FlexForward® Enrollment Form

Fax completed enrollment form to 1-866-558-7939

FlexForward® Comprehensive Access Support

Zilretta® triamcinolone acetonide extended release injectable suspension 32 mg

Note: Fields marked with * are required.

1. Patient Information

Last name*: _____ First name*: _____

Address*: _____ City*: _____ State*: _____ ZIP*: _____

Cell phone #: _____ Home phone #: _____ Email: _____

Gender*: ❑ Male ❑ Female Date of birth*: _____/_____/_____ SSN (for insurance verification purposes only): _____

2. Prescriber Information

Last name*: _____ First name*: _____

NPI #*: _____ State license #: _____ Tax ID #: _____ DEA #: _____

Office name: _____

Address*: _____ City*: _____ State*: _____ ZIP*: _____

Phone #*: _____ Fax #*: _____

Primary Contact

Last name: _____ First name: _____ Title: _____

Email: _____ Phone #: _____ Fax #: _____

Preferred method of contact: ❑ Phone ❑ FlexForward Portal

3. Insurance Information

❑ **Patient is uninsured**

Attach a copy of both sides of the patient's insurance card(s) and/or fill out the insurance information below.

Is the patient enrolled in a government-funded healthcare program such as Medicare, Medicaid, VA, DoD, TRICARE, a qualified health plan (QHP), or a plan offered under a state or federal exchange?* ❑ Yes ❑ No

Primary Insurance

Plan name*: _____

ID #*: _____ Group #: _____

Plan phone #*: _____

Policy holder: _____

Date of birth of policy holder (if different from patient): _____/_____/_____

Relationship to patient: _____

Secondary Insurance

Plan name: _____

ID #: _____ Group #: _____

Plan phone #: _____

Policy holder: _____

Date of birth of policy holder (if different from patient): _____/_____/_____

Relationship to patient: _____

4. Diagnosis and Clinical Information

ICD-10 Code*: ❑ M17.0 ❑ M17.11 ❑ M17.12 ❑ M17.2 ❑ M17.31 ❑ M17.32 ❑ M17.4 ❑ M17.5 ❑ Other: _____

Select the appropriate injection-site location: ❑ Left knee ❑ Right knee ❑ Bilateral

Clinical Information—Has the patient tried any of the following? (Please check all that apply):

❑ Immediate release intra-articular steroids (date of last injection: _____/_____/_____) ❑ NSAIDS ❑ Analgesics ❑ Physical therapy/exercise program

❑ Other (list all that apply): _____

❑ ZILRETTA (date of last injection: _____/_____/_____) (select previous injection-site location): ❑ Left knee ❑ Right knee ❑ Bilateral

Known drug allergies and notes: _____

5. Prescription Information

ZILRETTA® (triamcinolone acetonide extended-release injectable suspension), 32 mg (5 mL) **Quantity:** _____

Directions for use: Administer ZILRETTA as a single intra-articular injection of triamcinolone acetonide, 32 mg (5 mL) for extended release. ZILRETTA is supplied as a single-dose kit containing a vial of 32 mg sterile triamcinolone acetonide (extended-release), 5 mL of sterile diluent, and a sterile vial adapter. Prepare using the diluent supplied in the kit. Refer to the "Instructions for Use" provided with the kit for preparation and administration of ZILRETTA.

Additional directions: _____

Dispense as written

Please attach a separate prescription if this section does not comply with your state's prescription law. Prescriptions from New York must be issued electronically.

6. Physician Authorization

By signing below, I certify that (1) the above therapy is medically necessary and in the best interest of the patient listed above; (2) I authorize Flexion Therapeutics, Inc. and its contractors and business partners ("Contractors") to (i) supply any information to the insurer of the above named patient, (ii) forward the above prescription by fax or other means of delivery to a licensed pharmacy, and (iii) verify benefits and coordinate the dispense of ZILRETTA where appropriate; and (3) I understand that information I provide on this form, if signed by the patient, will be used by Flexion Therapeutics, Inc. and its Contractors as authorized by the patient; and (4) I agree to the Business Associate Agreement as presented at https://baa.flexforward.com/.

Healthcare professional name (please print): _____

Healthcare professional signature: _____ Date: _____/_____/_____

Call us at 1-844-FLEXION (1-844-353-9466), Monday - Friday, 8 AM - 8 PM ET

Fax us the completed enrollment form at 1-866-558-7939

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7. Patient Authorization

Patient name: _____ Date of birth: _____/_____/_____

In order to receive FlexForward services, you must complete this authorization to share protected health information. Please note that you do not need to complete this authorization to start ZILRETTA. You may:

- Fax this completed form to FlexForward at 1-866-558-7939, or
- Call FlexForward at 1-844-FLEXION (1-844-353-9466) for instructions on other methods to complete this authorization

Some of the information that FlexForward needs to obtain from my healthcare provider(s) and health plan(s) about me, such as my name, address, health insurance benefits, prescription drug coverage, and medical information, including medical conditions and treatment and drug history, is protected health information. The collection, use, and disclosure of such protected health information is protected under federal and some state privacy laws. In order for FlexForward to provide me with the services described in the FlexForward services overview, the FlexForward staff may need to obtain from my healthcare provider(s) and health plan(s) the protected health information about me described above. FlexForward may, in turn, share my clinical experience with my healthcare provider. I have the right to revoke this authorization at any time. Revocation can be completed by calling 1-844-FLEXION (1-844-353-9466). I understand that I do not have to enroll in the program, and that I can still receive ZILRETTA as prescribed by my physician.

By signing the FlexForward Patient Authorization, I authorize my healthcare providers (such as my doctor and pharmacies and pharmacists) and my health plan and/or health insurer to disclose protected health information about me to Flexion Therapeutics, Inc., the manufacturer of ZILRETTA, and the companies working with it to provide the FlexForward services, so that they may use this information as necessary to assist with:

(1) researching insurance coverage for ZILRETTA; (2) helping to arrange financial assistance to help me pay for my ZILRETTA treatment by contacting my insurer, other potential funding sources, social workers, patient advocacy organizations, or patient assistance programs on my behalf in order to determine if I am eligible for other financial assistance; (3) coordinating delivery and administration of ZILRETTA to my designated treatment site(s); (4) collecting information related to ZILRETTA treatment to assist in the coordination of my care and care of other osteoarthritis patients; (5) providing me with educational and support services, materials and information related to ZILRETTA treatment to assist in the coordination of care; and (6) providing me with information related to ZILRETTA and knee osteoarthritis or contacting me by mail, email, and/or telephone to ask me about my experiences with, or thoughts about, products, services, and programs that FlexForward offers or sponsors, and to help Flexion Therapeutics, Inc. develop new products, services, and programs. I understand that the companies working with Flexion Therapeutics, Inc. to provide FlexForward receive compensation for the services that they provide, including the service of contacting me to discuss products and services.

Patient signature: _____ Date: _____/_____/_____

Patient phone #: _____ Patient email: _____

Authorized representative name: _____ Relationship/Title: _____

Authorized representative signature: _____ Date: _____/_____/_____

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