# Patient Enrollment Form

Fax completed form to 1-800-621-5203

## Genetic Testing Information

| | | | |
|---|---|---|---|
| ☐ Exon 51 Amenable | ☐ Exon 53 Amenable | ☐ Exon 45 Amenable | ☐ Please attach a copy of Genetic Testing |

## Patient Information

| | | | | |
|---|---|---|---|---|
| First Name: | | Last Name: | | Middle Initial: |
| Address: | | City: | State: | ZIP: |
| Date of Birth: | SSN: | Patient Weight (lbs): | | Gender: ☐ M ☐ F |
| Primary Contact: | | Relationship to Patient: | | |
| Primary Phone: | | Secondary Phone: | | |
| Best Time to Call: ☐ AM ☐ PM | | Ok to Leave Message? ☐ YES ☐ NO | | Language, other than English: |
| Email Address: | | | | |

## Insurance Information ■ Check if you are attaching a copy of the patient's insurance cards (front & back copy)

| | | | |
|---|---|---|---|
| Primary: | ID #: | Group #: | Phone: |
| Policy Holder: | | Relationship to Patient: | |
| Secondary: | ID #: | Group #: | Phone: |
| Policy Holder: | | Relationship to Patient: | |

## Physician Information

| | | | | |
|---|---|---|---|---|
| First Name: | Last Name: | | Affiliation: | |
| Address: | | City: | State: | ZIP: |
| Office Contact: | Phone: | Fax: | Email: | |
| NPI #: | State License #: | Tax ID #: | DEA ID #: | |

## Site of Care Information ■ Hospital Clinic ■ Homecare ■ Unknown

| | | | | |
|---|---|---|---|---|
| Site Name: | | NPI #: | | |
| Address: | | City: | State: | ZIP: |
| Site Contact: | Phone: | Fax: | Email: | |

## Physician Declaration (a physician's signature is required in order for SareptAssist to perform a benefits verification)

By signing below, I certify that (1) the therapy is medically necessary and in the best interest of the patient identified above; (2) the patient is appropriately indicated for the therapy; and (3) I have obtained and provide any consent required under federal and state law for the release and use of the patient's information on this form to Sarepta Therapeutics, Inc. ("Sarepta") and its agents, including its commercial and field-based teams, for purposes of benefits verification and coordination of dispensing the therapy.

Print Prescriber Name

Physician Signature

Date

Please contact us with any questions
SareptAssist, 215 First Street, Cambridge, MA 02142
Phone: 1-888-SAREPTA (1-888-727-3782) | Fax: 1-800-621-5203 | Email: SareptAssist@Sarepta.com

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Fax completed form to 1-800-621-5203

## Patient Authorization for the SareptAssist Program

| Patient Name: | Date of Birth: |
|---|---|

I authorize my healthcare providers (e.g., physicians, pharmacies) and my insurance company to disclose personal health information about me, including information related to my medical condition and treatment, my health insurance coverage, and my address, email address and telephone number (collectively, my "PHI") to Sarepta Therapeutics, its agents, including its commercial and field-based teams, and the SareptAssist Program (collectively "Sarepta") so that Sarepta may use the information for purposes of: (1) verifying, investigating, assisting with, and coordinating my coverage for the therapy with my health insurers; (2) assessing my eligibility for co-pay assistance or free drug or referring me to other programs or sources of funding and financial support; (3) coordinating delivery of the therapy to me or my healthcare provider; (4) providing education, information on Sarepta products and services, and ongoing support services to me related to the therapy; (5) gathering feedback on my therapy and/or disease state; (6) contacting me by mail, email, phone or fax for any of the above purposes and (7) creating information that does not identify me personally for use for other legitimate purposes. I understand that my pharmacy providers may receive remuneration for making such disclosures. I also authorize Sarepta and my healthcare providers and my insurance company to use my PHI to communicate with me about Sarepta products and services and I understand that my healthcare providers and my insurance company may receive remuneration for making such communications. I understand that once disclosed pursuant to this authorization, my PHI may no longer be protected under federal or state law and could be disclosed by Sarepta to others, but I also understand that Sarepta will make reasonable efforts to keep my PHI private and to disclose it only for purposes set forth in this authorization.

I understand that I do not have to sign this authorization to obtain healthcare treatment or benefits; however, in order to receive the services and communications described above, I must sign the authorization. I understand that I may cancel my authorization at any time by contacting SareptAssist by fax at 1-800-621-5203, or by mail at 215 First Street, Cambridge, MA 02142. My cancellation of this authorization will be effective for Sarepta upon receipt, and will be effective for each of my healthcare providers and insurance companies when they are notified of it, but the cancellation will not affect prior uses or disclosures of PHI.

I understand that I have a right to receive a copy of this authorization.

This authorization expires 5 years after the date I sign it as shown below, or such earlier date as may be required by the state in which I reside, unless I cancel it before then.

| Patient or Legal Guardian Signature | Date |
|---|---|
| Printed Name of Patient or Personal Representative | Date |

If signed by personal representative, state relationship to patient _____