NS Support
NS PHARMA ACCESS SOLUTIONS
833-NSSUPRT (833-677-8778)

VILTEPSO® (viltolarsen) Start Form

Viltepso® (viltolarsen) injection

SEND THE COMPLETED FORM TO NS SUPPORT USING ONE OF THE FOLLOWING OPTIONS:

UPLOAD: https://nssupport.iassist.com/upload
EMAIL: nssupport@nspharma.com
FAX: 888-212-0482
MAIL: PO Box 7613, Overland Park, KS 66207

This form is for physicians to complete. To avoid processing delays:

1. Provide your **signature** and include patient's **insurance card(s)**
2. Confirm patient is **amenable to exon 53** skipping therapy by **submitting genetic test results** with this form

Please instruct your patients to submit the required NS Support Patient Consent Form.
This has been included for convenience and can also be completed separately online at: **https://nssupport.iassist.com/consent**

1. PATIENT & PRIMARY CONTACT INFORMATION

PATIENT FIRST NAME _____ PATIENT LAST NAME _____ DOB MM/DD/YYYY GENDER (Assigned at Birth) ❑ M ❑ F Last 4 SSN (Opt) XXXX
ADDRESS _____ CITY _____ STATE XX ZIP XXXXX

PRIMARY CONTACT ❑ **Check if patient is 18 years of age or older and is their own primary contact.**
If patient is their own primary contact, caregiver or additional contact information can be captured below.
FIRST NAME _____ LAST NAME _____ RELATIONSHIP TO PATIENT _____ SSN (Last 4 Digits) XXXX
PHONE (XXX) XXX-XXXX ❑ MOBILE ❑ LAND EMAIL _____ PREFERRED LANGUAGE _____

2. INSURANCE INFORMATION—Please submit front and back copies of all insurance cards with this form.

PRIMARY MEDICAL _____ ID # _____ GROUP # _____ PHONE (XXX) XXX-XXXX
POLICYHOLDER NAME _____ RELATIONSHIP TO PATIENT _____ POLICYHOLDER DOB MM/DD/YYYY

SECONDARY MEDICAL _____ ID # _____ GROUP # _____ PHONE (XXX) XXX-XXXX
POLICYHOLDER NAME _____ RELATIONSHIP TO PATIENT _____ POLICYHOLDER DOB MM/DD/YYYY

PRESCRIPTION INSURANCE _____ Rx GROUP # _____ Rx ID # _____ Rx BIN # _____ Rx PCN # _____
POLICYHOLDER NAME _____ RELATIONSHIP TO PATIENT _____ POLICYHOLDER DOB MM/DD/YYYY

3. PREFERRED SITE OF CARE (OPTIONAL)—Check all that apply.

❑ Hospital Clinic ❑ Home Infusion ❑ Physician's Office ❑ Other ❑ Needs Site of Care Identification PREFERRED PROVIDER(s) (If Available) _____

4. PHYSICIAN INFORMATION AND DECLARATION—Physician information and matching signature are required for benefits verification.

FIRST NAME _____ LAST NAME _____ NPI # _____ TAX ID # _____
FACILITY NAME _____
ADDRESS _____ SUITE # _____ CITY _____ STATE XX ZIP XXXXX

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 G71.01 Duchenne muscular dystrophy and has a confirmed mutation amenable to exon 53 skipping; and (3) I have obtained any consent as required under federal and state law for the release and use of the patient's information on this form to NS Pharma, Inc. and its agents, contractors, and assignees, including but not limited to commercial and field-based teams (together, "Company"), for purposes of benefits verification and coordination of dispensing the therapy. I also certify that I may be contacted by NS Pharma by fax, email, phone calls, and detailed voice messages.

PHYSICIAN NAME (Please Print) _____
PHYSICIAN SIGNATURE _____ DATE MM/DD/YYYY

OFFICE CONTACT INFORMATION

FIRST NAME _____ LAST NAME _____ EMAIL _____

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Questions? Call NS Support at 833-NSSUPRT (833-677-8778), Monday–Friday, 8AM–8PM ET.

NS Pharma