PRESCRIPTION INFORMATION AND NAPOCARES™ ENROLLMENT FORM

By enrolling in NapoCares™, patients will receive services to support access to Mytesi (crofelemer), including:

- Benefits investigations and reimbursement support
- Assistance with prior authorizations and coverage denials
- Specialty pharmacy triage and coordination
- Eligibility assessment for financial assistance programs
- Mytesi Copay Savings Program enrollment for commercially insured patients

All NapoCares programs are offered at no cost to Mytesi patients.

To prevent processing delays, please ensure both patient and prescriber complete all applicable sections of this enrollment form.

PATIENT INSTRUCTIONS

☐ Sign to give consent

Read, sign, and date **Patient Authorization** on page 2 to release your personal information

☐ Provide personal and insurance information

- Include your **preferred method of contact** and indicate **permission to leave a message**
- If you are insured, provide copies of the front and back of all **medical and prescription cards** to your prescriber

PRESCRIBER INSTRUCTIONS

☐ Complete patient's personal and medical information

- Fill in personal and insurance **information provided by your patient**
- Indicate **ICD-10 diagnosis code** and **medication history**
- Include any supporting documentation helpful in establishing diagnosis to specialty pharmacy
- Guidance for a letter of medical necessity is available at **mytesi.com/hcp/lmn**

☐ Specify prescription information

- Indicate supply **quantity** and number of **refills** for **new and maintenance prescription**
- Select **Quick Start prescription** for eligible patients who need a temporary supply of Mytesi
- Sign prescriptions(s)

☐ Complete prescriber information

- Include **state license and NPI numbers**
- Read, sign, and date **Prescriber Authorization** on page 3

Please complete and fax this form, along with a cover page, to (415) 963-9830
Or, mail, to NapoCares at P.O. Box 7613, Overland Park, KS 66207

For assistance, call (888) 527-NAPO (6276) Monday-Friday, 8 am-5 pm CST

napo pharmaceuticals | Mytesi (crofelemer) 125 mg delayed-release tablets

P.O. BOX 7613 OVERLAND PARK, KS 66207
TELEPHONE: (888) 527-NAPO (6276)
FAX: (415) 963-9830

NAPOCARES™ PATIENT SUPPORT ENROLLMENT

PATIENT INFORMATION

FIRST NAME / MIDDLE INITIAL / LAST NAME

_____ / _____ / _____
DATE OF BIRTH

GENDER: ☐ Male ☐ Female ☐ Nonbinary

STREET ADDRESS

CITY / STATE

ZIP CODE

PRIMARY PHONE #

PHONE # TYPE: ☐ Home ☐ Mobile ☐ Work ☐ Other

BEST TIME TO CALL: ☐ Morning ☐ Afternoon

OKAY TO LEAVE MESSAGE? ☐ Yes ☐ No

ALT PHONE #

PHONE # TYPE: ☐ Home ☐ Mobile ☐ Work ☐ Other

BEST TIME TO CALL: ☐ Morning ☐ Afternoon

OKAY TO LEAVE MESSAGE? ☐ Yes ☐ No

CAREGIVER FIRST NAME / LAST NAME (OPTIONAL)

CAREGIVER PHONE # (OPTIONAL)

PHONE # TYPE: ☐ Home ☐ Mobile ☐ Work ☐ Other

BEST TIME TO CALL: ☐ Morning ☐ Afternoon

OKAY TO LEAVE MESSAGE? ☐ Yes ☐ No

RELATIONSHIP TO PATIENT (OPTIONAL)

INSURANCE INFORMATION

CARDHOLDER FIRST NAME / LAST NAME

CARDHOLDER DATE OF BIRTH (OPTIONAL)

PATIENT RELATIONSHIP TO CARDHOLDER (OPTIONAL)

RX INSURANCE NAME

RX PLAN TYPE (OPTIONAL)

RX GROUP # (OPTIONAL)

MEMBER ID # (OPTIONAL)

RX BIN (OPTIONAL)

RX PCN (OPTIONAL)

RX INSURANCE PHONE # (OPTIONAL)

PLEASE PROVIDE COPIES OF FRONT AND BACK OF MEDICAL AND PRESCRIPTION BENEFIT CARDS

PATIENT AUTHORIZATION

By signing this Authorization, I authorize each of my healthcare providers, pharmacists, including any specialty pharmacy that receives my prescription for Mytesi (crofelemer), other healthcare providers (together "Healthcare Providers"), and any of my health insurers (together, "Insurers") to disclose my Protected Health Information to Napo Pharmaceuticals, Inc., its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Napo Pharmaceuticals, Inc."), including supporting NapoCares (the "Program") for Healthcare Providers and patients for the purposes described below. Protected Health Information may include, but is not limited to, medical records, information related to my medical condition and treatment, including HIV-related information, health insurance coverage, my name, address, telephone number, Social Security number, insurance plan, and/or group numbers (together, "Protected Health Information").

I am authorizing disclosure of my Protected Health Information in order to:

I. Enroll me in and contact me about the Program, including online support, financial assistance services, co-pay assistance, and compliance and persistency services,
II. Communicate with my Healthcare Providers and Insurers about benefits, coverage, and medical care, including compliance with Product treatments,
III. Locate a specialty pharmacy that can fill my prescription and facilitate dispensing of my prescription by such pharmacy,
IV. Provide me with educational materials, information, and services related to my treatment experience with Mytesi and my condition,
V. Contact me and leave messages about my use of Mytesi and my medical care,
VI. Verify, investigate, assist with, and coordinate my coverage for Mytesi with my Insurers,
VII. Coordinate prescription fulfillment,
VIII. Conduct surveys, data analytics, market research, and other internal business activities related to the Program, Mytesi, and other Napo Pharmaceuticals, Inc. products and programs, and
IX. Contact me as otherwise required or permitted by law.

I understand that pharmacies that ship my medication may be paid to share my Protected Health Information with the Program and for providing support services to me, including sending communications to me for purposes of the Program pursuant to this authorization. Once my Protected Health Information has been disclosed to Napo Pharmaceuticals, Inc., I understand that federal privacy laws no longer protect the information. However, Napo Pharmaceuticals, Inc. agrees to protect my Protected Health Information by using and disclosing it only for the purposes described in this authorization or as permitted by law. We do not sell de-identified Protected Health Information to third parties.

I understand that I may refuse to sign this Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me, but should I decline to sign, I will not have access to the Program and the services provided by Napo Pharmaceuticals, Inc. or others under the Program. If I refuse to sign the Authorization, or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from the Program.

This Authorization will last for a period of five (5) years (unless earlier termination is required by applicable state law). I understand that I may revoke this Authorization at any time in the future, except to the extent that actions have been taken in reliance on the Authorization, by mailing a request to P.O. Box 7613, Overland Park, KS 66207, via fax at (415) 963-9830, or by calling (888) 527-NAPO (6276). I understand that revoking this Authorization will end further uses and disclosure of my Protected Health Information by the parties identified above except to the extent those uses and disclosures have been made in reliance upon this Authorization as permitted by applicable law. I am entitled to receive a copy of this Authorization.

The information I have provided on this form is complete and accurate to the best of my knowledge. I will update my information promptly if any of the information reflected on this Form changes by contacting the Program at (888) 527-NAPO (6276).

I have read and agree with the terms of the Patient Authorization above and the NapoCares Program Guidelines set forth on page 4 of this Form.

OPT OUT OF COMMUNICATIONS: ☐ **Please check here if you do not wish to receive communications other than those related to the program.**

SIGN HERE

PATIENT SIGNATURE

DATE

SIGN HERE

PATIENT LEGAL REPRESENTATIVE (IF APPROPRIATE)

RELATIONSHIP TO PATIENT (IF APPROPRIATE)

PLEASE COMPLETE ALL APPLICABLE FIELDS ON THIS FORM (TO PREVENT DELAYS IN PROCESSING).

P.O. BOX 7613 OVERLAND PARK, KS 66207
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NAPOCARES™ PATIENT SUPPORT ENROLLMENT (CONTINUED)

PATIENT INFORMATION

PATIENT FIRST NAME / MIDDLE INITIAL / LAST NAME

PATIENT DATE OF BIRTH

MEDICAL INFORMATION

DIAGNOSIS ICD-10 CODE

- ☐ R19.7 Diarrhea, unspecified
- ☐ K59.1 Functional diarrhea
- ☐ K52.9 Noninfective gastroenteritis and colitis, unspecified
- ☐ B23.2 HIV disease resulting in haematological and immunological abnormalities, not elsewhere classified
- ☐ Other_____

DIARRHEA MEDICATION HISTORY (CHECK ALL THAT APPLY)

Mytesi	Loperamide	Lomotil	Other: _____
☐ Current treatment	☐ Current treatment	☐ Current treatment	☐ Current treatment
☐ Tried	☐ Tried	☐ Tried	☐ Tried
☐ Failed	☐ Failed	☐ Failed	☐ Failed
☐ Responded	☐ Responded	☐ Responded	☐ Responded

QUICK START PRESCRIPTION (TO BE FILLED BY ARX PATIENT SOLUTIONS PHARMACY)

MYTESI (crofelemer 125 mg delayed-release tablets) QTY: **15-day supply (30 tablets)** REFILLS: **ONE (1) REFILL (IF ELIGIBLE)** SIG: **ONE (1) tablet BID**

Quick Start prescription is intended to support access to therapy if there is a delay in insurance coverage determination. Quick Start prescription is at no cost, for eligible patients within labeled indication only, and not contingent on purchase of any kind. I, as the prescriber, with my signature below on this form, agree and attest that I will not submit a claim to or seek payment from the patient or any third-party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment/reimbursement for any free product(s) provided by Napo Pharmaceuticals, Inc. I agree and understand that any free product provided by Napo Pharmaceuticals, Inc. may not be sold, traded, bartered, transferred, or returned for credit and will only be used for the patient named above on the form. Napo Pharmaceuticals, Inc. reserves the right to modify or terminate the program without notice at any time.

SIGN HERE

PRESCRIBER SIGNATURE (DISPENSE AS WRITTEN) DATE

SIGN HERE

PRESCRIBER SIGNATURE (SUBSTITUTION PERMITTED) DATE

The prescriber is to comply with his/her 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 or rejection of the prescription.

PRESCRIPTION FOR NEW & MAINTENANCE PATIENTS (TO BE FILLED BY SPECIALTY PHARMACY)

MYTESI (crofelemer 125 mg delayed-release tablets) QTY: ☐ **30-day supply (60 tablets)** ☐ **90-day supply (180 tablets)** REFILLS: ☐ **5** ☐ **Other amount (enter #)**_____ SIG: **ONE (1) tablet BID**

SIGN HERE

PRESCRIBER SIGNATURE (DISPENSE AS WRITTEN) DATE

SIGN HERE

PRESCRIBER SIGNATURE (SUBSTITUTION PERMITTED) DATE

The prescriber is to comply with his/her 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 or rejection of the prescription.

PRESCRIBER INFORMATION

PRESCRIBER FIRST NAME / LAST NAME NPI # STATE LICENSE #

STREET ADDRESS CITY / STATE ZIP CODE

PHONE # FAX # OFFICE EMAIL ADDRESS (OPTIONAL)

OFFICE CONTACT NAME (OPTIONAL) OFFICE CONTACT PHONE # (OPTIONAL)

PRESCRIBER AUTHORIZATION

By signing below, I certify that (1) the above therapy is appropriate and medically necessary and in the best interest of the named patient; (2) I have received the appropriate permission from the patient (or the patient's Legal Representative) and met any other applicable legal or regulatory requirements such as those imposed under the Health Insurance Portability and Accountability Act of 1996 and/or state law needed to release the above information to Napo Pharmaceuticals, Inc. (Napo) and its agents; (3) I have obtained the patient's authorization to release the above information and such other information as may be required by AssistRx, as Napo Pharmaceuticals, Inc.'s agent, and its employees to assist in obtaining coverage for Mytesi; and (4) I appoint AssistRx as my agent for the purpose of conveying this prescription to the appropriate dispensing pharmacy by any means allowed under applicable law, verifying the patient's insurance coverage for MYTESI (crofelemer) 125 mg tablets, providing information regarding payer coverage and benefits and how to prepare prior authorization requests, coverage determination appeals, or other coverage issues, and providing my patient and me with educational and support services associated with MYTESI (crofelemer). I certify that I have reviewed the additional terms available at https://ebvterms.com, which are specifically incorporated herein by reference, and acknowledge and consent to their application and enforceability in regards to this certification.

SIGN HERE

PRESCRIBER SIGNATURE DATE

PLEASE COMPLETE ALL APPLICABLE FIELDS ON THIS FORM (TO PREVENT DELAYS IN PROCESSING).

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NAPOCARES™ PATIENT SUPPORT ENROLLMENT (CONTINUED)

PROGRAM GUIDELINES

1. **OVERVIEW** NapoCares Patient Support Program is designed to provide Mytesi to those for whom a medical need has been established, who cannot afford the cost of therapy, and who are below the maximum income requirements adjusted by household size and have no other insurance coverage or federally funded health benefit options available to access Mytesi.
2. **DEFINITIONS** For the purpose of this enrollment form and NapoCares Patient Support Program, the following definitions shall apply: "Patient" means one on whose behalf an application has been submitted for Benefits under NapoCares; "Applicant" means a person who submits an application for Benefits under NapoCares; "Beneficiary" means an Applicant whose application for access to Mytesi under the Patient Support Program has been granted in full or part pursuant to the NapoCares program; "Benefits" means Mytesi Delayed-Release Tablets that are provided pursuant to the NapoCares program; "You" means the Applicant and/or a Beneficiary, as appropriate from the context of this use; and "NapoCares" means the NapoCares Patient Support Program.
3. **SIGNATURES REQUIRED** In order to be considered for Benefits under NapoCares, both You (or your legal representative) and your prescribing healthcare provider must complete and sign the appropriate sections of the application form.
4. **ACCESS TO INFORMATION** Your application for Benefits allows access to financial, medical, and other information about You. In order for NapoCares to receive certain medical information about You in your application, the Health Insurance Portability and Accountability Act of 1996 and the related Privacy Rule 45 CFR Parts 160 and 164 (collectively "HIPAA") require NapoCares to obtain your written authorization. If You do not sign the enrollment form, NapoCares cannot process your application and You will not be able to participate in NapoCares.
5. **ELIGIBILITY** Quick Start Program Applicant must be covered under a commercial insurance policy or Medicare.
6. **US RESIDENTS ONLY** Only US Residents (excluding residents of Puerto Rico and other US territories) are eligible for Benefits under NapoCares.
7. **LIMIT ON SUPPLY** A Beneficiary may be awarded a maximum of two 15-day supplies of Mytesi through the Quick Start Program over the lifetime of the Beneficiary.
8. **NO RIGHT TO ASSISTANCE** An applicant for Benefits under NapoCares has no legal right to receive assistance from NapoCares. Any award of Benefits from NapoCares will involve the assessment of many criteria among potentially qualified Applicants. Therefore, we reserve the right to grant or deny an application, in whole or in part, on the basis of such criteria as we deem appropriate. In particular, the fact that an Applicant may be granted an award of Benefits at one time does not mean that the Applicant is entitled to, or will be granted, an award of Benefits at any time. Napo Pharmaceuticals, Inc. reserves the right to rescind, revoke, or amend this program, without prior notice, at any time.
9. **DISPENSING PHARMACY** NapoCares' contracted dispensing pharmacy is responsible for the dispensing activities provided, including any delays in shipment or other problems that might occur with the delivery of Mytesi.
10. **DRUG SHORTAGE** NapoCares will attempt to provide You with sufficient quantities of Mytesi to cover your needs while You are enrolled in the NapoCares program. However, in the event that a shortage of drug exists at any time during a period of time for which You have been awarded drug under NapoCares, NapoCares will give You written or verbal notice of such shortage.
11. **WAITING LISTS** NapoCares may receive numerous applications, resulting in requests for more Mytesi than is available through the NapoCares program. Therefore, NapoCares may not be able to approve all applications for Benefits. Moreover, a waiting list of Applicants may accrue, which may delay processing applications until a sufficient supply of Mytesi becomes available through the NapoCares program.
12. **RIGHT TO MODIFY BENEFIT** We, during the time period of any award to Beneficiary, reserve the right to review the award and/or the Patient's medical and financial situation, without prior notice, at any time. Based on that review, we reserve the right to increase, decrease, or terminate Benefits previously awarded to You.
13. **ADDITIONAL RESTRICTIONS** In the course of reviewing an application and/or administering an award of Benefits under NapoCares, we reserve the right to impose such other conditions and/or require that You provide such other information and/or that You take such actions as we deem appropriate.
14. **NO WARRANTIES** NapoCares does not make any representations or warranties, either expressed or implied, concerning any aspect of NapoCares.
15. **TERMINATION OF PROGRAM** NapoCares may be amended or terminated, without prior notice, at any time.

INDICATION AND IMPORTANT SAFETY INFORMATION

WHAT IS MYTESI?

Mytesi is a prescription medicine used to improve symptoms of noninfectious diarrhea (diarrhea not caused by a bacterial, viral, or parasitic infection) in adults living with HIV/AIDS on anti-retroviral therapy (ART).

PLEASE READ IMPORTANT SAFETY INFORMATION

Do Not Take Mytesi if you have diarrhea caused by an infection. Before you start Mytesi, your doctor and you should make sure your diarrhea is not caused by an infection (such as bacteria, virus, or parasite). If infectious diarrhea is not ruled out, there is a risk that patients with an underlying infection will not receive the appropriate therapy and the cause of the infection may worsen.

Possible Side Effects of Mytesi Include:

- upper respiratory tract infection (sinus, nose, and throat infection)
- bronchitis (swelling in the tubes that carry air to and from your lungs
- cough
- flatulence (gas)
- increased bilirubin (a waste product when red blood cells break down)

PLEASE SEE FULL PRESCRIBING INFORMATION AVAILABLE AT https://mytesi.com/mytesi_full_prescribing_information

NP-380-4, Revised 04/2021