Patient Enrollment Form

Lumvoq™ veligrotug-vvze | VIRIDIAN™ cares

Please complete form, ensure patient reviews and signs, then fax all 4 pages to 1-833-726-5151.

For any questions or help, please call: 1-866-VCARES1

*REQUIRED FIELD

Patient Information

Patient First Name* **Patient Last Name***

Gender* ○ Female ○ Male **Date of Birth (MM/DD/YYYY)***

Street Address*

City* **State*** **ZIP***

Phone (Primary)* **Preferred Language***

Email Address*

Alternate Contact Name

Alternate Contact Phone Number

Prescriber Information

Prescriber First and Last Name* **Specialty***

Street Address*

City* **State*** **ZIP***

Practice Name/Affiliation*

Office Phone* **Office Fax***

Office Contact Name*

Office Contact Email*

NPI* **Tax ID***

State License Number* **State Issued***

Preferred Communication: ○ Phone ○ Email ○ Fax

Insurance Information

Complete the following OR attach front and back copies of insurance card(s).

Primary Insurance	*Secondary Insurance*
Insurance Company*	**Insurance Company**
Policy Holder Name*	**Policy Holder Name**
Subscriber ID Number*	**Subscriber ID Number**
Group Number*	**Group Number**
Phone Number*	**Phone Number**
Fax Number*	**Fax Number**

☐ Patient is uninsured to my knowledge

Preferred Infusion Facility

If none, ViridianCares can provide options.

Facility Name

Street Address

City **State** **ZIP**

Facility Phone **Facility Fax**

Facility NPI **Facility Tax ID**

○ The infusion facility is the same as the prescribing office
○ Home infusion

Diagnosis (ICD-10 Code)*
(REQUIRED FOR BENEFITS VERIFICATION)

☐ **E05.00** - Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm
☐ **H05.831** - Thyroid orbitopathy, right orbit
☐ **H05.832** - Thyroid orbitopathy, left orbit
☐ **H05.833** - Thyroid orbitopathy, bilateral
☐ **H05.839** - Thyroid orbitopathy, unspecified orbit
☐ **Other**

Complete signatures and prescription information on following pages.

Patient Enrollment Form
(continued)

Lumvoa™ veligrotug-vvze | VIRIDIAN™ cares

Prescription

Patient Full Name* _____ **Date of Birth (MM/DD/YYYY)*** ___/___/___

Medication: Lumvoa (veligrotug-vvze) for injection, for intravenous use (500 mg/10 mL)/NDC: 85166-001-01 (Carton containing 1 single-dose vial)

Directions: The recommended dose of Lumvoa is an intravenous infusion of 10 mg/kg every 3 weeks, for 5 infusions. Calculate the dose (mg) and determine the number of vials needed for the 10 mg/kg dosage based on patient weight. Each Lumvoa vial contains 10 mL of veligrotug drug product at a concentration of 50 mg/mL of veligrotug antibody. Please see Dosing and Administration section of Prescribing Information for additional instruction.

Patient Weight* ○ lb ○ kg

Dosage* _____ mg (10 mg/kg)
21-day supply;
1 prescription;
4 refills

Allergies* _____

☐ **Patient Is Medically Urgent:** A Medically Urgent patient is a patient who (1) is at immediate risk of permanent vision loss due to Thyroid Eye Disease, with or without compressive optic neuropathy, and (2) requires treatment with Lumvoa while insurance coverage for Lumvoa is actively being pursued. I certify that the patient meets the definition of Medically Urgent above.

☐ **Nursing Orders for Home Infusion:** Provide skilled nursing visit to administer medication, provide education, and assess patient.

Fluids for Reconstitution/Administration: Use a 250 mL 0.9% sodium chloride, USP infusion bag to prepare the diluted solution. Please see dosage and administration in the Prescribing Information for more administration instructions.

Prescriber Certification

I certify that the above therapy is medically necessary, that the information provided is accurate to the best of my knowledge, and that my patient is being administered Lumvoa for infusion in accordance with the labeled use of the product and that I will supervise the patient's treatment accordingly. I represent that I have obtained any consent required under federal and state law for the release and use of my patient's personal health information including diagnosis, treatment, and medical and insurance information and that my patient has requested and authorized the disclosure of their personal health information to Viridian Therapeutics Inc., its affiliates, and their respective employees, agents, service providers, contractors, and representatives (collectively, "Viridian Therapeutics") for Viridian Therapeutics to administer the ViridianCares program (the "Program") for purposes of benefits verification and coordination of dispensing therapy, or to otherwise assist the patient to initiate or continue the prescribed therapy and/or to evaluate the patient's eligibility for ViridianCares or other programs for Lumvoa. I further understand and agree that (a) any medication or service provided through the Program as a result of this form is for the named patient only and is not being made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use Lumvoa or any other Viridian Therapeutics product or service, for any other person; (b) my decision to prescribe Lumvoa was based solely on my professional determination of medical necessity; (c) I am under no obligation to prescribe any Viridian Therapeutics therapies or to participate in ViridianCares; (d) I have not received, nor will I receive, any benefit from Viridian Therapeutics for prescribing a Viridian Therapeutics therapy; and (e) I will not seek reimbursement or payment from any payer, patient, or other source for free product provided to the patient. I understand that Viridian Therapeutics may modify or terminate the Program at any time without notice. The completion and submission of coverage- or reimbursement-related documentation are the responsibility of the patient and healthcare provider. Viridian Therapeutics makes no representation or guarantee concerning coverage or reimbursement for any item or service. I authorize Viridian Therapeutics to transmit this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan by any means allowed under applicable law. State requirements: I certify that the prescription I am submitting as part of this Patient Enrollment Form complies with my state's prescription requirements (eg, e-prescribing, state-specific prescription form, fax language). I understand that noncompliance with my state's specific prescription requirements will result in outreach to me to obtain a compliant prescription. By filling out and signing this form, the enrollment process in ViridianCares has initiated; however, your patient must sign a Patient Authorization to complete enrollment in ViridianCares. Please note that your patient will not receive services and support offered by the Program unless your patient signs a Patient Authorization, consenting to receiving such services. If your patient does not sign the Patient Authorization contained within this form, Viridian Therapeutics will contact the patient to determine whether the patient is interested in signing a separate Patient Authorization.

Signature below indicates prescription authorization and prescriber certification.

SIGNATURE REQUIRED

Prescriber Signature* _____ **Today's Date (MM/DD/YYYY)*** ___/___/___

Medically Urgent Attestation
If I have checked the "Patient is Medically Urgent" box, I understand and agree that (a) my determination that the patient is Medically Urgent is based solely on my professional medical judgment; (b) Viridian Therapeutics will provide Lumvoa at no cost to the patient, up to limits and terms and conditions defined by Viridian Therapeutics; (c) I am actively pursuing insurance coverage for Lumvoa for the patient; (d) I will not seek reimbursement, including from any government program, insurer, or the patient, for Lumvoa provided by Viridian Therapeutics at no cost to the patient; and (e) Viridian Therapeutics may modify or terminate the terms of this service at any time without notice.

Continue to next page to complete this form.

Patient Authorization to Use/Disclose Health Information

By signing this Patient Authorization to Use/Disclose Health Information form ("Authorization"), I hereby authorize each of my physicians and other healthcare providers (together, "Providers") and each of my health insurers (together, "Insurers") to disclose protected health information related to my medical condition and treatment (including prescription information), my health insurance coverage and policy number, and my personal information including personal identifiers such as my name, gender, mailing and email addresses, telephone number, and date of birth (together, "Health Information"), to Viridian Therapeutics, Inc., and its affiliates, and their respective employees, agents, service providers, contractors, and representatives (together, "Viridian Therapeutics"). My Health Information will be shared with Viridian Therapeutics so that they may: (i) communicate with me via mail, email, telephone, or if agreed to in this form, text me to (ii) enroll me in ViridianCares and provide patient support services, based on my eligibility, related to any of Viridian Therapeutics' medications, including but not limited to, online support, financial assistance services that may include co-pay card programs, free-drug or other financial assistance programs, drug coverage verification, patient access liaison services, adherence program, and disease management; (iii) provide me with educational and marketing materials and information related to my medications and ViridianCares; (iv) verify, investigate, assist with, and coordinate my coverage for my Viridian Therapeutics medication(s) with my Insurers and Providers; (v) determine my eligibility for and help me access potential savings, and/or free-drug programs for my Viridian Therapeutics medication(s); (vi) share information with my insurers and providers as needed to provide these services; (vii) de-identify my Health Information for use in program or system improvement, data analysis, or other internal business activities and/or compliance purposes.

Once my Health Information has been disclosed to Viridian Therapeutics pursuant to this authorization, it may be redisclosed by the recipient and I understand that federal or state privacy laws may no longer protect the information. However, Viridian Therapeutics 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 certain parties, such as my pharmacy provider, may receive remuneration from Viridian Therapeutics in exchange for the Health Information and/or for any support services provided to me.

I understand that I may refuse to sign this Authorization. I further understand that my treatment (including with a Viridian Therapeutics product), payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization; but if I do not sign it or later cancel it, I will not be able to receive ViridianCares services.

I may revoke this Authorization at any time. Your revocation must be in writing and submitted to ViridianCares at support@viridiancares.com. You may also revoke your Authorization by calling 1-866-VCARES1. If you revoke by phone, the program will document your revocation in writing on your behalf, including verification of your identity and the date and time of your request.

Continue to next page to complete this form.

Patient Authorization to Use/Disclose Health Information (continued)

Your revocation will be effective when the program receives your written revocation (including written documentation created from your phone request). Revocation will not apply to information already used or disclosed in reliance on this Authorization before the revocation was received.

Applicable state and other law may provide you with certain rights regarding your Health Information and personal information. This may include information about the categories of personal information that we collect and how we use it, described in more detail at https://www.viridiantherapeutics.com/privacy/.

This Authorization expires 5 years, or such shorter time frame required by applicable law, from the day I sign it as indicated by the date next to my signature unless otherwise canceled earlier as set forth above. I understand that I have the right to receive a copy of this Authorization once it is signed.

By signing below, I am indicating that I have read and understood the Patient Authorization, Authorization for Use and Disclosure of Protected Health Information (pages 3-4), that I am legally authorized to consent, and that I am providing my consent as the patient or the patient's legal representative for Viridian Therapeutics and its contractors and business partners to use and share the personal information I provide for the purposes described within the Authorization for Use and Disclosure of Protected Health Information.

Printed Patient Full Name*

SIGNATURE

Patient or Legal Representative Signature* **Today's Date (MM/DD/YYYY)***

Text Message Opt In (optional) ☐ Text

Text Messaging Consent: By selecting "Text" I consent to receive SMS/text messages from ViridianCares including, for example, service updates, enrollment support, infusion reminders, and educational messages to the provided mobile number. Message and data rates may apply. Message frequency varies. Text HELP for help. Text STOP to opt out. Consent to receiving SMS messages is not a condition of purchase of goods or services. Please see the mobile terms and conditions found at https://www.viridiantherapeutics.com/mobile/ and the privacy practices of Viridian Therapeutics at https://www.viridiantherapeutics.com/privacy/.

Please submit all 4 pages for a complete submission. If the patient signature is missing, ViridianCares will contact the patient regarding a separate Patient Authorization.