anovo SPECIALTY PHARMACY

Isturisa® (osilodrostat)

ISTURISA® (osilodrostat)
Patient Prescription Form
Complete the entire form and fax to 855-813-2039

www.Isturisa.com

If confirmation of receipt is not received within 24 hours after submission, refax or call 888-855-7273

Please select one: ☐ Newly Prescribed Patient ☐ Patient Currently on Isturisa®

Patient Information *(Please Print)*	**Last Name:**	**First Name:**	**SSN:**	**Sex:** ☐M ☐F
	Address:	**City:**	**State:**	**Zip:**
	Phone: Day #	**Evening #:**	**Cell #:**	
	DOB:	**Email:**		
	If Patient is a Minor, Guardian/Parent Name:		**Relation to Patient:**	
	Emergency Contact:		**Phone #:**	

Insurance Information *(Complete this section or include copy of insurance card)*	**Primary Insurance Co. Name:**		**Phone #:**
	Policy Holder Name:	**Policy #:**	**Group #:**
	Prescription Card Name:		**Phone #:**
	Policy #:		**Group #:**
	Secondary Insurance Co. Name:		**Phone #:**
	Policy Holder Name:	**Policy #:**	**Group #:**

Physician Information	**Prescriber Name/Title:**			
	NPI:	**Medicaid UPIN:**	**State License #:**	
	Address:	**City:**	**State**	**Zip:**
	Name of Contact Person:		**Phone #:**	
	Physician/Office Contact Email:		**Fax #:**	

Prescription	**ISTURISA® (Osilodrostat) tablets** *(Prior authorizations may be needed by each strength)*				
	☐ **1 mg tablet**	☐ **5 mg tablet**	**SIG: Take _____ mg 2 times/day**	**Refills:_____**	**Dispense** ☐**1 month** ☐**3 month**
	Prescriber to specify any titration instructions here:				

Medical Necessity	**Primary Diagnosis:**	**Date of Diagnosis:**	**Patient Age at Diagnosis:**
	Please check applicable ICD-10 code:		
	☐ **(E24.0) Cushing's Disease, pituitary-dependent**	☐ **(E24.9) Cushing's Syndrome, unspecified**	☐ **(C74.0) Adrenal Carcinoma**
	☐ **(E24.8) Other Cushing's Syndrome**	☐ **(E24.3) Ectopic ACTH**	☐ **Other (please specify)_____**

Clinical Background	**Allergies:**		☐ **NKDA**
	Concurrent and Previously Prescribed, if any *(optional)*		
	☐ **Ketoconazole: Dose_____Frequency _____**	☐ **Cabergoline: Dose_____Frequency _____**	**Metyrapone: Dose_____Frequency_____**
	☐ **Mifepristone: Dose_____Frequency_____**	☐ **Pasireotide: Dose_____Frequency_____** ☐**LAR** ☐**Subcutaneous**	

The undersigned certifies that: (1) the Prescriber has prescribed for the identified patient; (2) the Prescriber has determined that ISTURISA is medically necessary for this patient; (3) the Prescriber will comply with state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc; (4) the information provided on this form is accurate to the best of their knowledge.

Prescriber Signature *(no stamps allowed)*

Sign Here ▶ **(Dispense as Written)**	**Date:** *(MM/DD/YYYY)*	**Sign Here ▶** **(Substitution Permissible)**	**Date:** *(MM/DD/YYYY)*

I have discussed Patient Support with my patient, who has authorized me in a manner compliant with HIPAA and applicable state law to act as their agent to disclose their protected health information and personally identifiable information to Recordati for the limited purposes of (i) enrolling the patient in R.A.R.E. Patient Support Program, and (ii) contacting the patient by phone for the sole purpose of completing such enrollment.

☐ **Yes, I agree with this statement** ☐ **No, I do not agree with this statement**	**Prescriber Signature ▶** _____ *(No stamps allowed; may not be signed by an agent of the Prescriber)*	**Date:** *(MM/DD/YYYY)*

This patient form is only valid if FAXED directly from the prescriber to Anovo @ 855-813-2039
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Patient Liaison Program Enrollment
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R.A.R.E.® Recordati Access, Resources, and Engagement Patient Liaison Program Opt-in

As part of the Recordati Access, Resources, and Engagement (R.A.R.E.®) program, patients who are prescribed Isturisa may choose to have access to a Recordati Rare Disease Patient Liaison (PL) to receive personalized support.

By signing below, you will have access to a dedicated Patient Liaison who will be there to provide additional disease state education*, answer questions about Isturisa*, access to Isturisa, connect to additional resources regarding the disease state, and listen with an empathetic ear. If you choose not to enroll now, you can enroll at any time in the future by contacting Anovo Specialty Pharmacy at 888-855-7273.

** These services are provided at no additional cost to enrolled patients by Recordati Rare Diseases. Information provided by the PL program is for educational purposes only and is not intended to replace the care and advice of your health care providers.*

Patient Information

Last Name:	First Name:	DOB:
Patient's Legally Authorized Representative (if applicable):	Relation to Patient:	Phone #:
Emergency Contact:	Phone #:	

Is there someone else with whom we may discuss your protected health information? ☐ Yes ☐ No

Name and relation to you:

For a Patient Liaison to initiate contact, please confirm your HIPAA authorization below.

I hereby authorize and direct my health care providers and their staff (including pharmacies that fill my prescriptions), and my health insurer(s)and their staff(collectively, the "Treating Parties") to disclose to Recordati Rare Diseases, Inc. including its parents, affiliates, and its third party business partners and other agents (collectively, "Recordati") information about my disease, treatment, insurance coverage, and payment for my therapy (together with the information I have provided on this Enrollment Form and may provide in the future, "my Information") for the purposes of (1) my Isturisa treatment by the Treating Parties and (2) Recordati providing me with patient support services in connection with my Isturisa therapy or otherwise sending me communications that I have agreed to receive elsewhere in this Enrollment Form.

I authorize the Treating Parties and Recordati to use and disclose my Information for the purposes permitted by HIPAA and for providing certain support services I agree to in this Enrollment Form, including, but not limited to: (1) operating and enrolling me in, and/or continuing my participation in the Isturisa R.A.R.E. Program ("the Program") or any other Recordati-affiliated patient support services and activities related to my condition or treatment; and (2) contacting me for follow-up on any adverse event I may disclose regarding a Recordati product. I further authorize Recordati to de-identify my health information and use it in performing research, education, business analytics, and marketing studies, or for other commercial purposes, including linkage with other de-identified information Recordati may receive from other sources.

I understand that once my Information has been disclosed to Recordati, federal privacy laws may no longer protect the Information. However, Recordati intends to use and disclose my Information only in accordance with this Authorization or as otherwise permitted by law.

Further information regarding Recordati's privacy practices can be found at https://www.recordatirarediseases.com/us/privacy- policy. If you are a resident of California, a description of the personal information collected by Recordati and your rights under the California Consumer Privacy Act can also be found at this link.

I understand that I may refuse to sign this Authorization and that a refusal to sign will not affect my ability to obtain medical care, insurance coverage, or access to health benefits, including access to therapy. However, if I do not sign this Authorization, Recordati cannot provide me with support services.

This Authorization will remain valid until termination of enrollment in Recordati -sponsored patient support programs and activities, including the Recordati Programs, unless a shorter time is required by state law. I understand that I may revoke this Authorization at any time by sending a written notice that includes my name, address, and phone number, to AnovoRx Group, LLC Attn: R.A.R.E. Team 1710 N. Shelby Oaks Dr. Ste 2 Memphis, TN 38134. I understand that should I revoke this Authorization, I can no longer participate in the Programs and that such revocation will not impact uses and disclosures of my Information that have already occurred in reliance on this Authorization.

I certify that I have read and understand the Authorization for the Release and Use of Health Information, all the information provided is true and correct, and I agree to its terms. If I am the caregiver for the patient, I confirm I am authorized to sign on behalf of the patient.

Patient Authorization *(to be completed by the patient)*

Patient Signature ▶	Print Patient's Name:	Today's Date:

If signed by someone other than the patient,
describe your authority to sign on behalf of the patient:

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