Program Enrollment Form for Referring Physicians
Phone: 1-833-ORCHAST (833-672-4278) • Fax: 1-866-267-5189

How to initiate enrollment for your patient into Orchard Assist

Please complete all required fields to initiate enrollment for your patient into **Orchard Assist**, and return via fax to 1-866-267-5189.

Orchard assist

PATIENT INFORMATION

Fields with an * are required information

Patient Name: First* _____ Last* _____

Date of Birth (MM/DD/YYYY)* _____ Gender* ◯Male ◯Female Preferred Language (if not English) _____

Address* _____ City* _____ State* _____ Zip Code* _____

Phone* _____ Voicemail Permission* ◯Yes ◯No Email Address* _____

Primary Caregiver Name (required if patient is <18 years old) _____ Relationship to Patient _____ Phone Number _____

Secondary Caregiver Name _____ Relationship to Patient _____ Phone Number _____

Treatment Name* _____ Primary Diagnosis/ICD-10-CM Code* _____

Chain of Identity (COI) ID _____

FINANCIAL INFORMATION (if applying for Orchard Assist Financial Assistance Programs)

Total number of people in your household (include yourself, your spouse, and your dependents)* _____

Total household income ($)* _____ ◯ Annual ◯ Monthly

INSURANCE INFORMATION

Please include a copy of the front and back of all of the patient's insurance cards, if available.

Patient is uninsured ◯

Primary Insurance* _____ Policyholder Name* _____ Policyholder DOB* _____ Policy Number* _____

Phone Number* _____ Relationship to Policyholder* _____ Group Number* _____

Secondary Insurance _____ Policyholder Name _____ Policyholder DOB _____ Policy Number _____

Phone Number _____ Relationship to Policyholder _____ Group Number _____

QUALIFIED TREATMENT CENTER/PHYSICIAN INFORMATION

Qualified Treatment Center (QTC) Name* _____

Address* _____ City* _____ State* _____ Zip Code* _____

QTC Phone Number* _____ QTC Fax Number* _____

Prescriber/Physician Name* _____ NPI* _____ Tax ID* _____

Prescriber/Physician Practice Name _____

Anticipated Harvest Date (if known) (MM/DD/YYYY) _____

I certify to the following: (a) I have obtained any consent or authorization required under federal or state law for the use and disclosure of the patient's personal health information and other information on this form, including diagnosis, treatment, medical, and insurance information, to Orchard Therapeutics and its agents, contractors, and business partners, and designated Orchard Therapeutics personnel, including its commercial and field-based teams, for purposes of benefits investigation, to assess the patient's eligibility for participation in **Orchard Assist** programs, and for coordination and assisting the patient to initiate therapy; (b) I have obtained the patient's permission to enroll them in **Orchard Assist** and for them to be contacted by Orchard Therapeutics, its contractors, and business partners in connection with this application; (c) I allow Orchard Therapeutics and its contractors and business partners to utilize my information provided in this enrollment form, including NPI/Tax ID, for the purpose of providing the **Orchard Assist** services; (d) I understand that I am under no obligation to recommend any Orchard Therapeutics gene therapy and I have not received and will not receive any benefit from Orchard Therapeutics for recommending an Orchard Therapeutics gene therapy; (e) the information contained in this form is current, accurate, and complete to the best of my knowledge; and (f) I understand Orchard Therapeutics does not guarantee assistance and reserves the right to revise or cancel programs at any time.

Prescriber/Physician Signature* _____ Date* (MM/DD/YYYY) _____

PATIENT/CAREGIVER CERTIFICATION—ALL FIELDS BELOW TO BE COMPLETED BY PATIENT/CAREGIVER

- I authorize Orchard Therapeutics and their agents, employees, and contractors to provide me with services for which I may be eligible in connection with Orchard Therapeutics gene therapy. Such services include therapy-related communications and support, coverage and financial assistance support, education about Orchard Therapeutics gene therapy and my condition, and other support services
- I certify that the information that I provide to **Orchard Assist**, a patient support program provided by Orchard Therapeutics, is true and complete
- I understand that changes in my insurance provider, insurance coverage, or financial situation may affect my eligibility for certain **Orchard Assist** program services, and I agree to immediately notify **Orchard Assist** at 1-833-ORCHAST (833-672-4278) of any of these changes (ie, if I start to receive benefits from a federal or state government-funded program, such as Medicare or Medicaid)
- I understand that Orchard Therapeutics does not guarantee coverage or reimbursement for Orchard Therapeutics gene therapy
- I understand that **Orchard Assist** does not provide any medical or treatment advice, and that my doctor is the best resource for any medical questions or concerns about my treatment and my condition
- If necessary, I authorize **Orchard Assist** and/or its program administrator, under the Fair Credit Reporting Act, to obtain my credit report to verify the information provided and to determine my eligibility for **Orchard Assist** financial assistance programs. I understand that this information will be used to verify income ONLY and will have NO effect of my credit score. I understand that, upon request, Orchard Therapeutics will tell me whether an individual consumer report was requested and the name and address of the agency that furnished it. I further understand and authorize **Orchard Assist** to use any consumer reports about me and information collected from me, along with other information they obtain from public and other sources, to estimate my income in conjunction with the eligibility determination process and on an ongoing basis for financial assistance programs, if applicable

_____ _____

Signature of Patient or Legal Representative*† Date* (MM/DD/YYYY)

_____ _____

Patient name* Date of Birth* (MM/DD/YYYY)

_____ _____

Print Name of Patient or Legal Representative/Caregiver* Relationship to Patient

†By signing on behalf of the patient, as representative or guardian, I attest that I am legally authorized to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient (such as power of attorney or legal court order) may be requested.

Orchard therapeutics

For questions, call Orchard Assist at 1-833-ORCHAST (833-672-4278)

Orchard assist

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize and request that my treating physicians, health insurance plan(s), pharmacies or other Health Care Providers (collectively "Health Care Providers") disclose my protected health information including medical, laboratory, and/or pharmacy records related to my diagnosis of, eligibility for therapy to treat, and treatment of my medical condition relevant to an Orchard Therapeutics gene therapy, and other social determinants of health to Orchard Therapeutics North America and its and its affiliates' employees, its contractors, and business partners including Orchard Therapeutics' commercial and field-based teams. This authorization is made for the purpose of enrolling me in Orchard Therapeutics' patient services program, providing me with patient services, and administering the patient services program. I understand that Orchard Therapeutics, its employees, contractors, and business partners may use and disclose my protected health information for the activities described in this authorization, including but not limited to communicating with my Health Care Providers to administer Orchard Therapeutics' patient services programs.

I understand that I have the right to revoke this authorization, in writing, at any time, except where disclosures have already been made based upon my original authorization. This authorization shall remain valid for a period of fifteen (15) years from the date the authorization is signed, unless a shorter period is provided for by law or revoked in writing prior to that time. I understand that I need to send a written request to revoke my authorization to a designated person/office at the specific Health Care Provider(s) who provides information to Orchard Therapeutics.

I understand that it is possible that information used or disclosed with my permission pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that signing this authorization is voluntary. My treatment, payment, or eligibility for benefits is not conditioned upon my authorization of this disclosure. I acknowledge, however, that if I do not sign this authorization, I will not be able to participate in Orchard Therapeutics' patient services programs.

I understand that certain parties, such as my pharmacy provider, may receive remuneration (payment) from Orchard Therapeutics in connection with the activities described in this authorization.

I understand that I am entitled to receive a copy of this authorization.

Patient name*†

Signature of Patient or Legal Representative*† | **Date* (MM/DD/YYYY)**

Print Name of Patient or Legal Representative* | **Relationship to Patient**

†By signing on behalf of the patient, as representative or guardian, I attest that I am legally authorized to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient (such as power of attorney or legal court order) may be requested.

Patient/Caregiver Consent to Receive Marketing and Promotional Communications (optional)

- I consent to receiving communications by mail, email, or telephone about Orchard Therapeutics' products, services, and programs or other topics of interest. I authorize Orchard Therapeutics to contact me to conduct market research or otherwise ask me about my or my loved one's experience with or thoughts about such topics.
- I understand and agree that any information that I provide may be used by Orchard Therapeutics to help develop new products, services, and programs
- I understand that this Consent to Receive Marketing and Promotional Communications is not required to enroll in **Orchard Assist** and is not required as a condition of purchasing any goods or services
- I understand that Orchard Therapeutics will not sell or transfer my personal data to any third party for marketing purposes without my express permission
- I may opt out of marketing-related emails by clicking the "Unsubscribe" link at the bottom of each such email. To stop receiving other communications from Orchard Therapeutics, please contact **Orchard Assist** at 1-833-ORCHAST (833-672-4278) with your request
- This marketing consent expires after three (3) years, or such shorter time frame required by applicable law, from the day I sign it as indicated by the date next to my signature unless otherwise canceled earlier

Signature of Patient or Legal Representative† | **Date (MM/DD/YYYY)**

Print Name of Patient or Legal Representative | **Relationship to Patient**

†By signing on behalf of the patient, as representative or guardian, I attest that I am legally authorized to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient (such as power of attorney or legal court order) may be requested.