Vyjuvek®
beremagene geperpavec-svdt
5x10⁸ PFU/mL single-use vial

Krystal CONNECT™
Personalized Support Services

2100 Wharton Street #310, Pittsburgh, PA 15203
Call 1-844-5-KRYSTAL (1-844-557-9782)
Fax 1-833-782-7852 or 1-412-643-3380

Krystal Connect Enrollment Form

HOW TO ENROLL IN KRYSTAL CONNECT
PATIENT SUPPORT PROGRAM

Krystal Connect serves as a central point of contact between patients/caregivers, healthcare providers, insurance companies, and specialty pharmacies.

INSTRUCTIONS FOR PATIENTS

- Your Healthcare Provider will complete the steps outlined in **purple**.
- You need to complete **Steps 1 and 2** outlined in **green** on the Enrollment Form.
- Fill out all sections completely. Missing information could delay your enrollment in Krystal Connect.
  - ☐ Fill out the **Patient Information** Section in **Step 1**.
  - ☐ Sign the **Patient Support Services Authorization and Release of Health Information + Marketing Communications from Krystal Connect Opt-In** box in **Step 1** after you read the information on **page 4**.
  - ☐ Fill out the **Insurance Information** Section in **Step 2**.

Your provider will complete the remainder of the form and fax pages 2 and 3 to Krystal Connect.

INSTRUCTIONS FOR PRESCRIBERS

- ☐ Fill out the **Prescriber Information** Sections in **Steps 3-5**.
- ☐ Fax the completed form to **1-833-782-7852** or **1-412-643-3380**. Krystal Connect must receive pages 2 and 3 in order for the Enrollment Form to be complete.

Once a completed Enrollment Form is received, a Krystal Connect Patient Access Liaison will perform a benefits verification and review the patient's coverage and out-of-pocket responsibility with both the HCP and the patient typically within 1 business day. To learn more about Krystal Connect and support offerings, please call 1-844-5-KRYSTAL (1-844-557-9782), 8:30 am to 7:00 pm ET Monday through Friday or visit www.VYJUVEK.com.

QUESTIONS? Call Krystal Connect at **1-844-5-KRYSTAL (1-844-557-9782)**

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KRYSTAL CONNECT ENROLLMENT FORM

Questions? Call Krystal Connect at 1-844-5-KRYSTAL (1-844-557-9782)

Please print the form, fill it out completely, sign it, and fax to:
1-833-782-7852 or 1-412-643-3380
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Krystal CONNECT™ Personalized Support Services

Completed by the Patient/Authorized Party

STEP 1 PATIENT INFORMATION

Patient Name (First, Middle Initial & Last) _____

Patient Address _____

City _____ State _____ Zip _____

Date of Birth ____/____/_____ Gender ☐Male ☐Female

Scan to add Krystal Connect™ to the contacts list in your smartphone

Patient Phone _____ Caregiver Name (if applicable) _____

Email Address _____ Relationship to Patient _____

Language (other than English) _____ Caregiver Phone _____

I have read and agree to (check all that apply):

☐ The Patient Support Services Authorization and Release of Health Information, outlined in Sections 1 and 2 on page 4

☐ The Marketing Communications from Krystal Connect Opt-In, outlined in Section 3 on page 4

Print Name _____ Relationship to Patient (if other than patient signing) _____

SIGN _____ _____

PATIENT / Authorized Party Signature Date

STEP 2 INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Primary Insurance Name _____	Secondary Insurance Name _____
Policy ID # _____	Policy ID # _____
Group # _____	Group # _____
Phone _____	Phone _____
Policy Holder _____	Policy Holder _____
Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Other _____	Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Other _____
Copy of Insurance Card attached ☐Y ☐N	Copy of Insurance Card attached ☐Y ☐N

☐ Patient does not have insurance

Completed by the Prescriber

STEP 3 CLINICAL INFORMATION

PRIMARY DIAGNOSIS: ☐ Q81.2 Epidermolysis Bullosa Dystrophic ☐ Other _____

DIAGNOSIS CONFIRMED THROUGH: ☐ Genetic Test ☐ Biopsy ☐ Other _____

DEB TYPE: ☐ RDEB ☐ DDEB ☐ Unknown PERCENT OF BODY SURFACE AREA WITH WOUNDS: ☐ <10% ☐ 10-30% ☐ >30%

ALLERGIES: _____

(Continued on next page.)

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Please see accompanying full Prescribing Information and Patient Information. Completed by the Prescriber

STEP 4

PRESCRIBER INFORMATION

Prescriber Name (First & Last) _____

Practice/Facility Name _____

Address _____

_____

City _____

State _____ Zip _____

Phone _____

Fax _____

Office Contact Name _____

Office Contact Phone _____

Office Contact Email Address _____

NPI# _____

State License # _____

Tax ID # (optional) _____

STEP 5

VYJUVEK PRESCRIPTION

PRESCRIPTION: VYJUVEK® (beremagene geperpavec-svdt) 5 x10⁹ PFU/ml single use vial biological suspension mixed with excipient gel for topical application*

DIRECTIONS:

☐ Age 6 months to <3 years old: Apply up to 0.8mL of prepared VYJUVEK gel topically once a week to selected wounds until they are closed

☐ Age ≥3 years old: Apply up to 1.6mL of prepared VYJUVEK gel topically once a week to selected wounds until they are closed

Please select preferred acquisition channel: ☐ Specialty Pharmacy ☐ Buy and Bill

If acquiring through a specialty pharmacy, please complete the section below

Mixed Administration Syringe:
Dispense One (1) Prepared dose of Vyjuvek gel administration syringes according to VYJUVEK package insert to a final concentration of 5.0x10⁹ /2.5ml PFU to be applied topically once weekly to selected wounds. **# Weekly Refills** _____

Administration: Apply as directed by Prescriber.

Administration Site and Address Required:

Preferred Treatment Center:

☐ Prescriber Office ☐ Treatment Facility

☐ Other HCP Office ☐ Home (Healthcare Professional to Administer)

Location _____ Contact Person _____

City _____ State _____ Zip _____

*Prepare VYJUVEK gel at the pharmacy by mixing the VYJUVEK biological suspension into the excipient gel

PRESCRIBER SIGNATURE

By signing, I have read and agree with the Prescriber Attestation, outlined in Section 4 on page 4.
I certify that I have prescribed VYJUVEK as described above based on my professional judgement of medical necessity.

SIGN _____ _____

PRESCRIBER SIGNATURE – Dispense as written **Date**

The Prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements may result in outreach to the Prescriber.

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Krystal CONNECT™
Personalized Support Services

SECTION 1: Krystal Patient Support Services and Krystal Connect Consent Authorization

The purpose of this form is to permit Krystal Connect participants to receive information and support ("Patient Support") from Krystal Biotech, Inc., its affiliates, representatives, agents, and contractors ("Krystal"). Krystal Connect provides Patient Support to eligible patients who have been prescribed a Krystal therapy. This includes: (1) providing reimbursement and financial support to eligible patients (such as investigating your insurance coverage, confirming out-of-pocket costs, and reviewing eligibility for financial assistance); (2) working with you and your provider to fill your prescription; and (3) providing you with disease and medication-related educational resources and communications. Please read this form carefully and ask any questions that you may have before signing.

SECTION 2: Patient Support Services Authorization and Release of Protected Health Information

I authorize my healthcare providers, including physicians, labs, and pharmacies ("My Providers") and my health insurance plan ("My Plan") to share my (and/or my child's) individually identifying health information (including lab/genetic test, diagnosis, prescription, treatment, and insurance data) (collectively, "My Information") with Krystal for the following purposes: (1) to provide Patient Support; (2) to contact My Providers and My Plan to collect and maintain My Information in a Krystal database; (3) to contact me to receive education, study the effectiveness of therapy, assess the Krystal Connect service, and to provide future support services designed for patients prescribed VYJUVEK; and (4) for market research purposes or to perform data analytics with aggregated de-identified data. I understand that my pharmacy may receive payment from Krystal. I understand that once My Information has been disclosed to Krystal, federal privacy laws may no longer protect the information, but Krystal will protect My Information by using and disclosing it only for purposes described in this Authorization or as allowed by law. I understand that this Authorization is voluntary, and that my treatment and insurance benefits cannot be conditioned upon signing this Authorization. I also understand, however, that not signing this Authorization means that I will not participate in Krystal Connect or other Krystal patient support offerings. I may revoke this Authorization at any time by sending a letter to Krystal Connect 2100 Wharton Street #310, Pittsburgh, PA 15203 or an email to KrystalConnect@KrystalBio.com. I understand that if I revoke this Authorization, My Providers will stop disclosing my Information to Krystal, but my revocation will not affect Krystal's use and disclosure of My Information received by Krystal prior to my revocation in reliance upon this Authorization. This Authorization expires ten (10) years from the date signed below, unless I revoke it earlier as stated above or in accordance with local law. I understand that I may receive a copy of this Authorization.

Section 3: Marketing Communications

I authorize Krystal to contact me including by mail, email, fax, telephone call, and text message, including by calling/texting me at the phone number I provide on this form below (including autodialed and prerecorded calls and messages) to provide me with information about Krystal products, services, and programs or other topics of interest, conduct market research, or otherwise ask me about my experience with or thoughts about such topics. I understand and agree that any information that I provide may be used by Krystal to help develop new products, services, and programs. I note that Krystal will not sell or transfer my personal data to any unrelated third party for marketing purposes without my express permission. I understand that my consent to receive marketing communications is not required as a condition of purchasing or receiving any goods or services from Krystal, to receive information or further contact from Krystal, including receiving Patient Support services from Krystal. I understand that I may revoke this marketing consent and choose not to receive information or further contact from Krystal by clicking the unsubscribe link in future Krystal communications or by visiting KrystalBio.com/privacy.

SECTION 4: Prescriber Attestation

(The Prescriber must sign if this form is to be used as a prescription to be triaged to a Specialty Pharmacy, to request Home Health Services or to enroll a patient for free goods as part of the Patient Assistance Program (PAP). If the request is limited to Benefit Verification or Copay Assistance Support, the Prescriber, or an individual acting at the direction of the Prescriber [and involved in the patient's care, such as an Office Practice Manager, Financial Coordinator, Financial Counselor, Patient Assistance Coordinator, Patient Navigator, Social Worker, Insurance Coordinator, Patient Coordinator, or Patient Care Advocate,] may sign this form.)

By signing below, I certify that a prescription signed by a licensed prescriber is on file for the above therapy and that the patient named on this form has provided the necessary authorization to release the information herein and medical and/or patient information relating to VYJUVEK® therapy to Krystal and its agents or contractors for the purpose of seeking reimbursement for VYJUVEK® therapy, assisting in initiating or continuing VYJUVEK® therapy, and/or evaluating the patient's eligibility for Krystal's patient support programs administered by Krystal Connect™. I authorize Krystal to be my agent and to forward the above prescription, by fax or other mode of delivery, to the pharmacy chosen by the patient named on this form. For the state of New York, copies of all prescriptions should be on official New York state prescription forms.

I certify that any medications received from Krystal in connection with any Krystal Connect™ program will be used only for the named patient. These medications will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning any medications received from Krystal, or any services provided by Krystal Connect™, to any payor, including Medicare, Medicaid, or any other federal or state health insurance program, nor will any medications be returned for credit. If the named patient does not return for therapy, the product will be returned to Krystal. I acknowledge that I have assisted the patient in enrolling in Krystal Connect™ exclusively for purposes of patient care and not in consideration for, expectation of, or actual receipt of remuneration of any sort.