KYE FIRDAPSE® PATIENT SUPPORT PROGRAM
ENROLLMENT AND AUTHORIZATION FORM
FIRDAPSE® (amifampridine phosphate) Tablets 10 mg
Please FAX: 1-833-338-0525

By signing this Enrollment and Authorization Form, you agree to enroll into KYE's FIRDAPSE® Patient Support Program intended to help determine your eligibility to benefit from financial assistance options and, if eligible, to assist you in obtaining reimbursement of drug costs and/or other assistance so that you can obtain your prescription for FIRDAPSE® (the "Program"). The Program services may include health and product information, insurance reimbursement assistance or treatment related services (the "Services"). A third -party administrator of the Program, its employees and/or agents will handle your Personal Information, which is processed in accordance with privacy laws and the KYE Privacy Policy. You will be notified in the event that the program administrator changes, your Personal Information will continue to be protected with equivalent standards. This Program is not intended to provide medical advice or diagnoses, you should always seek the advice of your prescribing physician if you have any concerns. By signing this form, you authorize your information, including contact information and information about your finances, insurance, prescriptions, medical condition, and other health information (the "Personal Information") to be collected, used and/or disclosed to and by KYE and/or its agents for the purposes as set out in Section 5 (signed by the prescriber), the Patient Consent contained in Section 6 below and as otherwise set out herein. You have reviewed and hereby acknowledge that a copy of the KYE Privacy Policy has been provided to you."

SECTION 1 – Patient Information (to be filled in by prescriber or patient)

Last Name:_____________________ First Name: ____________________ DOB (D/M/Year): __________ Sex: ______

Address:__________________________ City:__________________ Province: ________ Postal Code:_____________

Phone (preferred): ☐ Home: (____)___________ ☐ Work: (____)___________ ☐ Cell: (____)_____________________

Caregiver name (if applicable):_______________Relationship to Patient: ______________Phone #:(____)____________

SECTION 2 – Insurance Information (to be filled in by prescriber or patient). Please fax a copy of the patient's private payor insurance card (front and back)

☐ Patient Insured Primary Insurance Company Name: _______________________ Phone #: (____) ____________

Policyholder Name:____________________________ Policy #:___________________ Group #: _________________

Secondary Insurance Company Name:_________________________________ Phone #: (____) __________________

Policyholder Name:_________________________ Policy #:______________________ Group #: _________________

SECTION 3 – Prescriber Information (to be filled in by prescriber only)

Prescriber Name: __________________________________Prescriber Email:______________________________

Address:___________________________ City:__________________ Province: ________ Postal Code:_________

Name of Contact Person: _____________________ Phone #: (____) ___________________

Provincial Licence #: __________________________ Preferred method of communication:

Contact Person Email: ___________________________ Fax #: (____)_____________ ☐ Email ☐ Fax ☐ Phone

© 2020 KYE Pharmaceuticals Inc. All Rights Reserved.

***SECTION 4* – Rx (to be filled in by prescriber only)**

FIRDAPSE® 10 mg tablets Prescription:

Day Supply: _______________ Refills: ______________
Available in bottles of 240 of 10 mg divisible tablets.

Physicians Signature :X___________________________

Date: ____

Recommended Dose and Dosage Adjustment

Adult patients 18 years of age and older diagnosed with LEMS:

- **The recommended starting dose is 15 mg per day, taken orally in divided doses (3 times daily). If the patient is known to be N-acetyltransferase 2 (NAT2) fast acetylators the starting dose can be 30 mg.**
- **The dosage can be increased by 5 mg daily every 3 or 4 days; the patient should be closely monitored for adverse reactions.**
- **The maximum recommended total daily dosage is 80 mg.**
- **The maximum single dose is 20 mg.**

***SECTION 5* – Medical Criteria (to be filled in by prescriber only)**

Allergies: ____

☐ Lambert-Eaton Syndrome, unspecified
☐ Lambert-Eaton Syndrome in Disease classified elsewhere
☐ Lambert-Eaton in Neoplastic Disease

Existing amifampridine patient: ☐ Yes ☐ No

VGCC Antibody Test: ☐ Yes ☐ No

Electrodiagnostic Testing for LEMS: ☐ Yes ☐ No

By signing below, I certify that (1) I am the patient's prescribing physician, (2) the above therapy is medically necessary based on the Canadian product monograph, my independent medical judgment and the patient's informed consent; (3) I have received the patient's (or the patient's Legal Representative) express consent and met any other applicable legal or regulatory requirements such as those imposed under provincial or federal law needed to provide KYE Pharmaceuticals (KYE) or its agent, the Program Administrator, and its employees with the information in this form and any other information relevant to provide the Program's services; (3) I have discussed the Program with the patient who wishes to enroll and has agreed that I share their personal information with the Program to contact the patient and complete the enrolment process, (4) I appoint the Program Administrator as my agent for the purpose of conveying this prescription to the appropriate dispensing pharmacy, and for the administration of the Services, and providing me and my patient with educational and support services associated with FIRDAPSE® (amifampridine phosphate) 10 mg tablets, (5) I accept that my information, including personal information, may be used by KYE or its agent and the Program Administrator for reasons in relation to improving, monitoring and auditing the Program, for commercial or market research purposes, or as otherwise permitted by law, and (6) I acknowledge that adverse events may be reported about my patient participating in the Program and understand that I may be contacted by KYE or its agents and the Program Administrator to provide follow-up information to Health Canada, I understand that my information may be processed and stored outside of Canada. I state the information contained in this application is complete and accurate to the best of my knowledge.

Prescriber Signature: X ____ Date: _______________________

© 2020 KYE Pharmaceuticals Inc. All Rights Reserved.

SECTION 6 – **Patient Consent (to be filled in by patient)**

By signing this Enrollment and Authorization Form, I authorize my healthcare providers, health plans and any other custodian of my healthcare records to disclose my Personal Information, including, but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any information about my prescriptions to KYE Pharmaceuticals Inc. and its representatives, agents, contractors, affiliates (collectively, "KYE") and the Program Administrator for the Program's administration and Services, including to investigate reimbursement options for my treatment and for the provision of financial support, if applicable. In addition, I consent to KYE, the Program Administrator or any independent third party acting on behalf of KYE and/or Program Administrator to administer the Program including, but not limited to, specialty pharmacies, insurance companies, provincial drug programs to contact me for the purposes of providing the Program Services.

I understand that further information about KYE's information handling practices is set out in KYE's Privacy Policy, the form of which has been provided to me in conjunction with this Enrollment and Authorization Form. I know that if I have any questions about the terms of this Enrollment and Authorization Form or KYE's Privacy Policy I am to contact Privacy Officer at privacyofficer@kyepharma.com. I confirm that I have read KYE's Privacy Policy, that I have had an opportunity to ask questions about it and by signing below I consent to its terms.

I understand that signing this Enrollment and Authorization Form is voluntary and that it is my right to refuse to sign this Enrollment and Authorization Form. If I decide not to sign this Enrollment and Authorization Form, I will not be eligible to participate in the KYE FIRDAPSE® Patient Support Program and I cannot receive assistance or Services from the Program. I also understand that my enrollment in this Program does not guarantee approval for any type of financial assistance from KYE (partial or in full), insurance copay support, or qualify me for any benefit or assistance in relation to the fulfillment of my prescription. I understand that I am entitled to a signed copy of this Enrollment and Authorization Form.

I understand that the Personal Information collected as part of the Program will be protected by reasonable technical and physical administrative safeguards to protect it against loss, theft and unauthorized consultation, communication, copying, use or alteration. I also understand that the file containing by Personal Information will be maintained at the offices of the Program Administrator and that only authorized employees, agents and mandataries of the Program Administrator may have access to my Personal Information where necessary for the purposes described in this form.

I may request access to or correction of my Personal Information at any time by contacting the Program Administer at 1-833-338-0524.

In the event that KYE appoints a new program administrator to replace the Program Administrator, I agree that my Personal Information may be transferred to the new service provider.

In the case of an adverse event, KYE may be legally required to report such an event to Health Canada and may be required to perform monitoring or auditing. In the case of adverse event processing and reporting, KYE, its employees and/or representatives and the Program Administrator may have access, use and report my Personal Information to regulators for drug safety and quality purposes. I understand that I may be contacted for additional information to fulfill these obligations.

The Program Administrator or KYE's agent may de-identify, aggregate (combine with other information) and/or anonymize your Personal Information to conduct analyses for commercial, research/publication purposes or to improve the Program. Your Personal Information may be stored or processed outside of Canada, including for adverse event processing and reporting requirements. In this event, KYE ensures that your Personal Information is protected. Your Personal Information may be subject to the laws of foreign jurisdiction, with a different level of protection that your country of residence.

I may withdraw my consent to the terms of this Enrollment and Authorization Form at any time by sending a notice in writing to KYE FIRDAPSE® Patient Support Program, c/o McKesson Specialty Health 6355 Discount Road, Mississauga ON L4V 1W2. I understand that withdrawal of my consent will end further uses and disclosures of the Personal Information and will put an end to my enrollment in the KYE FIRDAPSE® Patient Support Program and its Services. No new personal information will be collected. Any withdrawal of consent will not be retroactive and any activities relating to your

© 2020 KYE Pharmaceuticals Inc. All Rights Reserved.

Personal Information prior to your withdrawal will not be affected and will be maintained during the term of the Program for monitoring, regulatory purposes, de-identified or anonymized data may continue to be used as described herein.

If confirmed as eligible for insurance copay support financial assistance from KYE, I understand that copay card information will be sent to my specialty pharmacy, along with my prescription and any assistance with my cost-sharing or copayment for FIRDAPSE® will be made in accordance with the Program.

From time to time, the Program Administrator may communicate with me for the purposes of providing information and updates relating to the Program, including promotional materials, surveys, and newsletter. In addition, KYE may retain the services of third-party market research firms to better understand the patient experience of individuals enrolled in the Program or to make improvements to the Program. I authorize the Administrator to provide my contact information to such third parties solely for this purpose. At any time, I may withdraw my consent to participate in such communications and market research by contacting the Program Administrator at 1-833-338-0524.

My eligibility to receive the Services is not affected by whether I agree to participate in the market research.

I have read and understood the patient consent and agree to the collection, use and disclosure of my Personal Information in accordance with the terms contained herein.

Patient/Legal Guardian Signature: X____ Date: ______________________

Signatory's Relationship to Patient: ____

Print Patient Name: ____

© 2020 KYE Pharmaceuticals Inc. All Rights Reserved.