" includes but is not limited to authorized third-party agents involved in administration of Verona Pathway Plus. I understand that I may be contacted by Verona Pathway Plus in the event that I report an adverse event. Once my health information has been disclosed to Verona Pharma, I understand that it may be re-disclosed and federal privacy laws no longer protect the information. However, Verona Pharma agrees to protect my 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 specialty pharmacy provider may receive remuneration from Verona Pharma in exchange for the health information and/or for any support services provided to me. I understand that I am not required to sign this Authorization and that my Healthcare Entities will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. This Authorization will expire in 5 years or a shorter period if required by state law, unless I revoke it sooner by writing to 610 Crescent Executive Court, Suite 200 Lake Mary, FL 32746. I understand that revoking my Authorization will terminate my participation in Verona Pathway Plus but will not affect any use of my information that occurred before my request was processed. I am entitled to a copy of this signed Authorization. I also understand that by listing an Authorized Representative above they are authorized to be disclosed my health information and be contacted by Verona Pathway Plus , Healthcare Entities and Providers in association with my Verona Pharma medication and prescription.

Patient Assistance Program

I authorize Verona Pathway Plus to verify my eligibility for Patient Assistance Program (PAP), and I understand that such verification may include contacting me or my healthcare provider for additional information and/or reviewing additional financial, insurance, and/or medical information. I understand that, upon request, Verona Pathway Plus will tell me whether an individual consumer report was requested and the name and address of the agency that furnished it. I further understand and authorize Verona Pathway Plus to use any consumer reports about me and information collected from me, along with other information they obtain from public and other sources, to estimate my income in conjunction with the PAP eligibility determination process, if applicable. I further understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid, nor counted toward any true-out-of-pocket (TrOOP) cost, if applicable; and no free product may be sold, traded, or distributed for sale. Additionally, I understand that I must inform the PAP if my financial circumstance, insurance, or any other eligibility criteria changes. I understand that Verona Pharma does not have any obligation to provide the PAP services to me and is not liable in the provision of these services. Verona Pharma reserves the right at any time and without notice to modify or change eligibility criteria or discontinue Verona Pathway Plus.

☐ ***I authorize Verona Pathway Plus under the Fair Credit Reporting Act to use my demographic information to access reports on my individual credit history from consumer reporting agencies and verify my eligibility for the program.***

Messaging from Verona Pathway Plus

If I am unavailable when contacted by Verona Pathway Plus, I authorize the following options for a detailed message.

☐ **Any** ☐ Phone ☐ Text *(Must have cell listed above)*

* *I understand a non-detailed message will be left by voicemail, if no selection*

Other Resources

By checking below, I authorize Verona Pharma, and its affiliates, to contact me by mail, email, fax, text messaging, and or telephone regarding other helpful resources, services, potential market research, and other related topics of interest. I understand that I am not required to provide this consent as a condition of receiving any Verona Pharma medication or Patient support Services. Note that Verona Pharma will not sell or trade my personal data to any unrelated third party.

Full Terms and Conditions can be found at www.veronapharma.com/terms-and-conditions and our Privacy Policy at www.veronapharma.com/privacy-policy.

☐ ***I consent to receiving other resources, listed above.***

By signing below, I confirm that I have read and understand the Patient Services Authorization and Release of Health Information Consent Form and agree to the terms.

Patient Signature: _____ **Date:** _____

Verona Pathway Plus™

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Prescription Form

Ohtuvayre™ (ensifentrine) Inhalation Suspension 3 mg/2.5 mL

- **Please fill this entire form in and fax to (833) 392-8999**
- If you have any questions, please call Verona Pathway Plus at (833) 372-8492
- If you prefer to download a fillable Prescription Form, go to www.ohtuvayrehcp.com

Section 1: Preferred Specialty Pharmacy

☐ No Preference ☐ Acaria Specialty Pharmacy ☐ CVS Specialty Pharmacy
☐ Centerwell Specialty Pharmacy ☐ DirectRx Specialty Pharmacy

Section 2: Patient Information (required)

Is the patient currently in a long-term care facility? ☐ Yes ☐ No Facility Name: _____

First Name: _____ Last Name: _____ SSN: _____

Date of Birth (MM/DD/YYYY): _____ Gender Designation at Birth: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Preferred Phone: _____ Secondary Phone: _____

Email: _____

Alternate Contact: _____ Alternate Contact Phone: _____

Section 3: Patient Insurance Information (Please fill out below or provide front and back copy of the patient insurance card)

☐ Medicare ☐ Commercial ☐ Medicaid ☐ Uninsured

Medical Insurance	**Primary Insurance (required)**	**Secondary/Supplemental Insurance**
Payer Name		
Subscriber ID #		
Policy Holder		
Group #		
Payer Phone #		

Prescription Drug Plan	
Payer Name	
Subscriber ID #	
RX Group #	
RX BIN #	
RX PCN #	

Section 4: Clinical History (Include patient's last clinical visit notes along with the Prescription Form; **required for all Medicare patients**)

ICD-10 Diagnosis Code(s) (required): _____

**COPD ICD-10 Codes generally range from J41-J44.9. Other codes may apply*

Known Drug allergies: _____

Does the patient have an ineffective inspiratory flow to utilize inhalers? ☐ Yes ☐ No

Current or tried and failed Maintenance COPD Medications:

☐ LABA	☐ Current	OR	☐ Tried and Failed Product(s): _____
☐ LAMA	☐ Current	OR	☐ Tried and Failed Product(s): _____
☐ LAMA+LABA	☐ Current	OR	☐ Tried and Failed Product(s): _____
☐ LABA+ICS	☐ Current	OR	☐ Tried and Failed Product(s): _____
☐ LAMA+ICS	☐ Current	OR	☐ Tried and Failed Product(s): _____
☐ LAMA+LABA+ICS	☐ Current	OR	☐ Tried and Failed Product(s): _____
☐ Other	☐ Current	OR	☐ Tried and Failed Product(s): _____

Is this the first time the patient has been prescribed a nebulizer and nebulized medications? ☐ Yes ☐ No

- **If NO**, does the patient have a Standard Jet Nebulizer? ☐ Yes ☐ No
- If the patient has a Standard Jet Nebulizer approximate date when the patient received: _____

Other important clinical details: _____

Prescription Form

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Patient Name: _____ **DOB:** __/__/____ **Address:** _____

Section 5: Prescriber Information (required)

Prescriber Name: _____ NPI: _____ PTAN: _____

Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

Office Contact: _____ Office Email: _____

Section 6: Prescription (required)

Ohtuvayre Prescription Includes a Welcome Kit, if applicable

Rx: Ohtuvayre (ensifentrine) inhalation suspension: 3 mg ensifentrine per 2.5 mL aqueous suspension in unit-dose ampule. Oral inhalation use only.

Directions:
- ☐ 3 mg (one unit-dose ampule) twice daily, once in the morning and once in the evening, administered by oral inhalation using a standard jet nebulizer with a mouthpiece.
- ☐ Other: _____

Quantity:
- ☐ 60 ampules (per box); 30-day supply _____ refills
- ☐ Other: _____ ampules; 30-day supply _____ refills

Standard Jet Nebulizer Prescription

Refills are good for 12 months, unless otherwise noted **Refill:** _____

☐ Standard Jet Nebulizer and Administration Set
- E0570 - Compressor
- A7005 - Administration Set (One every 6 months)

☐ Administration Set ONLY
- A7005 - Administration Set (One every 6 months)

Ohtuvayre Bridge Program Prescription

Includes a Welcome Kit, if applicable

(Available to eligible patients during coverage delay)

☐ **Enroll my patient, if eligible**

Rx: Ohtuvayre (ensifentrine) inhalation suspension: 3 mg ensifentrine per 2.5 mL aqueous suspension in unit-dose ampule. Oral inhalation use only.

Directions: 3 mg (one unit-dose ampule) twice daily, once in the morning and once in the evening, administered by oral inhalation using a standard jet nebulizer with a mouthpiece.

Quantity: 60 ampules (per box); 30-day supply with up to 1 refill

Rx: E0570 - Standard Jet Compressor; Refill 0

Rx: A7005 - Administration Set; Refill 0

Prescriber Certification and Signature (required):

I certify that the information provided in the form is complete and accurate to the best of my knowledge. I have prescribed Ohtuvayre based on my judgment of medical necessity. I understand that my patient's information provided to Verona Pharma, Verona Pathway Plus and its affiliates and is for the use of solely to verify my patient's insurance coverage; to facilitate the filling of my patient's prescription; to assess, if applicable, my patients' eligibility for patient assistance and other support programs. I certify that I have obtained my patients' written authorization in accordance with applicable state and federal law, including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, to provide the individually identifiable health information on this form to affiliates and services providers of Verona Pharma and Verona Pathway Plus for eligibility, coverage authorization, coordination and dispensing of ensifentrine and necessary durable medical equipment prescribed in the above form. I authorize Verona Pathway Plus to conduct a benefits investigation for my patient and to act on my behalf for the limited purpose of transmitting this prescription to the appropriate pharmacy designated by the patient per their benefit plan if provided or to transmit this prescription to a network pharmacy. I understand that any free product distributed through the Bridge Program or Patient Assistance Program (PAP) 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, and no free product may be sold, traded, or distributed for sale. I authorize Verona Pathway Plus to forward this prescription to the pharmacy dispensing the BridgeRx and PAP product to the patient named herein, if eligible. I agree that Verona Pathway Plus may contact me for additional information relating to Ohtuvayre and necessary durable medical equipment, including but not limited to email, fax and telephone. I understand that Verona Pathway Plus may revise, change, or terminate any program services at any time without notice to me .

Prescriber Signature: _____ ☐ **Dispense As Written** **Date:** _____

CA, MA, NC: Interchanging is mandated unless the Prescriber writes the words "No Substitution" _____

NY Prescribers: Must ePrescribe directly to the **dispensing pharmacy** identified on the enrollment or attach a separate prescription on a **NY state prescription pad** in accordance with NY pharmacy law.

ATTN: Where law requires the prescriber to comply with state-specific prescription requirements, such as electronic prescription. Non-compliance with the specific state requirements may result in outreach to the prescriber.

Electronic Prescriptions to be sent to Phyz, NCPDP: 5908809, Phone: (844) 590-5792

Verona Pathway Plus™

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