Thank you for downloading this patient assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER - Send your completed application to address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the **"Patient Savings"** tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.

- **Free, Low Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low cost, and sliding scale medical and dental clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.

- **Coupons, Rebates & More** — You can use the NeedyMeds website to find nearly 2,000 cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.

- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. To date, our drug discount card has saved patients over $244,000,000. Check out the next page to learn more.

Feel free to call our toll-free helpline if you have any questions. You can reach us at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thanks for using NeedyMeds! Please let us know if we can do anything else to help you afford the costs of your healthcare.

Richard J. Sagall, MD
President, NeedyMeds

Clip the card and save

NeedyMeds
NeedyMeds.org

DRUG DISCOUNT CARD

BIN: 020750
RX PCN: NMeds
RX GRP: PDFPDF
ID: NMNA019309901930

Customer Care
1-888-602-2978

This is a drug discount program, not an insurance plan.

NeedyMeds Drug Discount Card
www.needymeds.org

Patient: You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com.

Pharmacist: Administered by Medical Security Company, LLC, Tucson, AZ.

Pharmacy Help Desk: 1-800-404-1031.

Powered by ScriptSave® WellRx

- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family
- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

You can also save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
PO Box 219
Gloucester, MA 01931

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

Reset Form

EPIDIOLEX® (cannabidiol) Patient Support Program

Start Form

Epidiolex engage™ by Greenwich Biosciences

Complete all requested information below to help your patients get started on treatment. All fields are required, unless the information is being provided on an accompanying EMR face sheet (or the like). If submitting directly to a Specialty Pharmacy, the appropriate prescription, in accordance with state-specific requirements, must be submitted separately from this start form.

SECTION 1: PATIENT INFORMATION

Patient First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Gender: ☐Male ☐Female Height: _____ Weight: _____ kg

Current Medications: _____

Known Allergies: _____ ☐No Known Allergies

Diagnosis:

The diagnosis designations below are intended to ensure communication of accurate information to your patient's insurance plan. **EPIDIOLEX is approved to treat seizures associated with Lennox-Gastaut syndrome or Dravet syndrome in patients 2 years of age and older.** See accompanying Prescribing Information.

Seizures associated with: ☐Lennox-Gastaut syndrome ☐Dravet syndrome

ICD-10 Code: _____ ☐Other (please specify) _____

If choosing "Other" and this medication is being prescribed for a use that is not listed on the FDA-approved label, by signing this patient start form and initialing here, I certify that the Prescriber has determined that EPIDIOLEX is medically necessary and appropriate for this patient and this patient's treatment will be supervised. **Healthcare Provider's Initials:** _____ **Date:** _____

Patient Address: _____ City/State/Zip Code: _____

Group Home/Long-term Care Facility? ☐Y ☐N If yes, facility name and contact: _____

Full Name(s) of Legal Guardian(s): _____

Primary Phone: _____ ☐Home ☐Mobile ☐Other Email: _____

Secondary Phone: _____ ☐Home ☐Mobile ☐Other

SECTION 2: INSURANCE INFORMATION *(only required if submitting directly to a Specialty Pharmacy)*

Please provide a copy of the front and back of all prescription and medical benefit insurance cards.

Prescription Drug Insurance Provider: ☐**Patient has no prescription drug coverage**

Insurer Name: _____ Insurer Phone: _____

Rx ID #: _____ Rx BIN: _____ Rx PCN: _____

Rx Group #: _____ Cardholder Name: _____ Date of Birth: _____

Patient's relationship to cardholder: ☐Self ☐Spouse ☐Child ☐Other _____

Does the patient have other health insurance? ☐Y ☐N

Other Insurance Provider Name: _____

Policy ID #: _____ Group #: _____

Insurer Phone: _____ Cardholder Name: _____ Date of Birth: _____

Patient's relationship to cardholder: ☐Self ☐Spouse ☐Child ☐Other _____

SECTION 3: HEALTHCARE PROVIDER INFORMATION AND AUTHORIZATION

Prescriber Name: _____ Title: _____ Specialty: _____ NPI #: _____

DEA License #: _____ State License #: _____ Tax ID #: _____ Medicaid Provider #: _____

Office Contact Name: _____ Contact Phone: _____

Contact Fax: _____ Contact Email: _____

Preferred method of contact: Primary: ☐Phone ☐Fax ☐Email Secondary: ☐Phone ☐Fax ☐Email

Office Address: _____ City/State/Zip Code: _____

As the undersigned Prescriber, or the Prescriber's Designated Agent, I hereby authorize the use or disclosure of the patient's health information contained on this start form to the patient's other healthcare providers (including pharmacies and Greenwich Biosciences, Inc.), their respective agents and contractors and other designees that are involved in the patient's treatment ("Providers") and health plans or insurers and their respective agents and designees ("Insurers") to: (1) determine the patient's insurance benefits for EPIDIOLEX; (2) transmit the necessary information to a pharmacy that will fill the patient's prescription, and to obtain information from the pharmacy regarding delivery of such prescribed medication and related matters; (3) contact the patient to obtain any necessary signatures, consents or information relating to the patient's treatment; (4) contact the patient in order to ask whether the patient would like to apply for the Greenwich Biosciences Patient Assistance Program, and to request information from the patient or from patient's designees needed to determine eligibility for the program; and (5) to provide other related care coordination services.

I certify that the patient's authorization to use and disclose the patient's personally identifiable health information for the purposes permitted under this "Healthcare Provider Authorization" section has been obtained, as required by HIPAA. I agree that the patient's Providers and Insurers may contact the Prescriber or the Designated Agent, as applicable, for additional information as needed relating to the patient's EPIDIOLEX therapy. The undersigned certifies that: (1) the Prescriber has prescribed EPIDIOLEX for the identified patient; (2) the Prescriber has determined that EPIDIOLEX is medically necessary for this patient; (3) if the undersigned is a "Designated Agent", such person is duly authorized by the Prescriber to sign this "Healthcare Provider Authorization" on the Prescriber's behalf, in accordance with applicable law and medical standards; and (4) the information provided on this form is accurate to the best of their knowledge.

Signature: _____ **Date:** _____ **Name/Title (if Designated Agent):** _____

Please fax the completed form, as well as the front and back of the patient's insurance cards, to one of the Epidiolex Engage Program providers below. If submitting directly to a Specialty Pharmacy, the appropriate prescription must also be submitted by fax or eRx.

	FAX	ADDRESS FOR eRx TRANSMISSION
AcariaHealth	1-877-541-1503	1311 West Sam Houston Pkwy, N #130 Houston, TX 77043
Accredo	1-888-302-1028	1640 Century Center Parkway Memphis, TN 38134
AllianceRx Walgreens Prime	1-877-231-8302	130 Enterprise Drive Pittsburgh, PA 15275
Amber Pharmacy	1-402-896-3774	10004 South 152nd Street Omaha, NE 68138
CVS Specialty	1-844-691-1343	800 Biermann Court, Suite B Mount Prospect, IL 60056
OR		
Epidiolex Engage™	1-855-518-7566	Prescription not required for submission to Epidiolex Engage

SECTION 4: HIPAA PATIENT AUTHORIZATION*

By signing this HIPAA Patient Authorization Form ("Authorization"), I hereby request and authorize my physicians, my pharmacists (including any specialty pharmacy that receives my prescription for EPIDIOLEX) and other healthcare providers ("Providers"), and my health insurers ("Insurers") and their respective agents and contractors, to disclose my protected health information, including but not limited to, information related to my medical condition and treatment (including prescription information), my health insurance coverage and policy number, my name, mailing and e-mail address(es), telephone number, date of birth and Social Security Number ("Protected Health Information" or "PHI"), to Greenwich Biosciences, Inc. and its affiliates, and their respective agents and contractors (collectively, "Greenwich Biosciences") for the following purposes: (i) to contact me, my personal representative(s), guardian(s) or designees, my Providers, Insurers or others I have identified, about my disease or treatment (including EPIDIOLEX); (ii) to provide me with information about support and patient assistance programs and services offered by Greenwich Biosciences; and (iii) to improve or develop products (including EPIDIOLEX), services, programs, or treatment related to my disease; (iv) to de-identify my PHI or combine it with other data for research or analysis. I understand that my pharmacy provider may receive remuneration from Greenwich Biosciences in exchange for sharing information or for my pharmacy providing any support services to me.

I understand that once my PHI has been disclosed to Greenwich Biosciences, my information may be protected by certain state privacy laws but may no longer be protected under federal privacy laws and that my PHI may be subject to re-disclosure. I understand that Greenwich Biosciences will not sell my name, address, e-mail address, or any other information to another party for their own marketing use. I understand that I am not required to agree to this Authorization. If I do not agree, my treatment (including receipt of EPIDIOLEX), payment for my treatment, or eligibility for insurance benefits will not be affected, but I may not receive the other services described above.

I understand that I may cancel this Authorization at any time by: faxing my cancellation to 1-855-518-7566, calling 1-833-GBNGAGE (1-833-426-4243) or mailing a letter to PO Box 5490, Louisville, KY 40255. The Greenwich Biosciences representative shall provide timely notification of my cancellation to the applicable parties. Once they receive and process the notice of cancellation of this Authorization, the applicable parties may no longer share my PHI with Greenwich Biosciences as permitted by this Authorization. However, cancelling this Authorization will not affect any action(s) taken by applicable parties based on this Authorization before receipt of my notice of cancellation. This Authorization will expire in five (5) years from the date this Authorization is signed below, unless a shorter period is required by law of my state of residence. I understand that I have a right to request and to receive a copy of this Authorization.

By signing below, I am indicating that I have read and understood the information set forth in this Authorization.

Patient Name:_____ Date of Birth:_____

Signature of Patient or Guardian, if Applicable:_____ Date: _____

Name (if Different from Patient): _____ Relationship to Patient:_____

Email:_____ Phone: _____

*HIPAA patient authorization is also available in Spanish at: www.EPIDIOLEXhcp.com/HIPAASpanish.

For additional assistance, call us at 1-833-GBNGAGE (1-833-426-4243). Please see accompanying full Prescribing Information.