Papzimeos™
zopapogene imadenovec-drba

Papzimeos SUPPORT Enrollment Form

PAPZIMEOS™ for Adults with Recurrent Respiratory Papillomatosis

Fax completed pages to (833) 813-8580.

Papzimeos SUPPORT Services ☐ All Support Services ☐ Benefits Investigation ☐ Prior Authorization ☐ Copay Support ☐ Order Support

Distribution Channel ☐ Buy & Bill ☐ Specialty Pharmacy

1. PATIENT INFORMATION & AUTHORIZATIONS

Name (First MI Last): _____

Date of Birth: _____ / _____ / _____ Gender: ☐ Female ☐ Male Language (if not English): _____

Address (no PO Box): _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ ☐ Mobile ☐ Home Secondary Phone: _____ ☐ Mobile ☐ Home

☐ Voicemail ☐ Text Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening Email: _____

☐ I have read the **Text Messaging Consent** in Section 8 and expressly consent to receive text messages by or on behalf of Papzimeos SUPPORT.

2. PATIENT AUTHORIZATION

☐ I have read and agree to the **Patient Authorization to Use and Disclose Health Information** in Section 7.

☐ I have read and agree to the **Patient Services Authorization** in Section 8.

☐ I have read and agree to the **Copay Authorization** in Section 9.

SIGN HERE _____ _____ / _____ / _____

Patient/Legal Representative Date

If signed by a legal representative, print name (First MI Last): _____ Relationship: _____

3. INSURANCE INFORMATION

☐ **Medicaid** ☐ **Medicare** ☐ **Commercial** ☐ **Other** ☐ **NO Insurance**

Please include a copy of all primary and secondary insurance cards, if available.

Prior Authorization already on file? ☐ Yes ☐ No

Primary Rx Insurance: _____

Phone: _____

Policy ID #: _____ Group #: _____

Rx BIN #: _____ Rx PCN: _____

Primary Medical Insurance: _____

Phone: _____

Policy ID #: _____ Group #: _____

Policyholder Name (First MI Last): _____

Relationship to Patient: _____

Secondary Medical Insurance: ☐ Yes ☐ No

4. DIAGNOSIS

Recurrent Respiratory Papillomatosis (RRP)

☐ J38.7 Other Diseases of the Larynx ☐ J39.2 Other Diseases of the Pharynx ☐ D14.1 Benign Neoplasm of the Larynx

☐ Other ICD-10-CM code: _____

ICD-10-CM=International Classification of Diseases, Tenth Revision, Clinical Modification.

Continue to next page.

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Patient Name (First MI Last): _____ Patient Date of Birth: _____ / _____ / _____

5. PRESCRIBER INFORMATION

Prescriber Name: _____ Site/Facility Name: _____

Specialty: _____ Office Contact Name: _____

Address: _____ Office Contact Email: _____

City: _____ State: _____ Zip Code: _____ Phone: _____ Fax: _____

Prescriber NPI #: _____ Tax ID #: _____

6A. PAPZIMEOS PRESCRIPTION

This prescription is for use by the patient's specialty pharmacy.

Rx: PAPZIMEOS
Dispense 1 vial, 5×10^{11} particle units (PU) per injection.

Administration Schedule
Administer the recommended dosage of 5×10^{11} PU via subcutaneous injection 4 times over a 12-week interval (initial dose, then 2, 6, and 12 weeks after the initial dose*).

Known Drug Allergies: _____

_____

*The second administration should occur no less than 11 days after the initial administration.

6B. PATIENT HISTORY

Has patient been previously treated with bevacizumab?

☐ Yes ☐ No

When was patient previously treated? Date: _____ / _____ / _____

Has patient been previously treated with Gardasil®?

☐ Yes ☐ No

When was patient previously treated? Date: _____ / _____ / _____

What was the date of the patient's most recent RRP surgical procedure?

Date: _____ / _____ / _____

SIGN HERE NO STAMPS

_____ _____ / _____ / _____
Prescriber Signature - **Dispense as Written** Date

_____ _____ / _____ / _____
Prescriber Signature - **Substitutions Permitted** Date

Collaborating MD Name (Nurse Practitioner/Physician Assistant): _____ NPI #: _____

This form allows Precigen, Inc., its affiliates, representatives, agents, partners, vendors, and contractors to provide patient support, resources, and education ("Patient Resources") to eligible patients who have been prescribed PAPZIMEOS. I certify that I have obtained the necessary written authorization from the patient referenced above, or the patient's legal representative, to release to Precigen the medical and/or other patient information included herein to allow participation in programs and services offered through Papzimeos SUPPORT, which may include, without limitation: (1) financial assistance programs; (2) verifying insurance coverage and/or evaluating the patient's eligibility for alternate funding; and (3) Patient Resources. My signature above certifies that the person named on this form is my patient and that: (i) the information in this form is complete and accurate to the best of my knowledge; (ii) the patient on this form has a diagnosis for an FDA-approved indication for PAPZIMEOS; (iii) any Patient Resource provided through Precigen to my patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use an Precigen medication or Patient Resource and I have not received nor will I receive any benefit from Precigen for doing so. I will not seek reimbursement from any third-party payer or government entity for any product provided free of charge by Precigen as part of Papzimeos SUPPORT. I prescribed PAPZIMEOS solely on my clinical determination and medical necessity; (iv) I authorize Precigen to forward the above prescription to the applicable pharmacy as allowed under applicable law.

The prescriber is to comply with state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Continue to next page.

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7. AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

PATIENT: PLEASE READ THE FOLLOWING CAREFULLY, THEN DATE AND SIGN WHERE INDICATED IN SECTION 2 ON PAGE 1.

I understand that I have certain rights related to the collection, use, and disclosure of my 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 medical records. Precigen will not use my PHI without my consent. By signing this Authorization, I authorize my healthcare provider, my health insurance company, and my pharmacy providers to disclose to Precigen, and affiliates working with Precigen, health information relating to my medical condition, treatment, and insurance coverage for Precigen to (i) provide me with support services (and related information and materials) related to any of Precigen's products, including but not limited to, online support, financial assistance services, compliance and persistency and other therapy support services, (ii) conduct data analysis, market research and other necessary internal business activities, and (iii) provide me with information about Precigen's products, services, and programs for educational or other purposes. Precigen 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 pharmacy provider may receive remuneration from Precigen in exchange for the health information and/or for any therapy support services provided to me. Once my information has been disclosed to the affiliates, I understand that federal privacy laws may no longer protect it from further disclosure.

I acknowledge that I am not required to sign this Authorization, and my decision not to sign will not affect my ability to obtain medical treatment, payment for treatment, insurance coverage, access to health benefits, or medications from covered entities such as healthcare providers, health insurers, and specialty pharmacies. However, I also understand that if I choose not to sign this Authorization, I will be unable to participate in Papzimeos SUPPORT. I understand that I am entitled to receive a copy of this signed Authorization, which shall expire 1 year from the date I have executed this Authorization. I understand that I may cancel this Authorization at any time by mailing a letter to: Papzimeos SUPPORT, 11800 Weston Parkway, Cary, NC 27513. Canceling this Authorization will end consent to further disclosure of my health information to Precigen by my healthcare affiliates 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 ability to receive treatment, payment for treatment, or my eligibility for health insurance. I understand that this disclosure is for the purpose of enrolling me in and providing services through Papzimeos SUPPORT, which may include determining my eligibility for coverage or patient assistance programs, investigating insurance coverage, obtaining prior authorizations, assisting with appeals, and administering the program. It may also involve referring me to or assessing my eligibility for other support options or alternative funding sources to help with medication costs. I understand that affiliates may deidentify my information and use it for research, education, business analytics, marketing studies, or other commercial purposes. Members of affiliates may share my information with each other to deidentify it, carry out program services, or contact me via mail, phone, email, or text messaging. **I understand that I may request a copy of this Authorization.**

8. PATIENT SERVICES AUTHORIZATION

I am enrolling in Papzimeos SUPPORT. By signing this Authorization, I authorize Precigen, and affiliates working with Precigen, to provide me with support services related to any of Precigen's products, including, but not limited to, online support, financial assistance services, and other therapy support services, as well as any information or materials related to such services. I understand and agree that personnel providing such support services on behalf of Precigen are not employed by my healthcare professional. I authorize Precigen, and affiliates working with Precigen, 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), chat, push notifications, and other forms of electronic messaging (communications). I also authorize Precigen, and affiliates working with Precigen, to use and disclose my medical and health information in connection with providing the services, including but not limited to, disclosing my information to vendors, processors, and service providers for business purposes associated with providing the services, sharing such information with my healthcare provider, insurance provider, or pharmacy, or disclosing my information where required by applicable laws or regulations. I also authorize the disclosure of my health information to specific individuals that I have designated.

I understand that I may opt out of communications, individual support services such as the Papzimeos SUPPORT Copay Program, or the entire Program at any time by phone at (866) 827-8180 or by mail at Papzimeos SUPPORT, 11800 Weston Parkway, Cary, NC 27513. I understand that the services may be changed or discontinued at any time, and that any health, contact, or other information shared with Precigen, and its affiliates and agents is used to provide requested assistance and for other business purposes.

TEXT MESSAGING CONSENT: By checking the Text Messaging Consent box on page 1, I agree to receive text messages from, or on behalf of, Papzimeos SUPPORT at the mobile number(s) I provide and confirm I am the subscriber for those numbers. I understand that message and data rates may apply. I may opt out of receiving texts at any time by calling (866) 827-8180. I understand that additional terms may be sent in an opt-in confirmation message.

9. COPAY AUTHORIZATION

The Papzimeos SUPPORT Copay Program is for eligible patients enrolled in Papzimeos SUPPORT who are commercially insured, and are not covered under government insurance programs such as Medicare, Medicaid, VA/DoD, or TRICARE. The program assists only with the cost of PAPZIMEOS and its administration, up to the program maximum. It does not assist with the cost of other administrations, medicines, procedures, or other visits. Patients receiving assistance through another program or foundation are not eligible for the program. Precigen reserves the right to modify or terminate the program at any time without notice.

If I seek reimbursement under the Papzimeos SUPPORT Copay Program on behalf of my patient(s), I certify the following for each request: (i) I have provided true and accurate information, (ii) the expenses requested for reimbursement are eligible under the program, and were actually incurred and not paid by the patient or any party, (iii) the patient is not insured under Medicare, Medicaid, VA/DoD, TRICARE, or any other federal or state government-funded program and has received PAPZIMEOS for the FDA-approved indication; (iv) I have not requested or received, and will not request or receive, any payments from the patient or any party for the amounts I seek reimbursement under the program.

PRECIGEN