GALDERMA

EST. 1981

ENROLLMENT FORM GUIDE

EVERSANA™

nemluvio™
(nemolizumab-ilto) for injection

NEMLUVIO® Enrollment Form

Fax your completed enrollment form to your preferred network specialty pharmacy.

Network Specialty Pharmacies

NEMLUVIO® (nemolizumab-ilto) is available through a limited distribution network of specialty pharmacies. Our specialty pharmacy network is contracted to provide enhanced service offerings, ensuring that you and your patients are supported throughout the entire NEMLUVIO patient journey. **Please have your patient scan the QR code of your preferred network specialty pharmacy to save their contact information to their address book.**

AcariaHealth
Phone: 800-511-5144
Fax: 877-541-1503

Accredo Health Group, Inc.
Phone: 866-839-2162
Fax: 866-531-1025

Amber Specialty Pharmacy
Phone: 888-370-1724
Fax: 877-645-7514

BioPlus Specialty Pharmacy
Phone: 888-292-0744
Fax: 800-269-5493

Blue Sky Specialty Pharmacy
Phone: 866-822-0103
Fax: 833-898-3992

CenterWell Specialty Pharmacy
Phone: 800-486-2668
Fax: 877-405-7940

CVS Specialty
Phone: 800-237-2767
Fax: 800-323-2445

Kroger Specialty Pharmacy
Phone: 888-355-4191
Fax: 888-355-4192

Lumicera Health Services
Phone: 855-847-3553
Fax: 855-847-3558

Optum Specialty
Phone: 855-427-4682
Fax: 877-342-4596

Senderra Pharmacy
Phone: 855-460-7928
Fax: 888-777-5645

Walgreens Specialty Pharmacy
Phone: 888-347-3416
Fax: 877-231-8302

We'll be calling your patient. If we are unable to reach them, we will leave a voicemail message. Please encourage them to check their messages regularly.

Give this page to your NEMLUVIO patient.

Please see full prescribing information at www.nemluvio.com.

US-NMO-2400560 (12/24)

A QR Codes

The form now includes **QR codes** for the SPs.

B Specialty Pharmacies

Two new Specialty Pharmacies have been inducted:

1. **Lumicera Health Services**
2. **Walgreens Specialty Pharmacy**

C Pharmacy Preference

The form now includes the **Already sent to Specialty Pharmacy?** checkbox.

If **Already sent to Specialty Pharmacy?** is checked, the prescription is sent to SP referral; else, it goes to HCP referral

E Middle Initial

Along with the First Name and Last Name, the patient information includes the **Middle Initial** field.

H Concurrent Medications

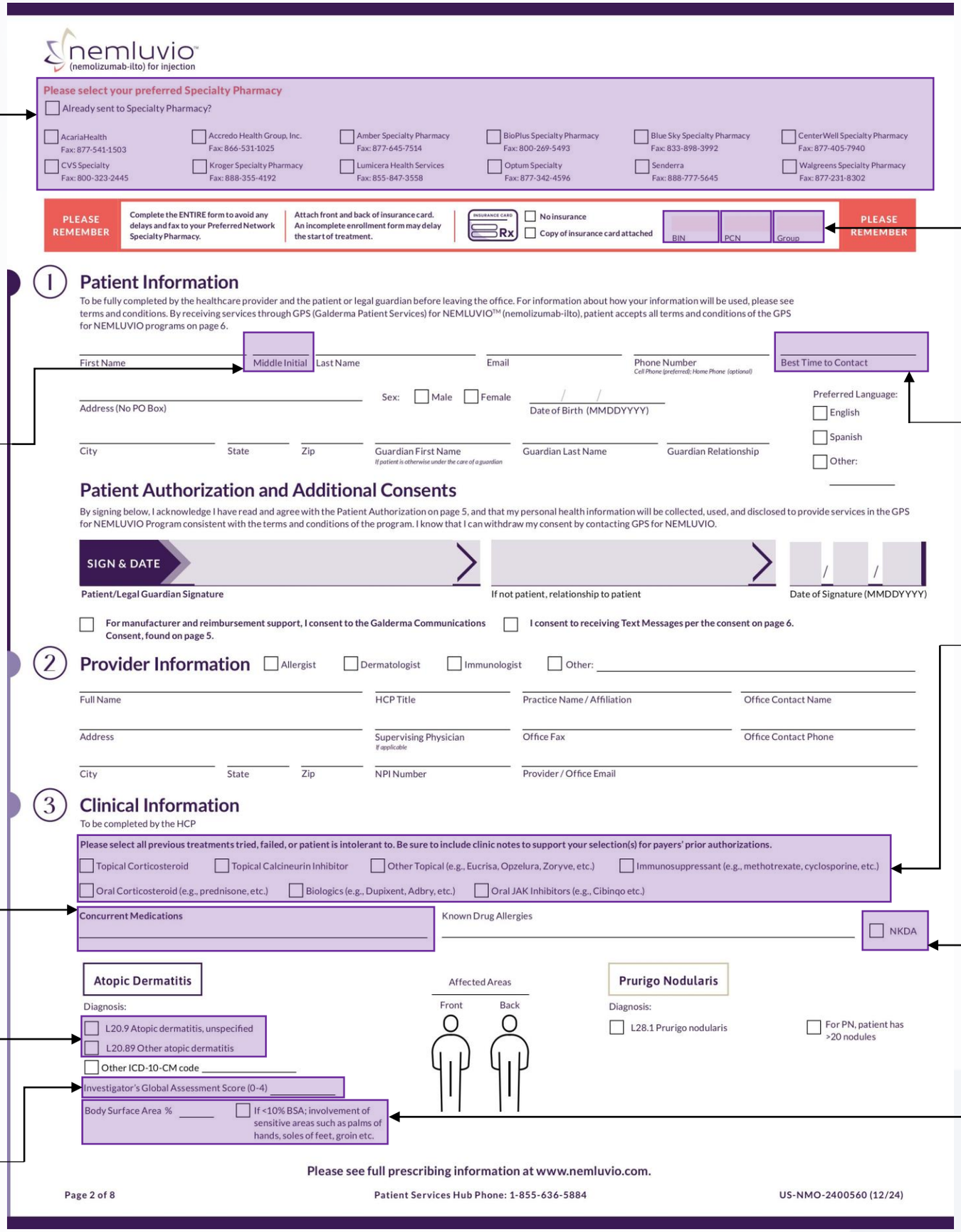
The form now includes the **Concurrent Medications** field.

J ICD-10 Code

New ICD-10 code is included in the form for Atopic Dermatitis.

K IGA Score

New field added for IGA score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Please select your preferred Specialty Pharmacy

Already sent to Specialty Pharmacy?

AcariaHealth Fax: 877-541-1503
Accredo Health Group, Inc. Fax: 866-531-1025
Amber Specialty Pharmacy Fax: 877-645-7514
BioPlus Specialty Pharmacy Fax: 800-269-5493
Blue Sky Specialty Pharmacy Fax: 833-898-3992
CenterWell Specialty Pharmacy Fax: 877-405-7940
CVS Specialty Fax: 800-323-2445
Kroger Specialty Pharmacy Fax: 888-355-4192
Lumicera Health Services Fax: 855-847-3558
Optum Specialty Fax: 877-342-4596
Senderra Fax: 888-777-5645
Walgreens Specialty Pharmacy Fax: 877-231-8302

PLEASE REMEMBER — Complete the ENTIRE form to avoid any delays and fax to your Preferred Network Specialty Pharmacy. Attach front and back of insurance card. An incomplete enrollment form may delay the start of treatment. No insurance. Copy of insurance card attached. BIN PCN Group — PLEASE REMEMBER

1 Patient Information

To be fully completed by the healthcare provider and the patient or legal guardian before leaving the office. For information about how your information will be used, please see terms and conditions. By receiving services through GPS (Galderma Patient Services) for NEMLUVIO™ (nemolizumab-ilto), patient accepts all terms and conditions of the GPS for NEMLUVIO programs on page 6.

First Name | Middle Initial | Last Name | Email | Phone Number (Cell Phone (preferred); Home Phone (optional)) | Best Time to Contact

Address (No PO Box) | Sex: Male Female | Date of Birth (MMDDYYYY) | Preferred Language: English Spanish Other:

City | State | Zip | Guardian First Name (If patient is otherwise under the care of a guardian) | Guardian Last Name | Guardian Relationship

Patient Authorization and Additional Consents

By signing below, I acknowledge I have read and agree with the Patient Authorization on page 5, and that my personal health information will be collected, used, and disclosed to provide services in the GPS for NEMLUVIO Program consistent with the terms and conditions of the program. I know that I can withdraw my consent by contacting GPS for NEMLUVIO.

SIGN & DATE — Patient/Legal Guardian Signature | If not patient, relationship to patient | Date of Signature (MMDDYYYY)

For manufacturer and reimbursement support, I consent to the Galderma Communications Consent, found on page 5. I consent to receiving Text Messages per the consent on page 6.

2 Provider Information — Allergist Dermatologist Immunologist Other:

Full Name | HCP Title | Practice Name / Affiliation | Office Contact Name

Address | Supervising Physician (If applicable) | Office Fax | Office Contact Phone

City | State | Zip | NPI Number | Provider / Office Email

3 Clinical Information

To be completed by the HCP

Please select all previous treatments tried, failed, or patient is intolerant to. Be sure to include clinic notes to support your selection(s) for payers' prior authorizations.

Topical Corticosteroid; Topical Calcineurin Inhibitor; Other Topical (e.g., Eucrisa, Opzelura, Zoryve, etc.); Immunosuppressant (e.g., methotrexate, cyclosporine, etc.); Oral Corticosteroid (e.g., prednisone, etc.); Biologics (e.g., Dupixent, Adbry, etc.); Oral JAK Inhibitors (e.g., Cibinqo etc.)

Concurrent Medications | Known Drug Allergies | NKDA

Atopic Dermatitis
Diagnosis:
L20.9 Atopic dermatitis, unspecified
L20.89 Other atopic dermatitis
Other ICD-10-CM code
Investigator's Global Assessment Score (0-4)
Body Surface Area %
If <10% BSA; involvement of sensitive areas such as palms of hands, soles of feet, groin etc.

Affected Areas — Front Back

Prurigo Nodularis
Diagnosis:
L28.1 Prurigo nodularis
For PN, patient has >20 nodules

Please see full prescribing information at www.nemluvio.com.

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D BIN, PCN, and Group

The form now includes **BIN, PCN,** and **Group IDs**.

F Contact Time

The form now includes **Best Time to Contact** field.

G Previous Treatments

Previous treatments tried and failed are now listed with check boxes instead of free text fields.

The form no longer has start/end dates or treatment outcome fields.

I NKDA Checkbox

The form now includes **No Known Drug Allergies (NKDA)** checkbox.

L Body Surface Area %

New **Body Surface Area %** field and **if BSA is <10%** checkbox has been added.

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Patient & Prescriber Information (all fields required)

Patient First Name | Middle Initial | Patient Last Name | Date of Birth (MMDDYYYY)

Prescriber Name | Prescriber Address | City | State | Zip

NPI # | Prescriber State License # | Prescriber Phone Number | Prescriber Fax Number

4 Prescription Information

Prurigo Nodularis

Weight (required): ☐ lb. ☐ kg

Did this patient start NEMLUVIO on a sample? ☐ Yes ☐ No — If yes, date sample product provided: ___/___/___

Send dose to (as allowable by law): ☐ HCP Address ☐ Patient's Home

Network Specialty Pharmacy Prescription
NEMLUVIO 30 mg/0.49mL single dose dual chamber pen (NDC 00299-6220-15)

Loading Dose:

☐ No, patient already on therapy

☐ **Yes, two 30mg/0.49mL pens (60mg);**
SIG: Inject contents of 2 pens (60mg), subcutaneously at week 0.
Dispense Qty: 2 pens

Maintenance Dose:

☐ **30 mg/0.49mL pen;**
SIG: Inject contents of 1 pen (30mg), subcutaneously every 4 weeks.
Dispense Qty: 1 pen Refills: ☐ 12, or ___

☐ **For patients > or = 90 kg/198.4 lb., two 30mg/0.49mL pens (60mg);**
SIG: Inject contents of 2 pens (60mg), subcutaneously every 4 weeks.
Dispense Qty: 2 pens Refills: ☐ 12, or ___

Prescriber Attestation
Prescriber must authorize these prescriptions and instructions by signing at the end of this section.

As the prescriber, I certify that NEMLUVIO is medically necessary for an FDA-approved indication for the previously identified patient and the information on this form is accurate to the best of my knowledge. I have reviewed the current full Prescribing Information for NEMLUVIO. I certify that I have obtained all necessary authorizations and consents as required by federal and state laws including HIPAA to disclose to Galderma, patient information including to facilitate insurance coverage for the product, initiating/dispensing therapy, and administering GPS for NEMLUVIO. I authorize Galderma and its affiliates, business partners, and agents to forward this prescription to the appropriate dispensing pharmacies, and I will comply with my state-specific prescription requirements, such as e-prescribing, state specific prescription forms, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

SIGN & DATE

Prescriber Signature
(Dispense as Written/Brand Medically Necessary)

Date of Signature (MMDDYYYY) ___/___/___

SIGN

Prescriber Signature
(Substitution Permissible)

Quick Start or Other GPS for NEMLUVIO Free Goods Program
NEMLUVIO 30 mg/0.49mL single dose dual chamber pen (NDC 00299-6220-15)

Loading Dose:

☐ No, patient already on therapy

☐ **Yes, two 30mg/0.49mL pens (60mg);**
SIG: Inject contents of 2 pens (60mg), subcutaneously at week 0.
Dispense Qty: 2 pens

Maintenance Dose:

☐ **30 mg/0.49mL pen;**
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Dispense Qty: 2 pens Refills: ☐ 12, or ___

Prescriber Attestation
Prescriber must authorize these prescriptions and instructions by signing at the end of this section.

I certify that any medication received will be used only for the patient named on this form and will not be offered for sale, trade, or barter. Furthermore, no claim for reimbursement will be submitted concerning this medication, nor will any medication be returned for credit. I acknowledge that this program is exclusively for purposes of patient care and not for remuneration of any sort. I understand that Galderma may revise, change, or terminate programs at any time without notice.

SIGN & DATE

Prescriber Signature
(Dispense as Written/Brand Medically Necessary)

Date of Signature (MMDDYYYY) ___/___/___

SIGN

Prescriber Signature
(Substitution Permissible)

Please see full prescribing information at www.nemluvio.com.

M Date Sample

The form now includes **Date Sample product provided** field.

N Maintenance Dose (PN)

The Prurigo Nodularis (PN) Maintenance Dose now includes a checkbox for refills. *If left unchecked, it defaults to **ZERO** refills.*

P **Maintenance Dose (AD)**

The Atopic Dermatitis (AD) Maintenance Dose only allows **ONE (1) pen**.

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Patient & Prescriber Information (all fields required)

Patient First Name | Middle Initial | Patient Last Name | Date of Birth (MMDDYYYY)

Prescriber Name | Prescriber Address | City | State | Zip

NPI # | Prescriber State License # | Prescriber Phone Number | Prescriber Fax Number

4 Prescription Information

Atopic Dermatitis

Did this patient start NEMLUVIO on a sample?

☐ Yes ☐ No If yes, date sample product provided: ___/___/___

Send dose to (as allowable by law):

☐ HCP Address ☐ Patient's Home

Network Specialty Pharmacy Prescription
NEMLUVIO 30 mg/0.49mL single dose dual chamber pen (NDC 00299-6220-15)

Loading Dose:

☐ No, patient already on therapy

☐ **Yes, two 30mg/0.49mL pens (60mg);**
Sig: Inject contents of 2 pens (60mg), subcutaneously at week 0.
Dispense Qty: 2 pens

Maintenance Dose:

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As the prescriber, I certify that NEMLUVIO is medically necessary for an FDA-approved indication for the previously identified patient and the information on this form is accurate to the best of my knowledge. I have reviewed the current full Prescribing Information for NEMLUVIO. I certify that I have obtained all necessary authorizations and consents as required by federal and state laws including HIPAA to disclose to Galderma, patient information including to facilitate insurance coverage for the product, initiating/dispensing therapy, and administering GPS for NEMLUVIO. I authorize Galderma and its affiliates, business partners, and agents to forward this prescription to the appropriate dispensing pharmacies, and I will comply with my state-specific prescription requirements, such as e-prescribing, state specific prescription forms, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

SIGN & DATE | ___/___/___

Prescriber Signature
(Dispense as Written/Brand Medically Necessary) | **Date of Signature** (MMDDYYYY)

SIGN

Prescriber Signature
(Substitution Permissible)

Quick Start or Other GPS for NEMLUVIO Free Goods Program
NEMLUVIO 30 mg/0.49mL single dose dual chamber pen (NDC 00299-6220-15)

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SIGN & DATE | ___/___/___

Prescriber Signature
(Dispense as Written/Brand Medically Necessary) | **Date of Signature** (MMDDYYYY)

SIGN

Prescriber Signature
(Substitution Permissible)

Please see full prescribing information at www.nemluvio.com.

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O **Atopic Dermatitis**

Atopic Dermatitis has **no weight requirement.**