PRESCRIPTION START FORM

Deflazacort Suspension

CRANBURY Connects

PHONE **(888) 213-8747** FAX **(732) 647.2128**

Patient Information

First Name: _____ Last Name: _____ Date of Birth: _____

Patient Weight (lbs): _____ Gender: ☐ M ☐ F

Primary Contact: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Best Time to Call: ☐ AM ☐ PM Ok to Leave Message? ☐ YES ☐ NO

Email Address: _____

Insurance Information

☐ Copy of the patient's prescription insurance cards (front & back copy)

Primary ID #: _____ Group #: _____ Phone: _____

Policy Holder: _____ Relationship to Patient: _____

Secondary ID #: _____ Group #: _____ Phone: _____

Policy Holder: _____ Relationship to Patient: _____

☐ Patient Uninsured

Patient Authorization

I authorize my health plan, physician, healthcare professional, hospital, clinic, pharmacy provider, or other healthcare provider (collectively, "Providers") to disclose my personal health information, including personal information relating to my medical condition, treatment, care management, health insurance, and contact information ("Information"), to Cranbury Pharmaceuticals, LLC, its affiliates, and their representatives, agents, and contractors (collectively, the "Company"). I authorize Company to provide this Information, and any specific information related to my prescription that I provide to the Company directly, to a specialty pharmacy to fulfill the prescription. Further, my Providers and the Company may use and disclose this Information for support services, such as verification of insurance benefits and drug coverage, prior authorization support, financial assistance with copays, patient assistance programs, alternate funding sources, other related programs, and communication with me or my prescribing physician by mail, email, or telephone about my medical condition, treatment, care management, product information, and health insurance. This Information may also be used for internal purposes by the Company, including data analysis, or to improve, develop, and evaluate products, services, and programs related to my condition. I also authorize the Company to use my Information to provide me with educational and/or promotional information about Deflazacort and related Company products and services, adherence reminders and support, and disease education, and to contact me to conduct market research. I understand that my Providers may receive payment for activities described in this authorization. I understand that once disclosed to the Company, my Information disclosed under this Authorization may no longer be protected by applicable privacy laws, including HIPAA. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by sending written notice of revocation to Cranbury Pharmaceuticals, LLC, 2031 US Highway 130, Monmouth Junction, NJ 08852. I understand that such revocation will not apply to any Information already used or disclosed through this Authorization. I understand that revoking my Authorization will end my participation in the Cranbury Connects™. This Authorization will remain in effect for five (5) years from the date this Authorization is signed by me, unless a shorter period is provided for by law. I understand that I may refuse to sign this Authorization and that refusing to sign this Authorization will not change my Provider's treatment or my insurance benefits. I also understand that if I do not sign this Authorization, I will not be able to receive Cranbury Connects ™services. The personal, insurance, and health information I have provided on this form is complete and accurate to the best of my knowledge. I will update my information promptly if any of the information reflected on this form changes by contacting Cranbury Connects™ at (888) 213-8747.

Patient/Legal Guardian Signature: _____

Relationship: _____ Date: _____

PRESCRIPTION START FORM Deflazacort Suspension

Prescriber Information — To be filled in by prescriber only

Prescriber First Name: _____ Prescriber Last Name: _____

Clinic Name: _____

Address: _____

City: _____ State: _____ Zip: _____

NPI: _____ State License #: _____ Tax ID #: _____

Office Contact Person: _____ Phone #: _____

Prescriber Email: _____ Fax #: _____

Preferred method of communication _____

Medical Criteria — To be filled in by prescriber only

Primary Diagnosis: _____ Primary ICD-10: _____

Current weight: ____ lbs. ____kg. Date weight obtained: _____ Date of last clinic visit: _____

Is patient currently on deflazacort? ☐ Yes Milligrams per day: _____ Start date: _____ ☐ Not on deflazacort

Other medications tried:

Corticosteroid use: ☐ Yes ☐ No If yes, name of corticosteroid: _____

Dates of corticosteroid use: _____

Mutation type (attach genetic test): _____

Prescription — To be filled in by prescriber only

DEFLAZACORT Oral Suspension (22.75mg/mL)

Dose (check one):

☐ Take 0.9 mg/kg orally once per day ☐ Take ____ mg orally once per day ☐ Take _____

Dispense quantity needed for _____ Days with _____ Refills

Prescriber Signature: _____

☐ Physician attests this is his/her signature. No Stamps.

Prescriber Authorization:

By signing below, I certify that in my professional judgment the above therapy is medically necessary and in the best interest of the named patient. I have obtained and hereby provide any consent required under federal and state law for the release and use of the patient's information on this form to Cranbury Pharmaceuticals, LLC. its affiliates, and their representatives, agents, and contractors (collectively, the "Company"), for purposes of providing support services, including verifying insurance benefits, processing prior authorizations, and coordinating the fulfillment of the prescription. I authorize Company to act on my behalf for the limited purposes of transmitting this prescription to the appropriate specialty pharmacy and submitting any necessary forms to applicable health plans.

Prescriber Signature: _____ Date: _____

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