INVIVYD care
www.invivydcare.com

ENROLLMENT FORM

For questions and assistance, call 844-VYD-2220 (844-893-2220) or email, InvivydCare@7bspecialty.com, Monday - Friday: 8am- 8pm ET

To initiate enrollment, fax completed form to (855) 233-1706 or complete form online by following QR code.

Fields with an * are required to initiate enrollment.

Submitted By: ☐ Provider ☐ Patient ☐ Infusion Center

SECTION 1: PATIENT INFORMATION

Patient Name*: _____ Gender*: ○ Male ○ Female ○ Unspecified
Street Address*: _____ City*: _____ State:* _____ ZIP Code*: _____
Date of Birth*: (MM/DD/YYYY) _____ Phone Number*: _____
Email*: _____ Check here to opt-in to text messaging/I consent to receive text messages from Invivyd Care
Primary Language Preference: _____
Need assistance locating a provider Need assistance locating an infusion site/facility
(If applicable) Primary Contact Legal Guardian/Caregiver Name: _____ Relationship to Patient: _____
Treating Physician Name: _____ Treating Physician Phone Number: _____

Marketing Communications

I would like to receive marketing and other communications from Invivyd†

† By checking this box, I agree that Invivyd, Inc. and its vendor partners may use the information I am submitting to provide me with updates via email or text about Invivyd products, including PEMGARDA®, and related programs, services, special opportunities, disease state education, and general health information that Invivyd believes may be of interest to me. I understand that all personal information I have submitted will be used and kept confidential in accordance with Invivyd's Privacy Policy, and I agree to the Terms of Use. Providing this consent is not required or a condition of purchasing any products or services. Message frequency varies.

Insurance Information (complete section in its entirety or include a copy of the patient's insurance card [front and back])

Primary Insurance Name*: _____
Policy Number*: _____
Group Number: _____
Policy Holder Name*: _____
Insurance Phone Number*: _____

Secondary Insurance Name: _____
Policy Number: _____
Group Number: _____
Policy Holder Name: _____
Insurance Phone Number: _____
Need assistance with authorization/predetermination denial support

SECTION 2: PRESCRIBER INFORMATION (TO BE COMPLETED BY THE PRESCRIBER)

Prescriber Name: _____ MD DO NP PA Other: _____
Prescriber Billing NPI: _____ Prescriber Tax ID: _____ Specialty: _____
Practice/Facility Name: _____
Street Address: _____ City: _____ State: _____ ZIP Code: _____
Facility NPI: _____ Facility Tax ID : _____ Facility Phone: _____ Fax: _____
Primary Contact (if applicable) Name: _____ Phone Number: _____
Email: _____ Communication preference: Email Fax Phone Text _____

Prescription Information

Primary ICD 10: _____ Secondary ICD 10: _____
Dispense PEMGARDA 125mg/ml/HCPCS Code: Q0224 per unit. 1 unit=9 vials Initial Dose: Infuse 4500 mg intravenously Qty: 9 x 500mg/4ml Vials
Maintenance: Infuse 4500 mg intravenously approximately every 90 days from the date of the most recent PEMGARDA dose Refills: _____
DAW (Dispense as Written) Targeted Treatment Date: _____

SIGN HERE **Prescriber Signature*:** _____ **Date:** _____
No Stamp Allowed

I certify that I am the healthcare professional who has prescribed the therapy identified in this form. I further certify that I have made an independent judgment that the above therapy is medically necessary and that the information provided in this form is accurate to the best of my knowledge. I authorize Invivyd, and its affiliates, agents, representatives, and service providers to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy. I also give my permission to receive calls related to Program services from Invivyd, Invivyd Care, and parties acting on their behalf.

SECTION 3: INTENDED SITE OF ADMINISTRATION/INFUSION (TO BE COMPLETED BY THE PRESCRIBER)

Please coordinate with: Healthcare Provider Office Site of Administration Infusion Center Patient Outpatient Facility Home
Facility Name: _____
Primary Site Contact: _____ NPI: _____ Tax ID: _____
Contact Phone: _____ Contact Email: _____
Street Address: _____ City: _____ State: _____ ZIP Code: _____
Communication preference: Email Fax Phone _____

SECTION 4: CONSENT TO COLLECT AND USE PERSONAL DATA

Invivyd Inc. ("Invivyd") collects certain Personal Data (described below) about individuals so that it may provide patient support services to eligible patients through the Invivyd Care Patient Support Program (the "Program"). Invivyd is seeking this consent because it needs to collect and use such data, which is considered sensitive data in some jurisdictions, in connection with operation of the Program.

Personal Data Collected and/or Used. The Personal Data Invivyd and its service providers may collect and use includes name, patient identifier, test results, medical records, healthcare provider information, other data that identifies that you are seeking health care services, and data otherwise related to your health condition, diagnosis, and/or treatment (collectively "Personal Data").

Purposes of Collection and Use. Your Personal Data will be used for the following purposes: Your Personal Data will be used by Invivyd who will provide patient support services to eligible patients including, where applicable, determining eligibility for copay support.

Duration. By signing this consent to collect and use, I agree that these entities may use the Personal Data to provide applicable patient support services or as permitted or required by applicable privacy laws. I permit such use for five years after the date I sign the consent, unless and until I revoke (i.e., take back) it in writing prior to that time.

Revocation. I may revoke my consent at any time, except to the extent that Invivyd has taken any action in reliance on my consent. I understand that if I revoke my consent, it will not have any effect on any collection, uses, or disclosures of my Personal Data that occurred prior to receiving my revocation. To revoke, I understand that I must notify Invivyd Care by emailing InvivydCare@7bspecialty.com or by calling 844-893-2220, M-F 8AM–8PM ET.

SECTION 5: HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Invivyd Pharmaceuticals, Inc. ("Invivyd") offers patient services including educational resources, case management support, and financial assistance for eligible patients.

I authorize (i.e., allow) the use and/or disclosure of my Protected Health Information, described below, which is protected under a federal law known as the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). In general, Protected Health Information is information, including demographic information, which (1) relates to my past, present, or future physical or mental health or condition, the provision of health care to me, or the past, present, or future payment for the provision of health care to me, and (2) that identifies me or for which there is a reasonable basis to believe can be used to identify me. I understand that this authorization is voluntary.

By signing the next page, I give permission for my healthcare providers, health plans, other insurance programs, pharmacies, and other healthcare service providers ("My Healthcare Entities") to share information, including protected health information relating to my medical condition, treatment, and health insurance coverage (collectively "My Information") with Invivyd, and companies working at its direction. My Information that may be used and/or disclosed includes my name, patient identifier, test results, medical records, healthcare provider information, other data that identifies that I am seeking health care services, and data otherwise related to my health condition, diagnosis, and/or treatment.

Invivyd may use and disclose My Information for the following purposes:

- Enrolling into "Invivyd Care," a support resource to assist in questions regarding the coordination of insurance coverage for Invivyd products, access to Invivyd products or to provide educational information regarding use of Invivyd products or disease awareness
- Providing updates regarding the status of my insurance coverage, including reasons for any insurance denial, to me and my healthcare provider and review my insurance coverage and eligibility for benefits for treatment with an Invivyd product
- Informing you of nearby infusion centers or home infusion providers, based on your insurance plan
- Educating and following up on patient logistics for scheduled infusion appointments
- Communicating with my Healthcare Entities about an Invivyd medicine and Invivyd Care activities
- Reviewing my infusion history and provide corresponding patient support related to treatment coordination and follow-up
- Invivyd also may use My Information for quality assurance purposes and to evaluate and improve their operations and services
- Supporting my prescribed Invivyd treatment, marketing, data collection, research, quality assurance, surveys, and other business activities in connection with Invivyd products. This information may be de-identified and combined with other data for use in research, regulatory submissions, business improvement initiatives, and publication purposes

I understand that My Information is also subject to the Invivyd Privacy Notice available at https://www.invivyd.com/privacy/, and that the Invivyd Privacy Notice provides additional information about Invivyd's privacy practices and the rights that may be available to me. Although Invivyd has implemented privacy and security controls designed to help protect My Information, I understand that persons or entities that receive my Protected Health Information under this authorization may not be required by privacy laws (such as HIPAA) to protect the information and they may share it with others without my permission, if permitted by laws that are applicable to them.

I understand that I may refuse to sign this Authorization and that My Healthcare Entities may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. I also understand that if I do not sign this Authorization, I will not be able to receive support through the Invivyd Care Patient Support Program.

This Authorization expires five (5) years from the date next to my signature, unless I cancel/revoke it sooner, or unless a shorter time frame is required by applicable law. I understand that I may revoke my authorization, or unsubscribe or modify the services I receive, at any time by mailing a letter to Invivyd Invivyd Care Patient Support Program, 205 Church Street, Unit PHF, New Haven, CT 06510 or by emailing InvivydCare@7bspecialty.com. I also understand that modifying my authorization will not affect any use or disclosure of My Information that occurred before Invivyd received notice of my cancellation. I also understand I have a right to receive a copy of this Authorization after it is signed and can request a copy at any time by contacting Invivyd Care at 844-893-2220.

Patient Consents and Signatures (To be completed by patient or legal representative)

My signature below certifies that I have read and/or had the contents read to me of Sections 4 and 5 above and agree to the Consent to Collect and Use Personal Data and the HIPAA Authorization for Use and Disclosure of Protected Health Information

SIGN HERE **Patient or Legal Representative Signature*:**_____ **Date*:**_____

PRINT HERE **Patient or Legal Representative (please print full name)*:** _____

Relationship to Patient, including authority for status as Legal Representative: _____

By signing on behalf of the patient as representative or guardian, I attest that I am legally able to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient may be requested such as power of attorney or legal court order.

Invivyd Care may verbally share my/the patient's medical information with:

PRINT HERE **Name (please print full name):** _____ **Relationship to patient:**_____

SECTION 6: ELIGIBILITY FOR PATIENT SAVINGS PROGRAM

Invivyd Patient Savings Program (To Enroll):

The Invivyd Patient Savings Program provides copay support for Invivyd products for commercially insured patients.

- **Commercial Insurance:** I have commercial health insurance in effect and will utilize this insurance as the primary payer for my healthcare expenses
- **No Government Insurance:** I am not currently enrolled in any government insurance programs, including Medicare, Medicaid, Medigap, VA, DoD, CHAMPUS, TRICARE®, or other federal or state health programs that would cover and seek payment in whole or part
- **Program Eligibility:** I understand that this financial assistance program is intended to supplement, not replace, my existing commercial insurance coverage

I, or as the legal guardian of the Patient, certify that the information provided in this attestation is true and accurate to the best of my knowledge. I have reviewed and agree to the full terms and conditions available at: https://invivydcare.com/media/downloads/Invivyd_Patient_Support_and_Savings_Terms_and_Conditions.pdf. I understand the above information and give consent to the healthcare provider to submit and receive claims payment on my/their behalf. All program claims will be paid directly to the patient's administration site or pharmacy upon receipt of appropriate claim submission. My/their pharmacy or administration site will be responsible for submitting claims directly to the Invivyd Patient Savings Program

I have read and agree to the terms and conditions of the Invivyd Patient Savings Program.

SIGN HERE **Patient or Legal Representative Signature*:**_____ **Date*:**_____

PRINT HERE **Patient or Legal Representative (please print full name)*:** _____