ZEALAND PHARMA ConnectedCare

ZEGALOGUE® (dasiglucagon) injection 0.6 mg / 0.6 mL

Patient Assistance Program Enrollment Form

PHONE 1-877-501-ZEGA (9342)
FAX 1-866-854-3772

A PATIENT INFORMATION

LEGAL NAME First, Middle, Last:	**SUFFIX:**	**GENDER:** ☐ MALE ☐ FEMALE	**DATE OF BIRTH** MM/DD/YYYY:

CELL PHONE:	**ALTERNATE PHONE:**	**EMAIL ADDRESS:**

STREET ADDRESS NO PO BOX:	**APT#:**	**CITY:**	**STATE:**	**ZIP:**

PATIENT REPRESENTATIVE NAME IF APPLICABLE:	**RELATIONSHIP TO PATIENT:**

CURRENT MEDICATIONS PLEASE LIST OR ATTACH:

B PRESCRIPTION INSURANCE INFORMATION

PRESCRIPTION INSURANCE:	**RX PCN#:**	**RX BIN#:**	**RX GROUP#:**

CARDHOLDER NAME:	**MEMBER ID#:**	☐ PATIENT DOES NOT HAVE INSURANCE

C PATIENT VOLUNTARY USE AND DISCLOSURE OF HEALTH INFORMATION

[By signing below, I authorize my healthcare professionals, including my physicians and pharmacies ("My Providers"), and my health insurance plan ("My Plan") to use and share my identifiable personal and medical information (such as information about my name, date of birth, diagnosis and treatment) and my identifiable insurance information (collectively, "My Information") with Zealand Pharma US, Inc., affiliates, representatives, agents, and contractors ("Zealand") so that Zealand can provide me with information, assistance, and support through Zealand Pharma ConnectedCare ("Patient Support") as described below; administer and analyze the effectiveness of Patient Support; ask if I am interested in participating in market research; carry out other business purposes related to ZEGALOGUE®; and comply with law. I understand and agree that my pharmacies may receive payment from Zealand in exchange for sharing My Information with Zealand. Once My Information has been shared with Zealand, federal privacy laws may no longer protect the information. However, Zealand agrees to protect My Information by using and disclosing it only for purposes described in this authorization. I may refuse to sign this authorization and doing so will not affect my treatment, insurance coverage, or eligibility for benefits for which I am otherwise entitled. However, refusing to sign this authorization means that I cannot participate in Zealand Pharma ConnectedCare. I may cancel or revoke this authorization at any time by mailing a letter to Zealand Pharma ConnectedCare, 6000 Park Lane, Pittsburgh, PA 15275. If I revoke this authorization, My Providers and My Plan will stop using and sharing My Information, but my revocation will not affect uses and disclosures of My Information made in reliance upon this authorization prior to my revocation. This authorization expires five (5) years from the date signed below, or earlier if required by state or local law, unless I revoke it before then. I will receive a copy of my signed authorization.]

PRINT PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE NAME*:	**RELATIONSHIP TO PATIENT:**

SIGNATURE OF PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE*:	**DATE:**

D PATIENT CONSENT TO PARTICIPATE IN ZEALAND PHARMA ConnectedCare

[By completing and submitting this form, you agree to allow Zealand Pharma, its affiliates and its agents to collect the information provided and to be contacted by Zealand Pharma, its affiliates, agents, and contracted specialty pharmacies (together, "Zealand") to collect the information by mail, email, fax, telephone call or text message, including autodialed and prerecorded calls and messages, now and in the future, regarding information about Zealand's products, services, and other programs or topics of interest, as well as for marketing purposes, to 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 Zealand to help develop and improve products, services and programs. I understand that my consent is not required as a condition of purchasing or receiving any goods or services from Zealand. Zealand will not sell, rent or otherwise distribute or transfer your personally identifiable information to any unrelated third party for marketing purposes without your express permission, and will use your information in accordance with its Privacy Policy (https://www.zegalogue.com/privacy-policy). I understand that I may revoke this permission and choose to no longer receive information from Zealand by clicking the "unsubscribe" link provided in the emails I receive from Zealand or by replying "STOP" to SMS messages I receive from Zealand.]

PRINT PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE NAME*:	**RELATIONSHIP TO PATIENT:**

SIGNATURE OF PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE*:	**DATE:**

*The authorized patient representative may not be the patient's healthcare professional.

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PATIENT NAME First, Middle, Last:	**DATE OF BIRTH** MM/DD/YYYY:

E PRESCRIBER INFORMATION

PRESCRIBER NAME:	**PRESCRIBER PRACTICE NAME:**	**PRESCRIBER NPI:**

PRACTICE ADDRESS:	**STE#:**	**CITY:**	**STATE:**	**ZIP:**

CONTACT PERSON:

CONTACT PHONE:	**CONTACT FAX:**	**CONTACT EMAIL:**

F INCOME INFORMATION

LAST 4 DIGITS OF SSN:	**NO. OF PEOPLE IN HOUSEHOLD:**	**TOTAL ANNUAL HOUSEHOLD INCOME** BEFORE TAXES:
		$ (Include All Income: Wages, Pension, Social Security, Disability, Alimony, Interest/Dividends, Rental Property Income, etc)

Zealand Pharma has the right to require written proof of income (such as a Form 1040, Form W-2, or other documentation) from patients in connection with a financial eligibility determination should the Automated Income Verification process produce invalid or no results.

G PRESCRIPTION INFORMATION* To ePrescribe, please select Careform Pharmacy or NPI 1043762750

*Prescription Information section is not required if the prescription is already on file with Careform Pharmacy

PATIENT NAME First, Middle, Last:	**DATE OF BIRTH** MM/DD/YYYY:

SELECT MEDICATION:

- ☐ (QTY: 1) Single-dose autoinjector, 0.6 mg/0.6 mL, NDC 80644-0012-01
- ☐ (QTY: 2) Single-dose autoinjector, 0.6 mg/0.6 mL, NDC 80644-0012-02
- ☐ (QTY: 1) Single-dose prefilled syringe, 0.6 mg/0.6 mL, NDC 80644-0013-01
- ☐ (QTY: 2) Single-dose prefilled syringe, 0.6 mg/0.6 mL, NDC 80644-0013-02

MEDICATION ALLERGIES? IF YES, LIST ALL DRUG ALLERGIES

- ☐ YES
- ☐ NO

SHIP TO:

PATIENT'S HOME

SIG/DIRECTIONS:

- ☐ Inject contents of one device (0.6 mg) Sub-Q; may repeat in 15 minutes as needed using a new device.
- ☐ Inject contents of one device (0.6 mg) Sub-Q according to instructions on package.
- ☐ Other:

NO. OF REFILLS:

H PRESCRIBER AUTHORIZATION

[I attest that I am involved in the care and treatment of the above-named patient. By signing below, I certify and acknowledge that (1) ZEGALOGUE® is medically necessary and is in the best interests of my patient; (2) the information in this form is accurate and complete to the best of my knowledge; (3) I am submitting this form to Zealand Pharma ConnectedCare to enroll my patient in Zealand Pharma ConnectedCare; (4) submission of this form to Zealand Pharma ConnectedCare does not guarantee that my patient will be eligible for Zealand Pharma ConnectedCare; (5) services provided by or on behalf of Zealand and/or Zealand Pharma ConnectedCare do not include the provision of treatment or medical advice or replace the treatment and care provided by me or other healthcare professionals of my patient; (6) if my patient receives ZEGALOGUE® at no cost through Zealand Pharma ConnectedCare, I will not seek reimbursement for ZEGALOGUE® from any third-party (e.g. Medicare, Medicaid, other benefit provider); (7) any service provided by or on behalf of Zealand and/or Zealand Pharma ConnectedCare is not made in exchange for any express or implied agreement or understanding that I will recommend, prescribe, or use ZEGALOGUE® or any other Zealand product, and any decision to prescribe ZEGALOGUE® was, and in the future will be, based solely on my or another prescriber's determination of medical necessity; and (8) I have obtained the required authorizations from my patient to release the referenced medical and/or other patient information relating to my patient's treatment to Zealand and Zealand Pharma ConnectedCare.]

PRINT PRESCRIBER NAME:	**PRESCRIBER STATE LICENSE NUMBER:**

PRESCRIBER SIGNATURE:	**DATE:**

Please see full Prescribing Information at https://www.zegalogue.com