NEUROCRINE™ Access Support

Crenessity™ (crinecerfont)

ENROLLMENT FORM GUIDE

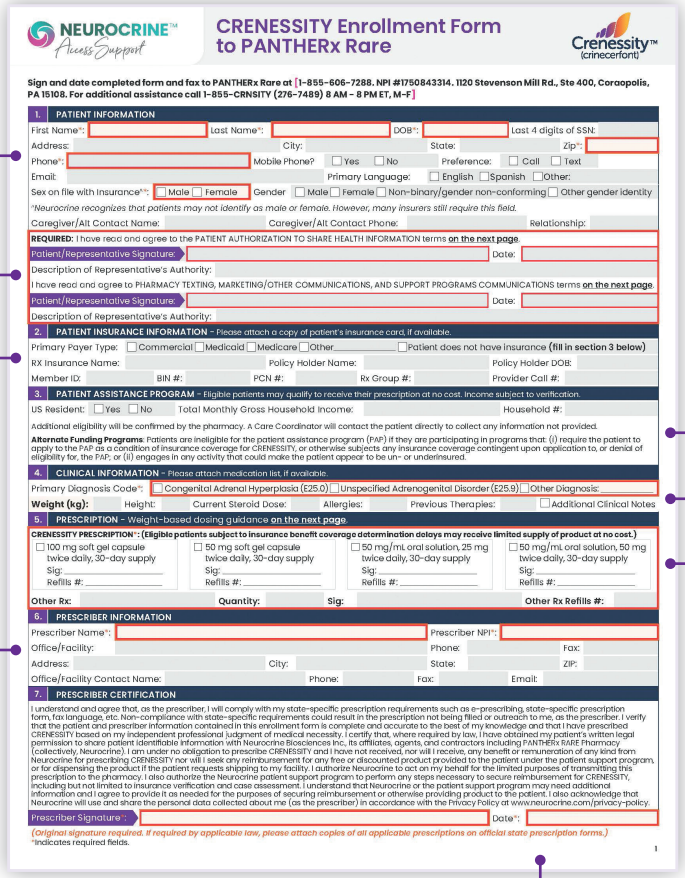
1. Patient Information
The highlighted patient information is required by the pharmacy for prescription processing.

Required Patient Signatures
Signed consent is important because it allows the patient to receive the following personalized support and services:

- Tailored assistance from the Neurocrine Access Support program
- The ability to text with the pharmacy about their prescription
- Educational materials and information about CRENESSITY

Ideally, obtain the patient's signatures if they are in the office. If not, PANTHERx Rare Pharmacy will follow up with them after enrollment form submission. (Consent language can be found on page 2 of the form. It is also available in Spanish for patients who need it.)

2. Patient Insurance Information
If the patient is insured, please provide their insurance information and, if possible, attach a copy of their insurance card. If the patient is uninsured, complete section 3 if information from the patient is available.



NEUROCRINE™ Access Support

CRENESSITY Enrollment Form to PANTHERx Rare

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Sign and date completed form and fax to PANTHERx Rare at [1-855-606-7288. NPI #1750843314. 1120 Stevenson Mill Rd., Ste 400, Coraopolis, PA 15108. For additional assistance call 1-855-CRNSITY (276-7489) 8 AM - 8 PM ET, M-F]

1. PATIENT INFORMATION

First Name*: Last Name*: DOB*: Last 4 digits of SSN:

Address: City: State: Zip*:

Phone*: Mobile Phone? ☐ Yes ☐ No Preference: ☐ Call ☐ Text

Email: Primary Language: ☐ English ☐ Spanish ☐ Other:

Sex on file with Insurance*: ☐ Male ☐ Female Gender ☐ Male ☐ Female ☐ Non-binary/gender non-conforming ☐ Other gender identity

*Neurocrine recognizes that patients may not identify as male or female. However, many insurers still require this field.

Caregiver/Alt Contact Name: Caregiver/Alt Contact Phone: Relationship:

REQUIRED: I have read and agree to the PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION terms **on the next page**.

Patient/Representative Signature: Date:

Description of Representative's Authority:

I have read and agree to PHARMACY TEXTING, MARKETING/OTHER COMMUNICATIONS, AND SUPPORT PROGRAMS COMMUNICATIONS terms **on the next page**.

Patient/Representative Signature: Date:

Description of Representative's Authority:

2. PATIENT INSURANCE INFORMATION - Please attach a copy of patient's insurance card, if available.

Primary Payer Type: ☐ Commercial ☐ Medicaid ☐ Medicare ☐ Other_____ ☐ Patient does not have insurance **(fill in section 3 below)**

RX Insurance Name: Policy Holder Name: Policy Holder DOB:

Member ID: BIN #: PCN #: Rx Group #: Provider Call #:

3. PATIENT ASSISTANCE PROGRAM - Eligible patients may qualify to receive their prescription at no cost. Income subject to verification.

US Resident: ☐ Yes ☐ No Total Monthly Gross Household Income: Household #:

Additional eligibility will be confirmed by the pharmacy. A Care Coordinator will contact the patient directly to collect any information not provided.

Alternate Funding Programs: Patients are ineligible for the patient assistance program (PAP) if they are participating in programs that: (i) require the patient to apply to the PAP as a condition of insurance coverage for CRENESSITY, or otherwise subjects any insurance coverage contingent upon application to, or denial of eligibility for, the PAP; or (ii) engages in any activity that could make the patient appear to be un- or underinsured.

4. CLINICAL INFORMATION - Please attach medication list, if available.

Primary Diagnosis Code*: ☐ Congenital Adrenal Hyperplasia (E25.0) ☐ Unspecified Adrenogenital Disorder (E25.9) ☐ Other Diagnosis:

Weight (kg): Height: Current Steroid Dose: Allergies: Previous Therapies: ☐ Additional Clinical Notes

5. PRESCRIPTION - Weight-based dosing guidance **on the next page**.

CRENESSITY PRESCRIPTION*: (Eligible patients subject to insurance benefit coverage determination delays may receive limited supply of product at no cost.)

☐ 100 mg soft gel capsule twice daily, 30-day supply	☐ 50 mg soft gel capsule twice daily, 30-day supply	☐ 50 mg/mL oral solution, 25 mg twice daily, 30-day supply	☐ 50 mg/mL oral solution, 50 mg twice daily, 30-day supply
Sig:	Sig:	Sig:	Sig:
Refills #:	Refills #:	Refills #:	Refills #:

Other Rx: Quantity: Sig: Other Rx Refills #:

6. PRESCRIBER INFORMATION

Prescriber Name*: Prescriber NPI*:

Office/Facility: Phone: Fax:

Address: City: State: ZIP:

Office/Facility Contact Name: Phone: Fax: Email:

7. PRESCRIBER CERTIFICATION

I understand and agree that, as the prescriber, I will comply with my state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in the prescription not being filled or outreach to me, as the prescriber. I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed CRENESSITY based on my independent professional judgment of medical necessity. I certify that, where required by law, I have obtained my patient's written legal permission to share patient identifiable information with Neurocrine Biosciences Inc, its affiliates, agents, and contractors including PANTHERx RARE Pharmacy (collectively, Neurocrine). I am under no obligation to prescribe CRENESSITY and I have not received, nor will I receive, any benefit or remuneration of any kind from Neurocrine for prescribing CRENESSITY nor will I seek any reimbursement for any free or discounted product provided to the patient under the patient support program, or for dispensing the product if the patient requests shipping to my facility. I authorize Neurocrine to act on my behalf for the limited purposes of transmitting this prescription to the pharmacy. I also authorize the Neurocrine patient support program to perform any steps necessary to secure reimbursement for CRENESSITY, including but not limited to insurance verification and case assessment. I understand that Neurocrine or the patient support program may need additional information and I agree to provide it as needed for the purposes of securing reimbursement or otherwise providing product to the patient. I also acknowledge that Neurocrine will use and share the personal data collected about me (as the prescriber) in accordance with the Privacy Policy at www.neurocrine.com/privacy-policy.

Prescriber Signature*: Date*:

(Original signature required. If required by applicable law, please attach copies of all applicable prescriptions on official state prescription forms.)

*Indicates required fields.

6. Prescriber Information
Prescriber name and NPI are required.

7. Prescriber Certification
A healthcare provider's signature is required to complete the prescription.

3. Patient Assistance Program
By completing section 3, qualifying patients will automatically be enrolled in the Patient Assistance Program. After enrollment form submission, PANTHERx Rare Pharmacy will contact patients directly to obtain any missing or additional information needed to confirm eligibility.

4. Clinical Information
- Health plans will likely need confirmation of the patient's diagnosis for prior authorizations
- Pediatric patient weight is needed for dosing. Baseline adult patient weight is also preferred, if available
- Submitting clinical notes and labs as needed to establish medical necessity of CRENESSITY with your referral may help expedite prior authorization submissions with insurance companies

5. Prescription
Verify appropriate dosing for your patient. Please also see dosage information section at the bottom of page 2 to confirm that the correct dose has been prescribed.

ENROLLMENT FORM GUIDE

English

NEUROCRINE™ Access Support

Patient Authorization and Consent

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8. PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

I authorize my/my child's healthcare providers, health insurance carriers, laboratory providers, pharmacy providers and other entities involved in my/my child's healthcare (collectively, Healthcare Entities) to share my/my child's individual health and identifying information, including but not limited to health insurance information, financial information, medical diagnosis and condition, physical examinations, clinical tests, blood tests, X-rays, and other procedures, treatment information including prescription information, and name, date of birth, sex, address, email address, and telephone number to Neurocrine and its agents, representatives, and contractors including but not limited to third parties authorized by Neurocrine (collectively, Neurocrine). Such information may be shared with Neurocrine so that Neurocrine can: (1) provide me/my child with support services (and related information and materials) related to any of Neurocrine's products, including but not limited to, online support, financial assistance services, compliance and persistency and other therapy support services; (2) conduct data analysis, market research and other necessary internal business activities; and (3) provide me/my child with information about Neurocrine's products, services, and programs for educational or other purposes. I understand that pharmacy providers, or others working on their behalf, may receive remuneration from Neurocrine in exchange for the health information and/or for any support services provided.

Once my/my child's health information has been disclosed to Neurocrine, I understand that it may be redisclosed by Neurocrine, and federal privacy laws no longer protect the redisclosed information. However, Neurocrine agrees to protect my/my child's health information by using and disclosing it only for purposes described above or as required by law or regulations. This authorization expires 10 years after the date I signed, or such shorter time as may be required by applicable law, unless otherwise canceled earlier. I understand I have a right to receive a copy of this authorization.

I understand that I may refuse to sign this authorization and that my/my child's treatment (including with a Neurocrine product), insurance enrollment, or eligibility for benefits are not conditioned upon my agreement to sign this authorization. I may cancel this authorization at any time by calling 1-855-CRNSITY (276-7489) or by mailing a letter to PANTHERx Rare, 121 Bayer Road, Pittsburgh, PA 15205 and that doing so will end my consent for my Healthcare Entities to further disclose my/my child's health information to Neurocrine after notification of my cancellation but will not affect previous disclosures pursuant to this authorization. Canceling this authorization will not affect my/my child's ability to receive treatment, insurance enrollment, or eligibility for benefits.

I understand that if I do not sign this authorization, or later cancel it, I/my child will not be able to receive Neurocrine's support program services.

9. PHARMACY TEXTING, MARKETING/OTHER COMMUNICATIONS, AND SUPPORT PROGRAMS COMMUNICATIONS

I authorize Neurocrine and its authorized agents, representatives, contractors and other third parties including PANTHERx RARE Pharmacy (collectively, Neurocrine) to:

1. To contact me by mail, email, fax, telephone, text message, chat, push notifications and other forms of electronic messaging (collectively, Communications Methods) to provide me/my child with CAH support services related to any of Neurocrine's CAH products, including any information or materials related to such services;
2. Use and disclose my/my child's medical and health information in connection with providing CAH support services, including but not limited to, disclosing my/my child's information to vendors, processors, and service providers for business purposes associated with providing CAH support services, sharing such information with my/my child's healthcare provider, insurance provider, or pharmacy, or disclosing my/my child's information where required by applicable laws or regulations; and
3. Contact me by any Communications Methods for marketing purposes related to, or to provide me with information about, Neurocrine's CAH products, services, and programs or other topics of interest, conduct market research, or ask me about my/my child's experience with or thoughts about such topics.

I understand that:

1. Personnel including but not limited to pharmacists, providing CAH support services on behalf of Neurocrine are not employed by my/my child's healthcare professional;
2. Any information I provide Neurocrine may be used by Neurocrine to help develop new products, services, and programs, or as otherwise described in Neurocrine's Privacy Policy at www.neurocrine.com/privacy-policy;
3. Neurocrine will not sell or transfer my/my child's personal data to any unrelated third party for marketing purposes without my express permission;
4. My authorization to receive marketing communications is not required as a condition of purchasing or receiving any goods from Neurocrine, but that if I do not provide authorization or later revoke my authorization, I/my child may not be able to receive CAH support services from Neurocrine; and
5. I may revoke my authorization to receive marketing communications and choose not to receive marketing or other communications from Neurocrine by following the process described in Neurocrine's Privacy Policy.

AGE AND BODY WEIGHT DOSAGE REGIMEN – Adults (18 and older), pediatrics (4-17)

Adult and pediatric patients weighing ≥55 kg (≥121 lb) 100 mg twice daily (200 mg per day)

Pediatric patients weighing 20 kg to <55 kg (44 lb to <121 lb) 50 mg twice daily (100 mg per day)

Pediatric patients weighing 10 kg to <20 kg (22 lb to <44 lb) 25 mg twice daily (50 mg per day)

2

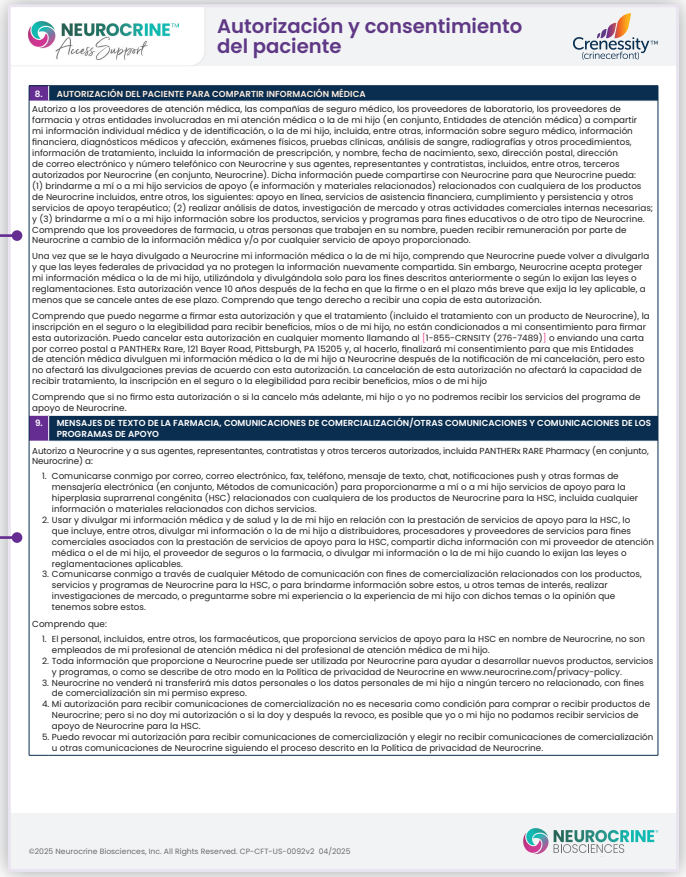
NEUROCRINE® BIOSCIENCES

8. Patient Consent to Share Health Information with Neurocrine

9. Patient Consent to Pharmacy Texting and Contact by Neurocrine

10. Prescription Dosing Information

Spanish



NEUROCRINE™ Access Support

Autorización y consentimiento del paciente

Crenessity™ (crinecerfont)

8. AUTORIZACIÓN DEL PACIENTE PARA COMPARTIR INFORMACIÓN MÉDICA

Autorizo a los proveedores de atención médica, las compañías de seguro médico, los proveedores de laboratorio, los proveedores de farmacia y otras entidades involucradas en mi atención médica o la de mi hijo (en conjunto, Entidades de atención médica) a compartir mi información individual médica y de identificación, o la de mi hijo, incluida, entre otras, información sobre seguro médico, información financiera, diagnósticos médicos y afección, exámenes físicos, pruebas clínicas, análisis de sangre, radiografías y otros procedimientos, información de tratamiento, incluida la información de prescripción, y nombre, fecha de nacimiento, sexo, dirección postal, dirección de correo electrónico y número telefónico con Neurocrine y sus agentes, representantes y contratistas, incluidos, entre otros, terceros autorizados por Neurocrine (en conjunto, Neurocrine). Dicha información puede compartirse con Neurocrine para que Neurocrine pueda: (1) brindarme a mí o a mi hijo servicios de apoyo (e información y materiales relacionados) relacionados con cualquiera de los productos de Neurocrine incluidos, entre otros, los siguientes: apoyo en línea, servicios de asistencia financiera, cumplimiento y persistencia y otros servicios de apoyo terapéutico; (2) realizar análisis de datos, investigación de mercado y otras actividades comerciales internas necesarias; y (3) brindarme a mí o a mi hijo información sobre los productos, servicios y programas para fines educativos o de otro tipo de Neurocrine. Comprendo que los proveedores de farmacia, u otras personas que trabajen en su nombre, pueden recibir remuneración por parte de Neurocrine a cambio de la información médica y/o por cualquier servicio de apoyo proporcionado.

Una vez que se le haya divulgado a Neurocrine mi información médica o la de mi hijo, comprendo que Neurocrine puede volver a divulgarla y que las leyes federales de privacidad ya no protegen la información nuevamente compartida. Sin embargo, Neurocrine acepta proteger mi información médica o la de mi hijo, utilizándola y divulgándola solo para los fines descritos anteriormente o según lo exijan las leyes o reglamentaciones. Esta autorización vence 10 años después de la fecha en que la firme o en el plazo más breve que exija la ley aplicable, a menos que se cancele antes de ese plazo. Comprendo que tengo derecho a recibir una copia de esta autorización.

Comprendo que puedo negarme a firmar esta autorización y que el tratamiento (incluido el tratamiento con un producto de Neurocrine), la inscripción en el seguro o la elegibilidad para recibir beneficios, míos o de mi hijo, no están condicionados a mi consentimiento para firmar esta autorización. Puedo cancelar esta autorización en cualquier momento llamando al (1-855-CRNSITY (276-7489)) o enviando una carta por correo postal a PANTHERx Rare, 121 Bayer Road, Pittsburgh, PA 15205 y, al hacerlo, finalizará mi consentimiento para que mis Entidades de atención médica divulguen mi información médica o la de mi hijo a Neurocrine después de la notificación de mi cancelación, pero esto no afectará las divulgaciones previas de acuerdo con esta autorización. La cancelación de esta autorización no afectará la capacidad de recibir tratamiento, la inscripción en el seguro o la elegibilidad para recibir beneficios, míos o de mi hijo

Comprendo que si no firmo esta autorización o si la cancelo más adelante, mi hijo o yo no podremos recibir los servicios del programa de apoyo de Neurocrine.

9. MENSAJES DE TEXTO DE LA FARMACIA, COMUNICACIONES DE COMERCIALIZACIÓN/OTRAS COMUNICACIONES Y COMUNICACIONES DE LOS PROGRAMAS DE APOYO

Autorizo a Neurocrine y a sus agentes, representantes, contratistas y otros terceros autorizados, incluida PANTHERx RARE Pharmacy (en conjunto, Neurocrine) a:

1. Comunicarse conmigo por correo, correo electrónico, fax, teléfono, mensaje de texto, chat, notificaciones push y otras formas de mensajería electrónica (en conjunto, Métodos de comunicación) para proporcionarme a mí o a mi hijo servicios de apoyo para la hiperplasia suprarrenal congénita (HSC) relacionados con cualquiera de los productos de Neurocrine para la HSC, incluida cualquier información o materiales relacionados con dichos servicios.
2. Usar y divulgar mi información médica y de salud y la de mi hijo en relación con la prestación de servicios de apoyo para la HSC, lo que incluye, entre otros, divulgar mi información o la de mi hijo a distribuidores, procesadores y proveedores de servicios para fines comerciales asociados con la prestación de servicios de apoyo para la HSC, compartir dicha información con mi proveedor de atención médica o el de mi hijo, el proveedor de seguros o la farmacia, o divulgar mi información o la de mi hijo cuando lo exijan las leyes o reglamentaciones aplicables.
3. Comunicarse conmigo a través de cualquier Método de comunicación con fines de comercialización relacionados con los productos, servicios y programas de Neurocrine para la HSC, o para brindarme información sobre estos, u otros temas de interés, realizar investigaciones de mercado, o preguntarme sobre mi experiencia o la experiencia de mi hijo con dichos temas o la opinión que tenemos sobre estos.

Comprendo que:

1. El personal, incluidos, entre otros, los farmacéuticos, que proporciona servicios de apoyo para la HSC en nombre de Neurocrine, no son empleados de mi profesional de atención médica ni del profesional de atención médica de mi hijo.
2. Toda información que proporcione a Neurocrine puede ser utilizada por Neurocrine para ayudar a desarrollar nuevos productos, servicios y programas, o como se describe de otro modo en la Política de privacidad de Neurocrine en www.neurocrine.com/privacy-policy.
3. Neurocrine no venderá ni transferirá mis datos personales o los datos personales de mi hijo a ningún tercero no relacionado, con fines de comercialización sin mi permiso expreso.
4. Mi autorización para recibir comunicaciones de comercialización no es necesaria como condición para comprar o recibir productos de Neurocrine; pero si no doy mi autorización o si la doy y después la revoco, es posible que yo o mi hijo no podamos recibir servicios de apoyo de Neurocrine para la HSC.
5. Puedo revocar mi autorización para recibir comunicaciones de comercialización y elegir no recibir comunicaciones de comercialización u otras comunicaciones de Neurocrine siguiendo el proceso descrito en la Política de privacidad de Neurocrine.

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