APDSAssist™

Joenja leniolisib

Patient Enrollment Form

Fax completed forms to: (833) 850-2737 (APDS)

Patient Consent Form

Patient Name: _____ **DOB:** _____

Patient Email: _____ **Patient Phone (Cell):** _____

Emergency Contact Name: _____ **Relationship to Patient:** _____

Emergency Contact Phone: _____

Consent to Share Health Information: By signing this Consent, I authorize my healthcare provider, my health insurance company, and my pharmacy providers ("Healthcare Entities") to disclose to APDS Assist Program ("Program") operated by Pharming Healthcare and companies working with Pharming Healthcare, health information relating to my medical condition, treatment, and insurance coverage for Pharming Healthcare to provide me with (i) support services (and related information and materials) related to any of Pharming Healthcare's products, including but not limited to, insurance coverage, prescription fulfillment, online support, financial assistance services, adherence, and other therapy support services; and (ii) information about Pharming Healthcare's products, services, and programs. I understand that Pharming may use my health information to conduct data analytics, market research, and other internal business activities. Once my health information has been disclosed to Pharming Healthcare, I understand that federal privacy laws no longer protect the information. However, Pharming Healthcare agrees to protect my health information by using and disclosing it only for purposes authorized in this Consent or as required by law or regulations. I understand that my pharmacy provider may receive remuneration from Pharming Healthcare in exchange for the health information and/or for any therapy support services provided to me. I understand that I may refuse to sign this Consent. I further understand that my treatment (including with a Pharming Healthcare product), payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this Consent; but if I do not sign it or later cancel it, I will not be able to receive Pharming Healthcare's patient program support. I may cancel this consent at any time by calling (877) 796-2737. Canceling this Consent will end my consent to further disclosure of my health information to Pharming Healthcare by my Healthcare Entities after they are notified of my cancellation but will not affect previous disclosures by them pursuant to this Consent. Canceling this Consent will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance. This Consent expires five (5) years from the date signed unless a shorter period is required by state law.

Patient Support Services: I authorize APDS Assist to contact me to provide me support related to any of Pharming Healthcare's products, including but not limited to insurance coverage, prescription fulfillment, financial assistance services, adherence, and other therapy support services, relevant disease-related information, as well as any information or materials related to such services. I understand that any personnel providing support as part of the APDS Assist is not employed by my healthcare professional. APDS Assist or Pharming Healthcare may contact me by mail, email, fax, telephone call, text message (including calls and text messages made with an automatic telephone dialing system or a prerecorded voice), and other mutually agreed upon means. I also authorize Pharming Healthcare to use my health information in connection with the services and programs, including, without limitation, sharing such information with my Healthcare Entities.

Opt-in for Other Resources: By signing below, I authorize Pharming Healthcare, and companies working with Pharming Healthcare, to contact me by mail, email, fax, text messaging, and/or telephone regarding other potential topics of interest to me, customer surveys, or occasionally for market research purposes. I understand that I am not required to provide this consent as a condition of receiving any Pharming Healthcare medicine or Patient Support Services. Note that Pharming Healthcare will not sell or trade my personal data to any unrelated third party.

☐ I would like to **opt out** of receiving other resources

Emergency Contact: By providing emergency contact information above, I authorize the licensed pharmacy PANTHERx to speak with the named person and accept medications requests/orders from the named person in the event that I am unable to speak with PANTHERx myself.

By signing below, I confirm that I have read and understand the Consent to Share Health Information and Patient Support Services above and agree to the terms.

Printed Patient/Legal Representative Name: _____

Patient Sign

Patient/Legal Representative Signature: _____ Date: _____

If Legal Representative, Relationship to Patient: _____

For more information, please read the full Prescribing Information.

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APPROVED USE

JOENJA® (leniolisib) is a prescription medicine that is used to treat activated phosphoinositide 3-kinase delta (PI3K) syndrome (APDS) in adults and children 12 years of age and older.

IMPORTANT SAFETY INFORMATION

Tell your healthcare provider if you are pregnant or plan to become pregnant. JOENJA may harm your unborn baby. Your healthcare provider will do a pregnancy test before you start receiving JOENJA.

Use effective birth control to prevent pregnancy while taking JOENJA and for one week after you stop taking JOENJA. If you plan to become pregnant, continue taking your birth control for one week after stopping JOENJA. Talk to your doctor about what type of birth control method is right for you while taking JOENJA.

It is not known if JOENJA passes into your breast milk. Talk to your doctor about the best way to feed your baby if you take JOENJA.

Tell your healthcare provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements. JOENJA and certain other medicines may affect each other.

Tell your healthcare provider if you are scheduled to receive an immunization (vaccine). JOENJA may affect how well a vaccine works.

Know the medicines you take. Keep a list of your medicines and show it to your healthcare provider and pharmacist when you get a new medicine.

The most common side effects of JOENJA include headache, inflammation of sinuses, and dry, itchy, and inflamed skin (eczema). These are not all the possible side effects of JOENJA. Tell your healthcare provider about any side effect that bothers you or does not go away.

You can also report negative side effects to FDA at 1-800-FDA-1088 or www.fda.gov/medwatch, or Pharming Medical Affairs at (800) 930-5221.

For more information, please read the full Prescribing Information.