



RECORLEV[®] Getting Started Forms

| STEP ONE | STEP TWO |
|---|---|
| <p align="center">SUBMIT START FORM with supporting documents to Xeris CareConnection™</p> | <p align="center">SUBMIT PRIOR AUTHORIZATION REQUEST FORM with clinical information to CloudTop</p> |
| WHAT TO INCLUDE | |
| <ul style="list-style-type: none"> • Start Form (page 1) • Patient Authorization (page 2) not required at submission • Copies of both sides of the patient's insurance and pharmacy benefits cards • Medication list from last 6 months | <ul style="list-style-type: none"> • Chart notes • Most recent diagnostic test results <i>See final page for details</i> |
| HOW TO SUBMIT | |
| <p align="center">FAX TO XERIS CARECONNECTION™ 1-312-276-4846</p> | <p align="center">THREE OPTIONS FAX TO CLOUDTOP 1- 872-201-1062 <i>(please note this is a different number than for the Start Form)</i> EMAIL xeris@cloudtophealth.com ONLINE PORTAL cloudtophealth.com</p> |

RECORLEV® (levoketoconazole) START FORM

FAX completed form to 1-312-276-4846 Phone 1-844-444-RCLV (7258)

1. PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____ MIDDLE INITIAL: _____ SEX: MALE FEMALE

DOB (MM/DD/YYYY): _____ PREFERRED LANGUAGE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

CAREGIVER NAME (IF APPLICABLE): _____ PHONE NUMBER: _____

2. PATIENT INSURANCE INFORMATION

SEND A COPY OF PATIENT'S INSURANCE CARDS, INCLUDING: PRESCRIPTION, MEDICAL AND ANY SECONDARY INSURANCE (BOTH SIDES)

PRIMARY INSURANCE: _____ RX BIN#: _____ RX PCN#: _____ RX ID#: _____ RX GROUP#: _____

CARDHOLDER NAME: _____ RELATIONSHIP TO CARDHOLDER: SELF SPOUSE CHILD OTHER

SECONDARY INSURANCE: _____ RX BIN#: _____ RX PCN#: _____ RX ID#: _____ RX GROUP#: _____

CARDHOLDER NAME: _____ RELATIONSHIP TO CARDHOLDER: SELF SPOUSE CHILD OTHER

3. PRESCRIBER INFORMATION

FIRST NAME: _____ LAST NAME: _____ NPI#: _____ DEA#: _____

OFFICE ADDRESS: _____ CITY/STATE/ZIP: _____

SHIP TO: PATIENT OFFICE PHONE: _____ FAX: _____

OFFICE CONTACT NAME: _____ OFFICE EMAIL ADDRESS: _____ OFFICE PHONE: _____

4. CLINICAL INFORMATION

SEND A LIST OF ALL CURRENT MEDICATIONS AND CURRENT/PRIOR THERAPIES FOR CUSHING'S

- CUSHING'S SYNDROME WITH ENDOGENOUS HYPERCORTISOLEMIA (PLEASE SPECIFY TYPE BELOW) _____
- OTHER: (PLEASE SPECIFY) _____

| HAVE BASELINE LIVER TESTS AND ELECTROCARDIOGRAM BEEN PERFORMED? | HAVE ALTERNATIVES BEEN TRIED AND FAILED? | DOES THE PATIENT HAVE ANY RISK FACTORS FOR OTHER OPTIONS? | |
|---|--|---|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> ISTURISA <input type="checkbox"/> KETOCONAZOLE <input type="checkbox"/> SIGNIFOR <input type="checkbox"/> KORLYM | <input type="checkbox"/> DIABETES <input type="checkbox"/> KETOCONAZOLE DRUG INTERACTION <input type="checkbox"/> NON-PITUITARY CUSHING'S | <input type="checkbox"/> HYPOKALEMIA <input type="checkbox"/> WOMEN'S HEALTH (PCOS) HORMONAL IMBALANCE <input type="checkbox"/> OTHER |
| SURGICAL STATUS: | IN THE PRESCRIBER'S OPINION, IS RECORLEV THE BEST TREATMENT OPTION FOR THE PATIENT? | | |
| <input type="checkbox"/> NOT A CANDIDATE FOR SURGERY <input type="checkbox"/> SURGERY NOT CURATIVE | <input type="checkbox"/> THE ALTERNATIVES WOULD NOT BE AS EFFECTIVE FOR TREATING THE PATIENT'S CONDITION. <input type="checkbox"/> THE ALTERNATIVES WOULD LIKELY HAVE ADVERSE EVENTS. | | |

| ACTH-DEPENDENT | ACTH-INDEPENDENT | OTHER |
|--|---|--|
| <input type="checkbox"/> E24.0: Pituitary-dependent Cushing's disease <input type="checkbox"/> E24.3: Ectopic ACTH syndrome | <input type="checkbox"/> E24.8: Other Cushing's syndrome (adrenal source) <input type="checkbox"/> D35.01: Benign neoplasm of right adrenal gland <input type="checkbox"/> D35.02: Benign neoplasm of left adrenal gland | <input type="checkbox"/> E24.9: Cushing's syndrome, unspecified <input type="checkbox"/> Other diagnosis code _____ Please describe _____ |

5. PRESCRIPTION INFORMATION AND DIRECTIONS FOR USE

PRESCRIPTION: RECORLEV (levoketoconazole) 150 mg tablets

DISPENSE: 30-DAY SUPPLY REFILLS (MAXIMUM: 11 REFILLS) _____

TAKE 1 TABLET BY MOUTH TWICE DAILY

TITRATION/OTHER DOSING INSTRUCTIONS: _____

I certify that I have prescribed RECORLEV as described above based on my professional judgement of medical necessity. I authorize the release of medical and/or other patient information relating to RECORLEV therapy to agents of Xeris Pharmaceuticals® and service providers (including, but not limited to pharmacies dispensing RECORLEV) to use and disclose as necessary for prior authorization processing and fulfillment of the prescription. I authorize CloudTop Health to prepare and submit prior authorization requests, appeal requests, and other administrative tasks on behalf of the prescriber and to receive notices in connection with requests which may include faxes, phone calls, mail, email, or any other form of communication. I authorize the forwarding of this start form (and the information included herein) to PANTHERx Rare Pharmacy.

PRESCRIBER'S SIGNATURE (CHOOSE ONE)

| | | | | |
|--------------|----------------------------|------------|----------------------------|------------|
| SIGN HERE | DISPENSE AS WRITTEN* _____ | DATE _____ | SUBSTITUTION ALLOWED _____ | DATE _____ |
| | _____ | | _____ | |

ANY SPECIAL INSTRUCTIONS: _____

* Certain states require "brand medically necessary" or other language to be handwritten by the prescriber if he/she has made this determination in his/her independent clinical judgment.

State requirements: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

Your patient will be contacted by PANTHERx Rare Pharmacy to arrange for delivery of RECORLEV. Obtain baseline electrocardiogram and liver function tests prior to initiating Recorlev.

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RECORLEV® (levoketoconazole) START FORM (PATIENT AUTHORIZATION)

FAX completed form to 1-312-276-4846 Phone 1-844-444-RCLV (7258)

PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____ MIDDLE INITIAL: _____ SEX: MALE FEMALE

CONFIDENTIALITY STATEMENT

This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information that is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 1-844-444-7258 to obtain instructions as to the proper destruction of the transmitted material.

CONSENT AND RELEASE OF HEALTH INFORMATION

By signing this Consent, I authorize each of my physicians, pharmacies, other healthcare providers, and each of my health insurers to use and disclose health information related to my taking RECORLEV® that identifies me personally, including my name, address, and telephone number(s) and information about my insurance, prescriptions, medical condition and health (my "information"), to Xeris Pharmaceuticals®, the manufacturer of RECORLEV®, its Xeris CareConnection™ Patient Support Services, and their respective agents, contractors, and third-party vendors, including providers of alternate sources of funding for prescription drug costs (collectively, "the Program") so that the Program may: (1) help to verify, assist with, and coordinate insurance coverage or otherwise obtain payment for my treatment with RECORLEV; (2) coordinate my receipt of, and payment for, RECORLEV; (3) conduct analytics to gain insight into and support the effectiveness of the Program; and (4) provide me with adherence reminders and support for RECORLEV, including email or text.

I understand that once my Information has been disclosed to the Program, state and federal privacy laws may no longer protect the Information and that it may be subject to further disclosure by the Program. I also understand that the Program intends to use and disclose my Information only for the purposes described in this consent and that results of the analytics will only be shared outside of the Program after being anonymized. I understand that my pharmacy, health insurance company, and healthcare providers may receive payment from Xeris Pharmaceuticals® in exchange for disclosing my Information to the Program and/or for providing me with therapy support services. I understand that I do not have to sign this consent and that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be affected if I do not sign it. I also understand, however, that if I do not sign this consent, the Program cannot provide me with assistance.

This consent will remain in effect for five (5) years, unless I cancel my enrollment before then. I understand that I may cancel (revoke) the consent at any time by sending a written notice of cancellation to: Xeris CareConnection Patient Support Services, 1375 West Fulton Street, Suite 1300, Chicago, IL 60607. I understand that if I do cancel this consent, the cancellation will be effective for each of my healthcare providers and health plans/insurers upon receipt by each such entity, respectively, but will not affect any information already disclosed. I understand that I am entitled to a copy of this consent after signing on the previous page.

By signing this consent, I understand I am giving Xeris Pharmaceuticals®, its affiliates, and business partners permission to use the personal information provided in this registration form to contact me by the following methods, but not limited to: mail, email, telephone call, or text, about disease and product information, disease or product-related events, support services, market research, and to share other promotional information. By submitting this form, I consent to these uses and agree to the Xeris Pharmaceuticals privacy statement located at xerispharma.com/privacy-policy. I understand I can opt out by clicking on the unsubscribe link in future communications or by sending a letter with my full contact information (eg, name, address, email address, phone number, etc) to Xeris CareConnection Patient Support Services, 1375 West Fulton Street, Suite 1300, Chicago, IL 60607.

PATIENT NAME: _____ AUTHORIZED PARTY NAME: _____ RELATIONSHIP TO PATIENT: _____

 PATIENT/AUTHORIZED PARTY SIGNATURE: _____ DATE: _____

