

**A. Patient information**

First name \_\_\_\_\_ Last name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

Email \_\_\_\_\_

Phone (preferred) \_\_\_\_\_ Phone (alternate) \_\_\_\_\_

Preferred contact: Text Email Phone

Preferred language: English Spanish Other \_\_\_\_\_

Sex on file with insurance: Male Female Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Prescription insurance information**

**Attach copies of both sides of patient's pharmacy benefit card(s)**

Patient does **not** have coverage (complete the Patient Assistance Application on page 5)

Patient has secondary insurance (attach copies of both sides of patient's secondary benefit card(s))

Primary insurance name \_\_\_\_\_ Policy no. \_\_\_\_\_

Group no. \_\_\_\_\_ Insurance company phone \_\_\_\_\_

Policy holder name \_\_\_\_\_

Prior authorization number (if known) \_\_\_\_\_ Prior authorization effective dates \_\_\_\_\_

**Patient authorization**

I have read and agree to the Authorization to Share Personal Health Information on Page 2.

Signature of patient/legal representative (Required) \_\_\_\_\_ Date (Required) \_\_\_\_\_

Name of patient/legal representative (Required) \_\_\_\_\_

Legal representative phone \_\_\_\_\_ Relationship to patient \_\_\_\_\_

**Additional opt-in:** By checking this box, I authorize Alfasigma, and third-party companies working on Alfasigma's behalf, to contact me by mail, email, telephone, or text message for (1) marketing purposes, including to provide me with information about Alfasigma's products, services, and programs or other topics of interest, and/or (2) to conduct market research.

**I have read and agree to the Terms and Conditions for the Interconnect Savings Program on page 3. You must sign below to participate in Interconnect Support Services.**

Signature of patient/legal representative (Required) \_\_\_\_\_ Date (Required) \_\_\_\_\_

**B. Prescriber information**

First name \_\_\_\_\_ Last name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

Phone \_\_\_\_\_ Ext. \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_ Clinic/facility name \_\_\_\_\_

NPI no. \_\_\_\_\_ State license no. \_\_\_\_\_ Prescriber tax ID \_\_\_\_\_

Preferred contact: Phone Fax Email

All correspondence regarding this patient will be communicated to the primary contact via phone, fax, and/or email.

**C. Interconnect Support Services (select 1 option)**

**Full Interconnect Support Services:** Interconnect will provide full reimbursement support, including benefit verification, evaluation of patients for eligible financial assistance programs, and enrollment of patients into adherence services.

**Patient Support Services Enrollment Only:** My patient is already receiving services from their specialty pharmacy, and I would like them to receive only adherence and education services from Interconnect.

**Quick Start Program (QSP)/Bridge Program (Bridge)/Patient Assistance Program (PAP):** My patient requires evaluation for patient support programs based on their eligibility due to indication of lack of financial concern or coverage through their insurance provider (must select QSP, Bridge, PAP in Section D).

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**D. Prescription and pharmacy information**

Complete both Prescriptions if you would like or need your patient to be reviewed for QSP, Bridge, PAP eligibility, in the event the patient is experiencing insurance delays or is uninsured (Terms and Conditions apply).

**For covered patients: LYNAVOY (linexibat) tablets**

- 40 mg, twice daily orally x 30 days, #60 tablets # of refills \_\_\_\_\_
- Other \_\_\_\_\_

NDC: 69516-140-60

Primary diagnosis code: L29.81

**Please sign one of the 2 options below:**

"Dispense As Written"/  
Brand Medically Necessary/  
Do Not Substitute/No Substitution/  
DAW/May Not Substitute/No Stamps  
Prescriber's Signature (Required)

OR

May Substitute/  
Product Selection Permitted/  
Substitution Permissible  
Prescriber's Signature (Required)

➔ \_\_\_\_\_  
Date \_\_\_\_\_

➔ \_\_\_\_\_  
Date \_\_\_\_\_

**\*CA, MA, NC & PR:** Interchange is mandated unless Prescriber writes the words **"No Substitution Below"**

**For Patients with pending/denied coverage: LYNAVOY tablets**

- 40 mg, twice daily orally x 30 days, #60 tablets # of refills \_\_\_\_\_

**Please sign one of the 2 options below:**

"Dispense As Written"/  
Brand Medically Necessary/  
Do Not Substitute/No Substitution/  
DAW/May Not Substitute/No Stamps  
Prescriber's Signature (Required)

OR

May Substitute/  
Product Selection Permitted/  
Substitution Permissible  
Prescriber's Signature (Required)

➔ \_\_\_\_\_  
Date \_\_\_\_\_

➔ \_\_\_\_\_  
Date \_\_\_\_\_

**\*CA, MA, NC & PR:** Interchange is mandated unless Prescriber writes the words **"No Substitution Below"**

Prior cholestatic pruritus treatment failures, contraindications, or intolerances (Select all that apply):

Cholestyramine Rifampicin Sertraline Naltrexone

Other \_\_\_\_\_

Concurrent cholestatic pruritus medications: \_\_\_\_\_

Prior primary biliary cholangitis medications: \_\_\_\_\_

Concurrent primary biliary cholangitis medications: \_\_\_\_\_

**The exclusive LYNAVOY Specialty Pharmacy Provider:**

PANTHERx Rare  
Fax: 1-833-636-1742 Phone: 855-726-8479  
Address: PANTHERx Rare, 121 Bayer Road, Building 5, Pittsburgh, PA 15205

Prescription already sent to pharmacy: Yes No

**Prescriber authorization**

I authorize Alfasigma Pharmaceuticals, Inc., as my designated agent and on behalf of my patient to (1) forward this statement of medical necessity to furnish any information on this form to and recruit necessary patient information from the insurer of above-named patient, and (2) forward this prescription, by fax or any means under applicable law, to the pharmacy. I certify that the rationale for prescribing LYNAVOY is for a primary diagnosis of cholestatic pruritus associated with primary biliary cholangitis (PBC) in adult patients; diagnostic code: L29.81, and I will be supervising the patient's treatment accordingly.

If applicable, I authorize Alfasigma to conduct a benefits investigation for my patient and to act on my behalf for the limited purpose of transmitting this prescription to the appropriate pharmacy designated by the patient per their benefit plan provided that, if this prescription is not so designated, Alfasigma is authorized to transmit this prescription to a network pharmacy it selects or to the pharmacy otherwise indicated.

Prescriber's Signature (Required) \_\_\_\_\_ Date (Required) \_\_\_\_\_

Alfasigma makes no representation that the information will comply with the requirements of any particular payer/insurer. The use of this information does not guarantee payment or that any payment received will cover prescription costs.

**Special note:** The physician is to comply with their state-specific prescribing requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance of state-specific requirements could result in outreach to the prescriber.

Please sign and return the completed form and required documentation via fax to 1-833-636-1742

Please see full [Prescribing Information](#), [Medication Guide](#), or visit [Lynavoy.com](#)



\_\_\_\_\_  
Patient name/Legal representative                      Date of birth                      Email                      Phone number

**I. Patient Authorization to Share Personal Health Information**

The Interconnect® Support Services program provides services which vary from patient to patient, such as prescription management, support in securing reimbursement, referrals to patient financial support programs, drug shipment and refills outreach, compliance, and persistency messaging to patients and the patients’ physicians, no-cost medication to qualified patients, and other related services in connection with Alfasigma products and programs (collectively, “Program”). The Program services may change from time to time.

This Authorization will allow the patient’s healthcare provider(s) and health insurer(s) to share information with Alfasigma Pharmaceuticals, Inc., and its affiliates and their employees, including field representatives (collectively, “Alfasigma”), as well as third-party companies working on Alfasigma’s behalf, for the purposes described in this Authorization.

**AUTHORIZATION:** By signing this Authorization, I (the patient or the patient’s personal representative on behalf of the patient) authorize each of my physicians, pharmacists, and other healthcare providers (collectively, “Healthcare Providers”) and each of my health insurers (collectively, “Insurers”) to use and/or disclose the personal information described below to Alfasigma and third parties administering Program services (including any Alfasigma service providers), for the purposes described in this Authorization. I understand that my pharmacy providers may receive remuneration for disclosing my protected health information and/or for any patient support activities pursuant to this Authorization. My personal health information may be disclosed orally or in writing, including by fax, email, and/or through other data transfer means.

My Healthcare Providers and Insurers may disclose to Alfasigma and other third parties helping to administer Program services (including any Alfasigma service providers) my personal health information such as: (1) my name, birth date, address, or telephone number; (2) medical records and treatment information; (3) information about my health benefits or health insurance coverage; and (4) financial information about me.

I understand that once my protected health information has been disclosed to Alfasigma, federal privacy laws may no longer protect the information from further disclosure, but Alfasigma has agreed to use and disclose my information only for purposes of providing Program services or as indicated in this Authorization.

Alfasigma may use and/or contact me about my personal health information for the following purposes:

- Contact me by phone, mail, or email to provide information about the Program;
- Verify the accuracy of the information on this form and request additional financial and insurance information;
- Determine my eligibility for the Program and the specific services of the Program, such as financial assistance;
- Facilitate the provision of Program services to me, which is separate from sales purposes. For example, including delivering Program services such as compliance, and persistency messaging, and analyzing the effectiveness of the Program;
- To send enrollment information to my pharmacy via phone/oral, email, postal mail, or fax;
- For Alfasigma’s medical and scientific research and related purposes, conducted by or under the oversight of Alfasigma’s medical affairs function. This might include helping the development of new products, services, and programs; and/or as necessary to comply with applicable laws, including, without limitations, any safety reporting obligations.

I also understand that:

- I do not have to sign this Authorization. My treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be affected. If I do not sign this Authorization, however, I will not be eligible to receive Program services.
- This Authorization will remain in effect until I am no longer participating in the Program, until the Authorization is required to be terminated pursuant to applicable laws, or until I revoke this Authorization, whichever occurs first.
- This Authorization will remain valid for the earlier of five (5) years or the maximum period allowed by applicable state law, unless I cancel it before that time or am no longer participating in the Program.
- I may revoke (cancel) this Authorization at any time by mailing a letter requesting such cancellation to Interconnect at P.O. Box 580, Somerville, NJ, 08876 or by emailing Interconnect at [privacyprotection.us@alfasigma.com](mailto:privacyprotection.us@alfasigma.com). If I revoke this Authorization, my Healthcare Providers and Insurers are not permitted to make further disclosures of my personal health information to Alfasigma, except for disclosures made in reliance on this Authorization prior to the receipt of the cancellation. Revocation of this Authorization will not affect Alfasigma’s ability to use or disclose information it has already received. If I revoke this Authorization, I will no longer be able to receive Program services.
- I am entitled to a copy of this signed Authorization.
- The information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA once disclosed.
- Pharmacies may receive financial remuneration from the manufacturer for disclosing personal health information (PHI) to provide services within the authorization.

**Please sign and return the completed form on Page 1 and required documentation via fax to  
1-833-636-1742**

Contact your Care Coordinator with any questions at 1-844-622-4278 // Monday-Friday, 8 AM-8 PM ET

## Interconnect Savings Program Terms and Conditions

The Interconnect Savings Program ("the Program") will provide financial assistance for the out-of-pocket costs for eligible patients with a valid prescription, up to a maximum of \$10,000 per calendar year.

**The Interconnect Savings Program is not insurance and is not intended to substitute for insurance.**

Before you enroll in the Program, you will be asked to provide personal information to your specialty pharmacy that may include your name, address, phone number, email address, information related to your prescription medication insurance and treatment, and your financial information necessary to determine eligibility and administer the Program. This information will be collected and processed by your specialty pharmacy and is needed to enroll you in the Program. Your personal information may be shared with Alfasigma and with third parties only where necessary to fulfill the purposes of the Program. This may include facilitating reimbursement for out-of-pocket costs such as co-payments or reaching out to you via email, phone, or text message to provide support related to the Program.

The patient must meet the Program requirements every time the co-pay program card/coupon is used. **The Interconnect Savings Program terms will expire at the end of each calendar year. The Program may change or end without notice, including within specific states. Significant changes to the Program will be communicated in a timely manner to all participants of the program.**

In order to participate in the Interconnect Savings Program and receive a benefit, the patient must meet certain eligibility criteria and comply with all the terms and conditions described below:

- **This Program is only available for patients 18 years or older who use commercial or private insurance.**
- This Program is not for patients who use:
  - any state or federal government funded health program. Examples of these programs are Medicaid, Medicare, Medigap, Veterans Affairs, Department of Defense, TRICARE, or other federal or state healthcare programs (including any state prescription drug assistance programs); or
  - private insurance plans or other health or pharmacy benefit programs that reimburse you for the entire cost of your prescription drugs.
- The savings received under this program must be deducted from any reimbursement request submitted to the patient's insurance plan, either directly or on behalf of the patient.
- The patient and the pharmacist each must report the patient's receipt of benefits under this Program as required by any insurer, health plan, or other third-party payer.
- Absent a change in Massachusetts law, effective until January 1, 2031, this offer is not valid for Massachusetts residents whose prescriptions are covered, in whole or in part, by third-party insurance.
- This Program offer may not be used with any other coupon, discount, prescription savings card, free trial, or other offer.
- This Program offer is valid only in the United States and Puerto Rico and void where prohibited, taxed, or limited by law.
- Alfasigma may change or discontinue the Program at any time. Significant changes to the Program will be communicated in a timely manner to all participants of the Program.

**You may end your participation in the INTERCONNECT Savings Program at any time by calling 1-844-622-4278.**

Contact your Care Coordinator with any questions at 1-844-622-4278 // Monday-Friday, 8 AM-8 PM ET

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### You are eligible for this program if:

- You do not have any prescription drug coverage for LYNAVOY (linciclib) tablets
- You are an adult (18 years and older) diagnosed with cholestatic pruritus associated with primary biliary cholangitis (PBC)
- You are a US citizen or permanent resident of the United States or Puerto Rico
- Your annual gross household income is at or below 500% of the Federal Poverty Level for all family sizes. Please visit the US Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation, to view the current Federal Poverty Guidelines at <https://aspe.hhs.gov/poverty-guidelines>

### Patient information (to be completed by the patient)

\_\_\_\_\_ / / \_\_\_\_\_ Male Female  
 First name Last name Date of birth

\_\_\_\_\_  
 Address City

\_\_\_\_\_  
 State ZIP code Email

Preferred contact: Email Phone \_\_\_\_\_  
 Phone (preferred) Phone (alternate)

Are you a US citizen? YES NO If no, are you a permanent resident of the United States? YES NO

Total household income \$ \_\_\_\_\_ No. of people in your household: \_\_\_\_\_

Do you have private prescription insurance coverage? YES NO

Have you enrolled in Medicaid? YES NO

Are you enrolled in Medicare Part A and/or Part B? YES NO Medicare ID no. (if applicable): \_\_\_\_\_

Ship LYNAVOY to: Patient's home HCP's office

### Patient declaration

**AUTHORIZATION:** I know that to qualify for free medicine, my household gross income must be at or below 500% of the Federal Poverty Level, and I certify that the patient financial information I have provided is correct. I certify I have no health plan coverage for LYNAVOY; this includes Medicare, Medicaid, or other public programs. I do not have the resources to pay for LYNAVOY. I agree to provide Alfasigma proof of my income, if requested. I agree that if my certification about my income is false, I will reimburse Alfasigma Pharmaceuticals, Inc. I understand that my income will be electronically verified based on the information I provided. I understand that Interconnect could ask me for a copy of my IRS 1040 form or other proof of income for the purpose of an audit. I agree to provide my financial documentation in a timely manner, if so requested.

➔ \_\_\_\_\_  
 Patient/Legal representative's signature (Required) Date (Required)

### Statement of Medical Necessity (to be completed by the prescriber)

To the best of my knowledge, this patient has no coverage (including Medicare, Medicaid, or other Federal healthcare programs) for LYNAVOY. I certify that, in my medical judgment, LYNAVOY is medically necessary for this patient, and that I will be supervising this patient's treatment.

➔ \_\_\_\_\_  
 Prescriber's signature (Required) Date (Required)

Please sign and fax the completed form and required documentation to:

**1-833-636-1742**

**Additional documentation attached** (e.g., Recent pay stubs (last 1–3 months) Tax documents (W-2s, 1040s, 1099s) Social Security, disability, unemployment benefit statements, written attestation of no income, when applicable, etc.)

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