Vyjuvek™
beremagene geperpavec-svdt
$5x10^9$ 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 3-6**.

☐ 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)**

Please see full Prescribing Information.

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KRYSTAL CONNECT ENROLLMENT FORM

Vyjuvek™ beremagene geperpavec-svdt 5x10⁹ PFU/mL single-use vial

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

Caregiver Name (if applicable) ______________________

Relationship to Patient ______________________

Patient Phone ______________________

OK to leave message? ☐ Y ☐ N Best time to call ☐ AM ☐ PM

Caregiver Phone ______________________

OK to leave message? ☐ Y ☐ N Best time to call ☐ AM ☐ PM

Language (other than English) ______________________

Email Address ______________________

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

Patient Name ______________________ Relationship to Patient (if other than patient signing) ______________________

SIGN ______________________

PATIENT / AUTHORIZED PARTY SIGNATURE Date

STEP 2

INSURANCE INFORMATION

Primary Insurance Name ______________________

Policy ID # ______________________

Group # ______________________

Phone ______________________

Policy Holder ______________________

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other ______

Copy of Insurance Card attached ☐ Y ☐ N

☐ Patient does not have insurance

Secondary Insurance Name ______________________

Policy ID # ______________________

Group # ______________________

Phone ______________________

Policy Holder ______________________

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other ______

Copy of Insurance Card attached ☐ Y ☐ N

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.)

Please see full Prescribing Information.

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Krystal CONNECT™ Personalized Support Services

Please see accompanying full Prescribing 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 ______

Preferred Method of Contact ☐ Phone ☐ Fax ☐ Email

NPI# ______

State License # ______

Tax ID # ______

DEA # ______

STEP 5

VYJUVEK™ PRESCRIPTION

PRESCRIPTION: VYJUVEK™ (beremagene geperpavec-svdt) 5 $x10^9$ 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 ☐ Undecided

If acquiring through a specialty pharmacy, please check the appropriate box for the way in which you would like to receive VYJUVEK

OPTION 1

☐ **Mixed Administration Syringe:**
Send to the administration site address below:

Prepared: Dispense One (1) Prepared dose of VYJUVEK gel administration syringes according to VYJUVEK package insert to a final concentration of $5.0x10^9$/2.5ml PFU to be applied topically once weekly to selected wounds. **# Refills** ______

Administration: Apply as directed by Prescriber.

Mixed administration syringes containing the VYJUVEK gel can be stored for up to 48 hours in the refrigerator (2º to 8ºC).

Administration Site and Address Required:

Preferred Treatment Center:

☐ Prescriber Office ☐ Treatment Facility
☐ Other HCP Office ☐ Home (Skilled Nurse to Administer)

Location ______

City ______ State ______ Zip ______

Contact Person ______

OPTION 2

☐ **Cartons:**
Send to the Pharmacy shipping address below:

☐ 1 carton / 7-day supply **# Refills** ______
☐ 2 cartons / 14-day supply **# Refills** ______
☐ 3 cartons / 21-day supply **# Refills** ______

Store the VYJUVEK carton at -15°C to -25°C. If a freezer is not available, the carton can be refrigerated (2º to 8ºC) for up to 1 month.

Pharmacy Address Required:

Location ______

City ______ State ______ Zip ______

Contact Person ______

*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 ______ OR ______

PRESCRIBER SIGNATURE – Dispense as written Date **PRESCRIBER SIGNATURE – Generic substitute allowed** 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.

Please see full Prescribing Information.

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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 Health Information

By signing below, I authorize my healthcare providers, including my physicians and pharmacies ("My Providers") and my health insurance plan ("My Plan") to share my medical information (such as information about my diagnosis, prescriptions, and treatment) and my insurance information (collectively, "My Information") with Krystal so that Krystal can provide Patient Support. I authorize My Providers to use My Information to provide me with certain offerings related to my medication and treatment. I understand that my pharmacy will receive payment from Krystal for disclosing My Information to Krystal. I understand that once My Information has been disclosed to Krystal, federal privacy laws may no longer protect the information. However, I understand that Krystal agrees to protect My Information by using and disclosing it only for purposes described in this Authorization or as required by law or regulations. I understand that I may refuse to sign this Authorization, and that my treatment, insurance enrollment, and eligibility for insurance benefits are not conditioned upon signing this Authorization. I also understand, however, that refusing to sign this Authorization means that I may not participate in Krystal Connect and will not be able to take advantage of other Patient Support offerings provided by Krystal. I may cancel or revoke this Authorization at any time by mailing a letter to Krystal Connect 2100 Wharton Street #310, Pittsburgh, PA 15203 or by sending an email to KrystalConnect@KrystalBio.com. I understand that if I revoke this Authorization, My Providers will stop disclosing my Information to Krystal pursuant this Authorization, but my revocation will not affect Krystal's use and disclosure of My Information received by Krystal from My Providers prior to my revocation in reliance upon this Authorization. This Authorization expires ten (10) years from the date signed below, or earlier if required by state or local law, unless I revoke it before then. I understand that I may receive a copy of this Authorization.

Section 3: Marketing Communications from Krystal Connect Opt-In

I authorize Krystal Biotech, Inc. ("Krystal"), and companies working with 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.

Please see full **Prescribing Information**.

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