orladeyo®
(berotralstat) capsules 150 mg

Phone: 1-866-5-EMPOWER (1-866-536-7693)
Fax: 1-844-336-7693

EMPOWER PATIENT SERVICES

Getting started with ORLADEYO®

- **Sign the consent form** on page 6 to access additional assistance and support.
- Your care coordinator at **Empower Patient Services will reach out to you by phone** within the next few days for an introductory call and to discuss next steps. **This conversation must take place before your first ORLADEYO shipment.**

Tip: Scan the QR code or save the number for Empower Patient Services (1-866-536-7693) so you don't miss a call.

- You may be eligible to access ORLADEYO while working through insurance approval via the Quick Start program.[a]
- **Schedule a follow-up appointment** within 1 to 2 months (or sooner if needed) to connect with your healthcare provider (in person or virtually) as you start treatment.
- **Stay in touch** with your healthcare provider's office or dedicated care team at Empower Patient Services as treatment questions, concerns, or needs arise.
- Follow your healthcare provider's **daily dosing** instructions when starting treatment.

[a]Subject to terms and conditions of the Quick Start program. BioCryst reserves the right to rescind, revoke, or amend the program at any time without notice.

BioCryst®

Complete ORLADEYO® start form checklist

ORLADEYO is administered through Optime Care Specialty Pharmacy, which is part of Empower Patient Services. From initial benefits investigation to delivery, this one care team approach offers you and your patient dedicated support throughout your patient's treatment with ORLADEYO.

Sign and return

- ☐ Prescribing healthcare professional must sign page 4
- ☐ Patient signature requested on page 6
- ☐ Return pages 3 to 6 with documentation outlined below to Empower Patient Services, via fax (1-844-336-7693) or email (info@EmpowerPS.com)

Required documents

It's critical to provide these comprehensive documents **up front** to help with a seamless approval process. Empower Patient Services will consolidate the necessary information for your patient's insurance provider.

- ☐ Both sides of insurance card
- ☐ Both sides of prescription benefit card (if available)
- ☐ Lab results supporting diagnosis of hereditary angioedema (HAE)
  - C1-inhibitor level (antigenic)
  - C1-inhibitor functional
  - C4 level (antigenic)
  - Supportive genetic test results (not required; if available)
- ☐ Up-to-date, detailed chart notes (reference recommended list below)

Recommended chart notes

List is intended as a guide; not all items are required and additional information may be included based on what is available for patient

- Attack history
- Family history
- History of treatment failure, intolerance, or contraindications to other medications
  - Androgens
  - Antifibrinolytics
  - Antihistamines
  - Epinephrine
  - Other HAE prophylactic medications
- Current HAE medications
- Previous HAE medications
- Letter of medical necessity
- Notes from most recent office visit
- Sequelae of attacks (HAE-related hospitalizations, ER visits, and intubations)
- Photos before and after attacks
- Concurrent medications

INDICATION

ORLADEYO® (berotralstat) is a plasma kallikrein inhibitor indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in adults and pediatric patients 12 years and older.

Limitations of use

The safety and effectiveness of ORLADEYO for the treatment of acute HAE attacks have not been established. ORLADEYO should not be used for the treatment of acute HAE attacks. Additional doses or dosages of ORLADEYO higher than 150 mg once daily are not recommended due to the potential for QT prolongation.

Patient information

Name (first, middle initial, last)

Gender
☐ Male ☐ Female
☐ Nonbinary

Date of birth (mm/dd/yyyy) | Phone | Alternate phone (opt.)

Email

☐ Spanish speaking

Street address | Street address 2 (optional)

City | State | ZIP

Caregiver (optional)

Name (first, middle initial, last) | Relationship to patient

Email | Phone

Insurance information

Attach both sides of the patient's insurance card and prescription benefit card (if applicable).
If you are unable to attach cards, please fill out the information below.

☐ Check here if patient is uninsured

Primary insurance

Subscriber name (first, middle initial, last)

Policy ID | Policy group ID

Rx BIN | Rx PCN

Pharmacist help desk phone | Relationship of subscriber to patient

Other insurance (if applicable)

Subscriber name (first, middle initial, last)

Policy ID | Policy group ID

Rx BIN | Rx PCN

Pharmacist help desk phone | Relationship of subscriber to patient

If allowed by insurance and with prescriber review and approval, would you like Optime Care to submit the insurance authorization?[a]

☐ Yes ☐ No

[a]Optime Care can only use clinical information that is provided directly from the prescriber's office to support insurance authorization.

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Prescriber information

Name (first, middle initial, last)

Specialty and/or designation

Phone

Email

Site/office name

Street address

City

State

ZIP

NPI

State license no.

Office information

Preferred contact name (first, middle initial, last)

Office phone

Fax

Email

Preferred method of contact (select all that apply)
☐ Phone ☐ Email ☐ Fax

Clinical and prescription information

Diagnosis:

☐ ICD-10 D84.1 (HAE)

☐ Other (please specify)

Dose: 1 (one) capsule orally, once daily with food.[a] Select 1 dose below.

☐ 150 mg ☐ 110 mg

Supply: Dispense quantity of 28 capsules (4-week supply) unless 12-week supply requested and available.

☐ Check for 12-week supply

Refills (select one):

☐ 12 ☐ Other

[a]You may also start appropriate patients at a reduced dosage of 110 mg once daily and adjust to 150 mg once daily when necessary. Please see accompanying full Prescribing Information for additional details.

Special precautions (eg, allergies)

Customized dosing directions

Transition directions

☐ If eligible and when all information required for prior authorization is received, I request for my patient to participate in the Quick Start program that will provide free drug during the insurance approval process. The Quick Start program is available to all insured patients ≥12 years of age who are US residents with a confirmed diagnosis of HAE. Eligibility is subject to the terms and conditions of the program. BioCryst reserves the right to rescind, revoke, or amend the program at any time without notice. Contact Empower Patient Services for details.

Prescriber signature (no stamps)

By signing below, I certify that (a) the above therapy is medically necessary and that I will supervise the patient's treatment accordingly; (b) I have received the necessary authorizations, including those required by state law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to release the above information and other health and medical information of the patient to the dispensing pharmacy.

Signature (dispense as written) *Date* *Signature (substitutions permitted)* *Date*

New York prescribers—please submit prescription on an original NY state prescription blank.

Please see accompanying full Prescribing Information.

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AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I authorize Optime Care, Inc. ("Optime") to share my, or my legal dependent's, as applicable, personal health information ("PHI"), including, but not limited to, my medical diagnosis, condition, treatment (including prescription information), health insurance information, financial information, demographic information, and contact information, whether provided to Optime previously or in the future, with BioCryst Pharmaceuticals, Inc. (including its representatives and service providers) ("BioCryst").

I authorize such disclosures so that BioCryst may use my PHI for the following purposes:

- to provide product support services for ORLADEYO, including, but not limited to, copay assistance, reimbursement support, and other forms of patient assistance
- to communicate with me by mail, email, text message, telephone, or other means about my medical condition, treatment, care management, and health insurance
- for reimbursement support
- for investigating insurance coverage including coordination of benefits

I authorize such disclosures so that BioCryst, and its agents may use my PHI for the following purposes:

- to evaluate patient experiences and product services, and to improve current and future products and services
- to contact me about my interest in participating in market research
- to contact me about participation in a mentor program

I authorize BioCryst and Optime to use my PHI for these purposes and to share my PHI in connection with these purposes, including with my healthcare providers, insurance providers, and pharmacy, and their representatives, in order for them to coordinate my benefits, provide, when applicable, reimbursement support, investigate my insurance coverage, coordinate shipments of dispensed drug and help with financial assistance for BioCryst products.

I also authorize Optime, BioCryst, and its agents to share my PHI related to my HAE condition and treatment with the patient support organizations related to HAE ("Support Organizations"), including their representatives and service providers.

I authorize such disclosures so that Support Organizations may use my PHI for the purposes listed above.

I understand that once my PHI is shared, the information could be re-disclosed, but that the intent is to use my PHI only for the purposes listed above. I understand that I do not have to sign this Authorization in order to receive healthcare, payment for healthcare, or to be eligible for healthcare benefits.

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This Authorization expires 20 years from the date of my signature below, unless otherwise required by law.

I agree that if I reside in the state of Maryland, this form will be valid for no longer than 1 year from the date signed.

If I reside in California, I also have the right to request that BioCryst and/or Support Organizations delete my PHI, although deletion is not required under certain circumstances. To cancel or request deletion, I must send a written notice to BioCryst at 4050 Emperor Blvd. Suite 200, Durham, NC 27703. If I cancel and request deletion, I know that BioCryst and Service Providers will no longer be able to assist me with access to ORLADEYO.

I have the right to cancel this Authorization. If I cancel, this means that BioCryst and/or Support Organizations will no longer use or share my PHI. This will not apply to PHI already used or shared or when it is required by law.

I understand that I may revoke this Authorization by sending a written notice of revocation to Optime Care at 4060 Wedgeway Court, Earth City, MO 63045. Notice may also be sent via fax to (844) 336-7693. I understand that if I do revoke the Authorization, that will not invalidate any uses or disclosures of my PHI made in reliance on the Authorization prior to the receipt by Optime, BioCryst, and Support Organizations of my notice of revocation.

I understand that I am entitled to receive a copy of this Authorization over the time it is valid. I certify that I am at least eighteen (18) years of age.

By signing below, I certify that I have read and agree to the above.

_____ _____

Patient signature *Date*

Patient full signature is required. No stamps.

Patient printed name

If being signed by authorized representative, please sign below and describe your relationship to patient

_____ _____

Signature *Date*

Patient's legally authorized representative signature (if applicable)

First name Last name

Relationship to the patient

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EMPOWER PATIENT SERVICES

What to expect next

1. Once the start form and chart notes (refer to checklist on page 2) have been submitted, Empower Patient Services will confirm receipt via email or fax, depending on office preference, and follow up with your office if additional documentation is required.
2. Encourage your patient to schedule a check-in within 1 to 2 months of starting treatment, or sooner if needed.
3. Empower Patient Services (1-866-536-7693) will reach out to your patient for an introductory call and to discuss next steps.
4. If applicable, your care coordinator will assess your patient's eligibility for the Quick Start program, financial assistance, and support programs.
5. Your dedicated care coordinator will work alongside you, your office, and your patient throughout the entire approval process as well as provide ongoing support after initiation of treatment with ORLADEYO®.

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