ACT™ Amylyx Care Team

Getting your eligible patients started with RELYVRIO™

A step-by-step overview

relyvrio™
(sodium phenylbutyrate and taurursodiol) for oral suspension 3 g/1 g

3 steps to get your patients started

relyvrio™
(sodium phenylbutyrate and taurursodiol) for oral suspension 3 g/1 g

1

Follow the provided instructions to complete the RELYVRIO™ Enrollment Form

- Please complete all sections of the form to ensure the process is not delayed
- Sign and fax completed form to 844-283-0375
- ACT will complete a benefit investigation and inform you of the outcome and any additional steps that may be needed
- Completing the form will serve as your patient's prescription for RELYVRIO

2

Complete the prior authorization (PA) and/or letter of medical necessity, if needed

- ACT will inform you if a PA is required per your patient's health plan
- If a PA is required:
  - ACT can provide guidance on the process and what forms are required for submission
  - ACT will follow up on the outcome of your PA submission and keep you informed
  - ACT will provide you education on the appeal process if the PA is denied and keep you informed

3

ACT will triage the prescription to one of our approved specialty pharmacies upon payer approval

- The specialty pharmacy will then work directly with your patient to coordinate delivery and any out-of-pocket requirements

To start your eligible patients on treatment with RELYVRIO™

Complete the RELYVRIO Enrollment Form

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HERE'S **WHY**

A Patient Information

It is important to collect necessary information from your patients to start them on RELYVRIO and enroll them in the Amylyx Care Team (ACT)™ Support Program. Once enrolled, they become eligible for the support that the program provides. If patients have questions about how their personal information will be used and disclosed as described in the Patient Authorization & Consent section of the Enrollment Form, please ask them to contact ACT prior to signing. Then obtain their signature (or that of their authorized representative).

B Prescribing Physician Information

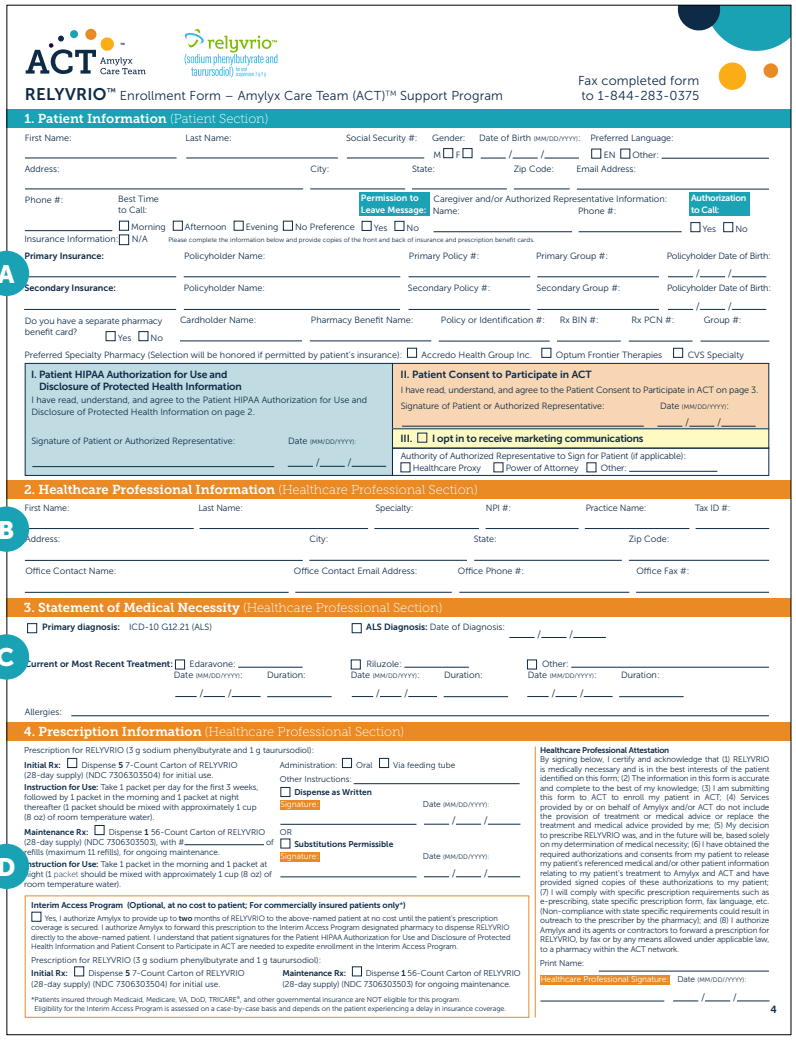
Filling out the Healthcare Professional Information section and your contact information allows us to keep you updated on your patient's progress. It is important to completely fill out the office contact information to ensure we contact the proper individual in your office throughout the process.

C Medical Information

Make sure to indicate your patient's diagnosis information, previous or current amyotrophic lateral sclerosis (ALS) treatments, and any known medication allergies.

D Prescription Information

Please complete the Prescription Information section, indicating initial and/or maintenance Rx and any other pertinent prescribing information. This information is necessary so the pharmacy can dispense RELYVRIO based on your direction. Please make sure to sign and date the form.



ACT Amylyx Care Team

relyvrio™ (sodium phenylbutyrate and taurursodiol) for oral suspension 3 g/1 g

RELYVRIO™ Enrollment Form – Amylyx Care Team (ACT)™ Support Program

Fax completed form to 1-844-283-0375

1. Patient Information (Patient Section)

First Name: Last Name: Social Security #: Gender: M F Date of Birth (MM/DD/YYYY): Preferred Language: EN Other:

Address: City: State: Zip Code: Email Address:

Phone #: Best Time to Call: Morning Afternoon Evening No Preference

Permission to Leave Message: Yes No

Caregiver and/or Authorized Representative Information: Name: Phone #:

Authorization to Call: Yes No

Insurance Information: N/A Please complete the information below and provide copies of the front and back of insurance and prescription benefit cards.

A

Primary Insurance: Policyholder Name: Primary Policy #: Primary Group #: Policyholder Date of Birth:

Secondary Insurance: Policyholder Name: Secondary Policy #: Secondary Group #: Policyholder Date of Birth:

Do you have a separate pharmacy benefit card? Yes No Cardholder Name: Pharmacy Benefit Name: Policy or Identification #: Rx BIN #: Rx PCN #: Group #:

Preferred Specialty Pharmacy (Selection will be honored if permitted by patient's insurance): Accredo Health Group Inc. Optum Frontier Therapies CVS Specialty

I. Patient HIPAA Authorization for Use and Disclosure of Protected Health Information

I have read, understand, and agree to the Patient HIPAA Authorization for Use and Disclosure of Protected Health Information on page 2.

Signature of Patient or Authorized Representative: Date (MM/DD/YYYY):

II. Patient Consent to Participate in ACT

I have read, understand, and agree to the Patient Consent to Participate in ACT on page 3.

Signature of Patient or Authorized Representative: Date (MM/DD/YYYY):

III. I opt in to receive marketing communications

Authority of Authorized Representative to Sign for Patient (if applicable): Healthcare Proxy Power of Attorney Other:

2. Healthcare Professional Information (Healthcare Professional Section)

B

First Name: Last Name: Specialty: NPI #: Practice Name: Tax ID #:

Address: City: State: Zip Code:

Office Contact Name: Office Contact Email Address: Office Phone #: Office Fax #:

3. Statement of Medical Necessity (Healthcare Professional Section)

Primary diagnosis: ICD-10 G12.21 (ALS) **ALS Diagnosis:** Date of Diagnosis:

C

Current or Most Recent Treatment: Edaravone: Date (MM/DD/YYYY): Duration: Riluzole: Date (MM/DD/YYYY): Duration: Other: Date (MM/DD/YYYY): Duration:

Allergies:

4. Prescription Information (Healthcare Professional Section)

D

Prescription for RELYVRIO (3 g sodium phenylbutyrate and 1 g taurursodiol):

Initial Rx: Dispense **5** 7-Count Carton of RELYVRIO (28-day supply) (NDC 7306303504) for initial use.

Instruction for Use: Take 1 packet per day for the first 3 weeks, followed by 1 packet in the morning and 1 packet at night thereafter (1 packet should be mixed with approximately 1 cup (8 oz) of room temperature water).

Maintenance Rx: Dispense **1** 56-Count Carton of RELYVRIO (28-day supply) (NDC 7306303503), with # of refills (maximum 11 refills), for ongoing maintenance.

Instruction for Use: Take 1 packet in the morning and 1 packet at night (1 packet should be mixed with approximately 1 cup (8 oz) of room temperature water).

Administration: Oral Via feeding tube

Other Instructions:

Dispense as Written Signature: Date (MM/DD/YYYY):

OR

Substitutions Permissible Signature: Date (MM/DD/YYYY):

Interim Access Program (Optional, at no cost to patient; For commercially insured patients only*)

Yes, I authorize Amylyx to provide up to **two** months of RELYVRIO to the above-named patient at no cost until the patient's prescription coverage is secured. I authorize Amylyx to forward this prescription to the Interim Access Program designated pharmacy to dispense RELYVRIO directly to the above-named patient. I understand that patient signatures for the Patient HIPAA Authorization for Use and Disclosure of Protected Health Information and Patient Consent to Participate in ACT are needed to expedite enrollment in the Interim Access Program.

Prescription for RELYVRIO (3 g sodium phenylbutyrate and 1 g taurursodiol):

Initial Rx: Dispense **5** 7-Count Carton of RELYVRIO (28-day supply) (NDC 7306303504) for initial use.

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*Patients insured through Medicaid, Medicare, VA, DoD, TRICARE®, and other governmental insurance are NOT eligible for this program. Eligibility for the Interim Access Program is assessed on a case-by-case basis and depends on the patient experiencing a delay in insurance coverage.

Healthcare Professional Attestation

By signing below, I certify and acknowledge that (1) RELYVRIO is medically necessary and is in the best interests of the patient identified on this form; (2) The information in this form is accurate and complete to the best of my knowledge; (3) I am submitting this form to ACT to enroll my patient in ACT; (4) Services provided by or on behalf of Amylyx and/or ACT do not include the provision of treatment or medical advice or replace the treatment and medical advice provided by me; (5) My decision to prescribe RELYVRIO was, and in the future will be, based solely on my determination of medical necessity; (6) I have obtained the required authorizations and consents from my patient to release my patient's referenced medical and/or other patient information relating to my patient's treatment to Amylyx and ACT and have provided signed copies of these authorizations to my patient; (7) I will comply with specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. (Non-compliance with state specific requirements could result in outreach to the prescriber by the pharmacy); and (8) I authorize Amylyx and its agents or contractors to forward a prescription for RELYVRIO, by fax or by any means allowed under applicable law, to a pharmacy within the ACT network.

Print Name:

Healthcare Professional Signature: Date (MM/DD/YYYY):

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Quick tips to fill out the form faster

If you prefer, you can fax a copy of your patient's insurance card in with the RELYVRIO Enrollment Form instead of filling out the insurance information.

If you have multiple patients to enroll, you can download the form from our website and prepopulate the Healthcare Professional Information section of the form.

If you are unable to obtain a patient's authorization, ACT can help by sending the authorization and consent to the patient electronically or by mail.

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HERE'S **HOW**

A Patient Demographics

- Patient demographics help the Amylyx Care Team (ACT)™ complete the enrollment process accurately and in a timely manner
- Additional documents, such as copies of the front and back of the insurance ID card, help expedite the process

B Specialty Pharmacy (SP) Selection

- RELYVRIO is available through a limited-distribution SP network
- Please select a preferred SP. Please note the payor may require a specific SP be utilized

C Patient Signatures

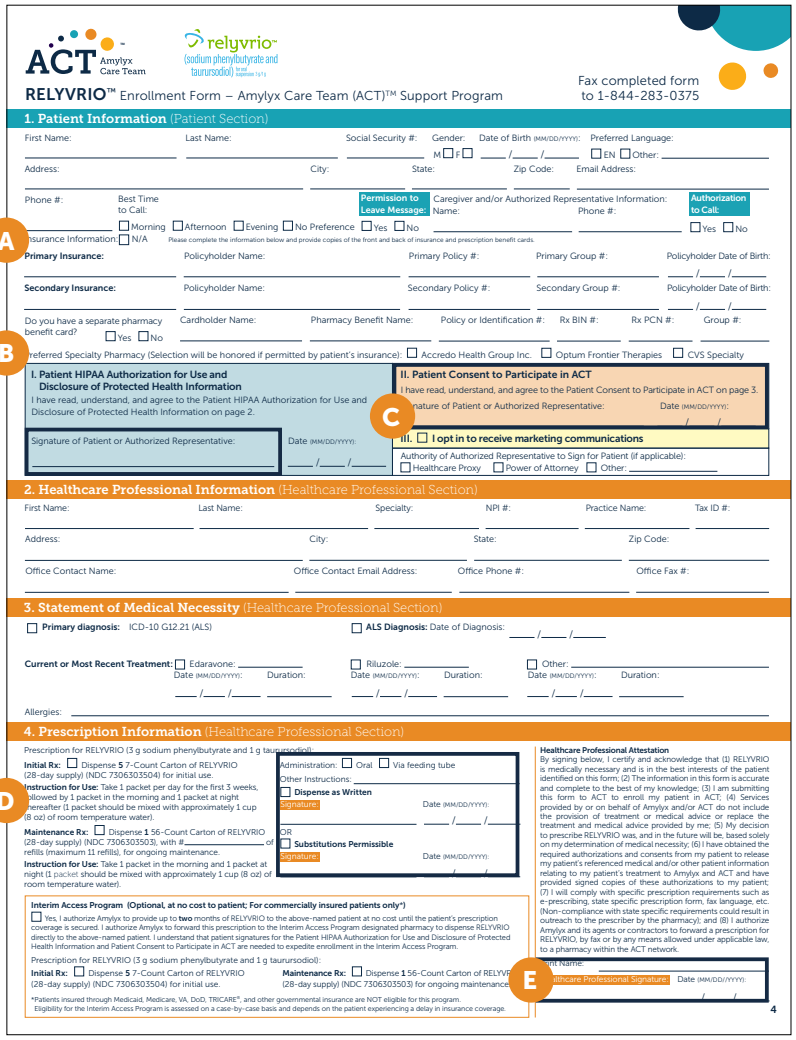
- Required for consent to participate in the ACT program and for ACT services
- Required for HIPAA authorization, which gives ACT permission to speak with your healthcare team and your patient's insurance companies
- For your patients who are not in office, ACT can reach out to offer alternative options to obtain consent

D Complete & Valid Prescription

- Requires healthcare professional (HCP) signature and date
- SPs will not accept stamped signatures
- Dispense as Written or Substitutions Permissible fields are required. If you do not want your prescription to be substituted, please sign in the appropriate spot

E Provider Attestation

- Requires HCP signature
- Gives authorization for the ACT team to act as your designated agent with facilitating coordination to the SP as well as providing ACT services



ACT Amylyx Care Team — relyvrio™ (sodium phenylbutyrate and taurursodiol)

RELYVRIO™ Enrollment Form – Amylyx Care Team (ACT)™ Support Program

Fax completed form to 1-844-283-0375

1. Patient Information (Patient Section)

First Name: | Last Name: | Social Security #: | Gender: M ☐ F ☐ | Date of Birth (MM/DD/YYYY): | Preferred Language: EN ☐ Other: ☐

Address: | City: | State: | Zip Code: | Email Address:

Phone #: | Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening ☐ No Preference | Permission to Leave Message: ☐ Yes ☐ No | Caregiver and/or Authorized Representative Information: Name: | Phone #: | Authorization to Call: ☐ Yes ☐ No

A — Insurance Information: ☐ N/A — Please complete the information below and provide copies of the front and back of insurance and prescription benefit cards.

Primary Insurance: | Policyholder Name: | Primary Policy #: | Primary Group #: | Policyholder Date of Birth:

Secondary Insurance: | Policyholder Name: | Secondary Policy #: | Secondary Group #: | Policyholder Date of Birth:

B — Do you have a separate pharmacy benefit card? ☐ Yes ☐ No | Cardholder Name: | Pharmacy Benefit Name: | Policy or Identification #: | Rx BIN #: | Rx PCN #: | Group #:

Preferred Specialty Pharmacy (Selection will be honored if permitted by patient's insurance): ☐ Accredo Health Group Inc. ☐ Optum Frontier Therapies ☐ CVS Specialty

I. Patient HIPAA Authorization for Use and Disclosure of Protected Health Information
I have read, understand, and agree to the Patient HIPAA Authorization for Use and Disclosure of Protected Health Information on page 2.
Signature of Patient or Authorized Representative: | Date (MM/DD/YYYY):

C — **II. Patient Consent to Participate in ACT**
I have read, understand, and agree to the Patient Consent to Participate in ACT on page 3.
Signature of Patient or Authorized Representative: | Date (MM/DD/YYYY):

III. ☐ **I opt in to receive marketing communications**
Authority of Authorized Representative to Sign for Patient (if applicable): ☐ Healthcare Proxy ☐ Power of Attorney ☐ Other:

2. Healthcare Professional Information (Healthcare Professional Section)

First Name: | Last Name: | Specialty: | NPI #: | Practice Name: | Tax ID #:

Address: | City: | State: | Zip Code:

Office Contact Name: | Office Contact Email Address: | Office Phone #: | Office Fax #:

3. Statement of Medical Necessity (Healthcare Professional Section)

☐ **Primary diagnosis:** ICD-10 G12.21 (ALS) ☐ **ALS Diagnosis:** Date of Diagnosis:

Current or Most Recent Treatment: ☐ Edaravone: Date (MM/DD/YYYY): Duration: ☐ Riluzole: Date (MM/DD/YYYY): Duration: ☐ Other: Date (MM/DD/YYYY): Duration:

Allergies:

4. Prescription Information (Healthcare Professional Section)

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Maintenance Rx: ☐ Dispense **1** 56-Count Carton of RELYVRIO (28-day supply) (NDC 7306303503), with # of refills (maximum 11 refills), for ongoing maintenance.
Instruction for Use: Take 1 packet in the morning and 1 packet at night (1 packet should be mixed with approximately 1 cup (8 oz) of room temperature water).

D — Administration: ☐ Oral ☐ Via feeding tube
Other Instructions:
☐ **Dispense as Written**
Signature: | Date (MM/DD/YYYY):
OR
☐ **Substitutions Permissible**
Signature: | Date (MM/DD/YYYY):

Interim Access Program (Optional, at no cost to patient; For commercially insured patients only*)
☐ Yes, I authorize Amylyx to provide up to **two** months of RELYVRIO to the above-named patient at no cost until the patient's prescription coverage is secured. I authorize Amylyx to forward this prescription to the Interim Access Program designated pharmacy to dispense RELYVRIO directly to the above-named patient. I understand that patient signatures for the Patient HIPAA Authorization for Use and Disclosure of Protected Health Information and Patient Consent to Participate in ACT are needed to expedite enrollment in the Interim Access Program.

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E — Print Name: | Healthcare Professional Signature: | Date (MM/DD/YYYY):

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Top 3 reasons for processing delays

1. Missing HCP signatures
2. Missing patient signatures
3. Incomplete insurance information

How to submit the RELYVRIO™ Enrollment Form

relyvrio™
(sodium phenylbutyrate and taurursodiol) for oral suspension 3 g/1 g

ALMOST **THERE**

Complete the RELYVRIO Enrollment Form and fax it to

844-283-0375

Download an electronic version of the RELYVRIO Enrollment Form at **AmylyxCareTeam.com**

Need assistance or more information?

Call ACT Today

866-318-2989

Monday-Friday, 8 AM to 8 PM ET

ACT™ Amylyx Care Team

ACT™
Amylyx Care Team

Ouriel
ACT Care Coordinator

To help your patients start and find support while on RELYVRIO™ (sodium phenylbutyrate and taurursodiol)

ACT™ provides personalized support throughout the treatment process

- Helps patients understand their insurance coverage and benefits
- Offers resources to support access, including a $0 Co-Pay Program, Interim Access Program, and Patient Assistance Program*
- Provides additional educational product support from registered nurses
- Partners with specialty pharmacies to coordinate medication delivery to your patient's home

Learn more about ACT
AmylyxCareTeam.com

*Out-of-pocket costs related to medication, appointments, evaluations, testing, or other related services are not covered by the RELYVRIO Co-Pay Program. The RELYVRIO Co-Pay Program is not available for prescriptions purchased under Medicare, Medicaid, TRICARE, or other federal- and state-funded programs. Amylyx reserves the right to amend or terminate the Program at any time without notice. Co-pay amounts after applying co-pay assistance may depend on the patient's insurance plan and may vary. The RELYVRIO Co-Pay Program is intended to help patients afford RELYVRIO.

AMYLYX
Rooted in Connection

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