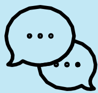
SENTYNL CARES | Zokinvy® (lonafarnib) capsules 50 mg/75 mg

The Sentynl Cares program

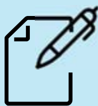
Provided by Sentynl Therapeutics, Inc. to help bring ZOKINVY to those who need it.

Instructions for Prescribers



Discuss the Sentynl Cares program with your patient's parents or caregivers

Once enrolled in the program the patient is evaluated for access options based on individual needs



Fill out practice information, including:

- NPI number
- Primary facility contact information
- Hospital information if applicable

Indicate prescription information and sign, including:

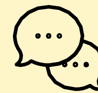
- ICD-10 codes and other related information

Sign, where applicable, for all program opportunities

Fax completed form to Sentynl Cares: 877-977-0011, including:

- All completed and signed pages (9)
- Medical coverage information

Instructions for Parents/Caregivers

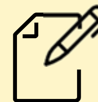


Discuss the Sentynl Cares application with your healthcare provider

Sentynl Cares offers programs that provide a high level of support during every step of the treatment journey

Read and sign to give consent for access to Sentynl Cares

- Insurance benefits verification and appeals support
- Patient affordability programs, which can help qualified patients get ZOKINVY



Provide insurance and contact information, including:

- Primary and secondary insurance information
- Medical and pharmacy information
- Preferred method of contact for follow-up

Please call 1-888-251-2800 with any questions

Sentynl Therapeutics, Inc. reserves the right to modify or discontinue the Sentynl Cares program at any time.

ZOKINVY is a trademark of Sentynl Therapeutics, Inc.

ZOKINVY Enrollment Form

To access program benefits for ZOKINVY, you must enroll in the Sentynl Cares | ZOKINVY Patient Access and Support Program. Print and fax completed and signed enrollment forms to 877-977-0011.
All pages must be received to process enrollment.

Phone: 1-888-251-2800
Fax: 877-977-0011
Web: ZOKINVY.com/sentynlcares

SUPPORT OFFERED TO PATIENT AND/OR THEIR CAREGIVER

In addition to dispensing your medication, the Sentynl Cares | ZOKINVY Patient Access and Support Program is your source to help you feel supported on your child's path with ZOKINVY.

Based on your selections below, your child will be enrolled in the Sentynl Cares | ZOKINVY Patient Access and Support Program (the "Program").

Sentynl Therapeutics, Inc. has designed this Program to help you learn more about your child's condition and treatment and to help your child get started on and throughout their ZOKINVY treatment journey.

Please complete the form and let us know which features of the Program you would like to be enrolled in by checking the relevant box(es) and signing below:

☐ **By checking this box, the patient will be evaluated for all features of the Program listed below and is opting in to receive program-related communications (e.g., phone, email, mail) as specified by your selections below. Otherwise, please check the program features below that you are interested in being evaluated for.**

☐ **Insurance Support and Financial Assistance**
May include benefits verification, prior authorization, appeals support, and presentation of potential financial assistance options. Additional information may be required to determine eligibility.

☐ **ZOKINVY Copay Assistance Program**
Helps patients manage out-of-pocket copay coinsurance costs for those with commercial insurance. This offer is not valid for prescriptions reimbursed under Medicaid, a Medicare drug benefit plan, or other federal or state programs (such as medical assistance programs).

☐ **Nurse and Educational Support**
Sentynl Cares clinical staff may provide educational information on your child's condition and information on ZOKINVY.

Please check your preferred method(s) of contact and list your contact information below:

☐ Mail Preferred Mailing Address: ______________________________

☐ Email Preferred Email Address: ______________________________

☐ Telephone Preferred Telephone Number: ______________________________

PATIENT/CAREGIVER CONSENT TO ENROLL IN SENTYNL CARES | ZOKINVY PATIENT ACCESS AND SUPPORT PROGRAM

By signing below, I agree to enroll in the features of the Program specified by my selection(s) above. I hereby agree to receive any Program-related communications necessary to fulfill the requirements of the Program, as specified above. I consent to the processing of any information provided herein or in connection with the Program for the purposes contemplated herein, consistent with this form [and the Sentynl privacy policy].

SIGN HERE

______________________________	______________________________	______________
Parent/Caregiver or Legal Representative	Print Name	Date

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PATIENT & CAREGIVER AUTHORIZATION TO SHARE HEALTH INFORMATION

By signing below, I authorize my healthcare providers, insurers, and pharmacies ("Healthcare team") to disclose my personal health information ("Health Information") to Sentynl Therapeutics, Inc., the pharmacy Biologics, Inc., and other third parties supporting the administration of the Sentynl Cares | ZOKINVY Patient Access and Support Program (the "Program") (together, the "Parties"). Health Information includes information such as: (1) name, address, telephone, and other personal and contact information, (2) health insurance coverage-related information, and (3) information related to my medical condition, treatment, and care management. Once my Health Information has been disclosed to the Parties, I understand that federal privacy laws may no longer protect it from further disclosure.

I authorize the Parties to use my Health Information for the following purposes:

- Enrolling me in the Program
- Providing me with educational information, nursing educational calls (if selected), and other treatment-related educational support
- Verifying, investigating, assisting, and helping with coordinating my health insurance coverage for ZOKINVY
- Assessing my initial and continued eligibility for various financial assistance programs
- Coordinating prescription fulfillment
- Contacting me regarding the Program
- Providing any other support to me under the Program
- Assisting with analyses related to the use of ZOKINVY
- Running the Program; and
- Undertaking other internal business activities.

I understand that I may refuse to sign this Authorization, that I may refuse to disclose all or some of my Information, and that a refusal to sign will not affect my ability to obtain medical care, insurance coverage, or access to health benefits including my prescription for ZOKINVY. However, if I do not sign this Authorization, I understand I will not be able to participate in the Program. Once signed, unless I cancel this Authorization sooner or unless otherwise required by state or local law, this Authorization will expire on / /20____ (mm/dd/yyyy), or ten (10) years from the date of signature on this Authorization, whichever occurs first. I may cancel this Authorization at any time by writing to Sentynl Cares | ZOKINVY at 11800 Weston Parkway, Cary, NC 27513, or by sending an email to ZOKINVY@mckesson.com. I understand that canceling this Authorization will end my participation in the Program and will not affect any use or disclosure of the Information made before my request is received and processed.

I understand that I have a right to receive a copy of this Authorization when it is signed.

SIGN HERE

Parent/Caregiver or Legal Representative	Print Name	Date

OPTIONAL PATIENT/CAREGIVER AUTHORIZATION TO RECEIVE COMMUNICATIONS FROM SENTYNL THERAPEUTICS, INC. REGARDING SENTYNL PROGRAMS AND INITIATIVES

Sentynl Therapeutics, Inc. ("Sentynl" or "we"), the manufacturer of ZOKINVY, would like to reach out to you regarding Sentynl programs and initiatives, such as opportunities to share your personal health journey, disease-state awareness/educational materials, patient advocacy opportunities, and other topics of interest.

We will not sell or share any personal information you disclose pursuant to this authorization ("Personal Information") to any third party, except for (1) Sentynl Affiliates (as defined below) or (2) regulatory authorities, as appropriate, without your express permission. We may contact you to ask about your experience with Sentynl and/or its products.

I authorize Sentynl and companies contracted or affiliated with Sentynl ("Affiliates") to contact me by mail, email, and/or telephone to provide me with the information I requested as specified by my selections below. I understand that I am not required to provide this consent as a condition of purchasing any property, goods, or services from Sentynl. I also understand that I may participate in the Sentynl Cares | ZOKINVY Patient Access and Support Program if I do not sign this optional authorization. To learn more about how your information is used or if you decide that you no longer wish to receive information about Sentynl programs and initiatives, please visit our privacy policy at Sentynl.com.

Check all that apply:

☐ Check here if you are interested in sharing your story and/or experience with others. By checking this box, I understand that a representative from Sentynl may contact me to discuss my personal health journey at my preferred method(s) of contact listed below.

☐ Check here if you are interested in receiving communications from Sentynl regarding patient advocacy opportunities. By checking this box, I understand that a representative from Sentynl may contact me to discuss patient advocacy opportunities at my preferred method(s) of contact listed below.

Please check your preferred method(s) of contact and list your contact information below:

☐ Mail Preferred Mailing Address: ______________________________

☐ Email Preferred Email Address: ______________________________

☐ Telephone Preferred Telephone Number: ______________________________

SIGN HERE

______________________________	______________________________	______________
Parent/Caregiver or Legal Representative	Print Name	Date

PATIENT INFORMATION

Name: ____________________ (First, MI, Last) DOB: __________ (mm/dd/yyyy)

Street: ____________________

City: ____________________ State: ______ ZIP: __________

Gender: ☐ Male ☐ Female Today's Date: __________ Current Weight: __________

PARENT/CAREGIVER INFORMATION (PARTY RESPONSIBLE FOR PATIENT)

Parent/Caregiver Name: ____________________ (First, MI, Last)

Relationship to Patient: ____________________

Primary Phone: __________ Primary Email: __________

I consent to allow Sentynl Cares to leave me a voicemail about access information.: ☐ Yes ☐ No

Primary Email: ____________________

Street: ____________________

City: __________ State: __________ ZIP: __________

DOB: __________ (mm/dd/yyyy) Gender: ☐ Male ☐ Female Preferred Language (If Not English): __________

Additional Contact Permitted to Receive Patient Information

Name: ____________________

Email: ____________________

Relationship to Patient: ____________________

Phone: ____________________

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PRIMARY INSURANCE INFORMATION

Please attach copies (front and back) of all available insurance and prescriptions card.

No Insurance? ☐

Note that Sentynl may request additional information from uninsured patients to determine if patients are eligible for other coverage or funding (such as enrollment in Medicaid).

Primary Medical Insurance Name: ____________________

Insurance Phone: ____________________

Policy ID#: ____________________

Group #: ____________________

Primary Rx Insurance Name (If Different): ____________________

Rx Insurance Phone: ____________________

Policy ID#: ____________________

Group #: ____________________

Rx Bin #: ____________________

Rx PCN #: ____________________

Relationship to Patient: ____________________

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Please attach copies (front and back) of all available insurance and prescriptions cards.

Secondary Medical Insurance Name: ____________________

Insurance Phone: ____________________

Policy ID#: ____________________

Group #: ____________________

Secondary Rx Insurance Name (If Different): ____________________

Rx Insurance Phone: ____________________

Policy ID#: ____________________

Group #: ____________________

Rx Bin #: ____________________

Rx PCN #: ____________________

Relationship to Patient: ____________________

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PRESCRIBER INFORMATION (PRESCRIBER TO FILL OUT)

Prescriber Name: ______________________ Facility/Site Name: ______________________

Facility/Site Contact: ______________________ Business Hours: ______________________

Address (Street, City, State, Zip): ______________________

Phone: ______________ Fax: ______________ Email: ______________

Tax ID: ______________ NPI#: ______________

State License #: ______________ Expiration: (mm/yyyy): ______________ DEA #: ______________

Specialty: ______________

Best Time to Contact: ______________

SIGN HERE ______________________ ______________________ ______________

Prescriber Signature Required – No Stamps | Print Name | Date

DIAGNOSIS AND ICD-10 CODE

Diagnosis: ______________________

ICD-10 Code: ______________________

TREATMENT AND PRESCRIPTION INFORMATION

Fill out this section to write your patient's prescription.
Below is a prescription for ZOKINVY. Please submit a separate prescription if required by state law (e.g., New York prescribers).
Dosage recommendations appear on the following page.
Prescriber is responsible for complying with applicable state-specific prescription requirements, such as e-prescribing, state-specific prescription form, or fax language. Note that noncompliance with state-specific requirements could result in outreach to the prescriber.

Prescription for ZOKINVY

Distributed by: Sentynl Therapeutics, Inc.

PRESCRIPTION INFORMATION		* indicates required
Patient's Full Name:		
Date of Birth (MM/DD/YYYY):	**BSA (m^2)**	**Dosage (mg):**
ZOKINVY Capsules Prescription*: Please check box/sign for each prescribed Strength/NDC		

☐ **ZOKINVY 50 mg Capsules**	☐ **ZOKINVY 75 mg Capsules**
Directions:______________________	**Directions:**______________________
Quantity:__________**Refills:**__________	**Quantity:**__________**Refills:**__________
Date: __________	**Date:** __________
Dispense as Written: (Prescriber Signature) **X** __________	**Dispense as Written:** (Prescriber Signature) **X** __________
----or----	*----or----*
Substitution Allowed: (Prescriber Signature) **X** __________	**Substitution Allowed:** (Prescriber Signature) **X** __________

I certify that (1) to the best of my knowledge, the information provided in this form is current, complete, and accurate; (2) the prescribed medication is medically necessary for this patient and the decision to prescribe the medication was based solely on my independent medical judgment; (2) no claims involving this medication will be submitted to any third party (such as Medicare or Medicaid, or private health plans) for reimbursement; (3) support provided to or for my patient by the Sentynl Cares | ZOKINVY Patient Access and Support Program (the "Program") is not provided in exchange for any express or implied agreement or understanding that I will recommend, prescribe, or use any Sentynl product or service; and (4) I have obtained any necessary consents or authorizations from my patient or their legal representative to provide the information contained in this form to the Program. I understand that Sentynl may reach out to me for further information or in connection with the administration of the Program.

If my patient is eligible for free product, I understand that receiving free product is not contingent on any purchase obligations. I also understand that no claims for free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; nor should it be sold, traded, bartered, transferred, or distributed for sale. I will notify the Sentynl Cares | ZOKINVY Patient Access and Support Program immediately if ZOKINVY is no longer medically necessary for this patient's treatment or if my patient's insurance status changes.

SIGN HERE

______________________	______________________	__________
Prescriber Signature Required – No Stamps	Print Name	Date

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DOSAGE RECOMMENDATIONS

Table 1 provides the BSA-based dosage recommendations for the recommended starting dosage of 115 mg/m^2 twice daily.

Table 1: Recommended Dosage and Administration for 115 mg/m^2 Body Surface Area-Based Dosing[1]

BSA (m^2)	Total Daily Dosage Rounded to Nearest 25 mg	Morning Dosing Number of Capsule(s)		Evening Dosing Number of Capsule(s)	
		ZOKINVY 50 mg	ZOKINVY 75 mg	ZOKINVY 50 mg	ZOKINVY 75 mg
0.39-0.48	100	1		1	
0.49-0.59	125		1	1	
0.6-0.7	150		1		1
0.71-0.81	175	2			1
0.82-0.92	200	2		2	
0.93-1	225	1	1	2	

Table 2 provides the BSA-based dosage recommendations for the recommended dosage of 150 mg/m^2 twice daily.

Table 2: Recommended Dosage and Administration for 150 mg/m^2 Body Surface Area-Based Dosing[1]

BSA (m^2)	Total Daily Dosage Rounded to Nearest 25 mg	Morning Dosing Number of Capsule(s)		Evening Dosing Number of Capsule(s)	
		ZOKINVY 50 mg	ZOKINVY 75 mg	ZOKINVY 50 mg	ZOKINVY 75 mg
0.39-0.45	125		1	1	
0.46-0.54	150		1		1
0.55-0.62	175	2			1
0.63-0.7	200	2		2	
0.71-0.79	225	1	1	2	
0.8-0.87	250	1	1	1	1
0.88-0.95	275		2	1	1
0.96-1	300		2		2

1. ZOKINVY [prescribing information] https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=956a142f-35d6-4fe3-8aef-7e4878d275ed

ZOKINVY.com
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