OPENDOORS®
Individualized care and support for patients like you®

OFEV® (nintedanib) capsules

OPEN DOORS® Patient Support Program and Boehringer Ingelheim Clinical Educator Enrollment Form

Please complete and fax this form to **1-844-880-OFEV (6338)** or mail it to: **P.O. Box 5070 Louisville, KY 40255**

The OPEN DOORS® Patient Support Program provides a variety of services, including those set forth below, which together with the services offered by the Boehringer Ingelheim Clinical Educator Program are referred to in this form as the "Services":

Nurse Support*
- Available via telephone 24 hours a day, 7 days a week to help you understand your disease and answer questions you may have about your treatment with OFEV®
- Receive treatment reminders and education on prescription fulfillment process

Financial Support
- Explore financial assistance options for OFEV®, including co-pay assistance or other benefits for which you may be eligible.
- Upon your request, conduct a preliminary assessment† of benefits to understand your insurance company's coverage of OFEV®.

Social Resource Support
- Periodic calls to see how you are doing, identification of local support for you and/or your caregiver, and identification of possible local social services, like meal delivery, in-home support, or rides to doctor appointments.

The Boehringer Ingelheim Clinical Educator Program provides the following services:

Provided by Boehringer Ingelheim, Clinical Educators‡ can help you understand more about your disease and your treatment with OFEV® to help you off to a good start. The educational classes can be offered in a variety of virtual or live formats including face-to-face, remote, private sessions or group setting.

You must be prescribed OFEV® for one of its approved indications to enroll in the OPEN DOORS® Patient Support Program.

*OPEN DOORS® does not provide healthcare advice. Please consult with your doctor if you have any specific questions or concerns about your treatment.
†Your Specialty Pharmacy will conduct a full investigation.
‡Clinical Educators do not provide medical advice and will refer you to your doctor for any question you may have related to your specific treatment.

SECTION 1: PATIENT INFORMATION

Patient Name (First, MI, Last): _____ Gender: ❑ M ❑ F

Address: _____ Phone (_____)_____ ❑ Home ❑ Work ❑ Cell

City: _____ State: _____ Zip Code: _____ DOB (MM/DD/YY): _____

Preferred Language (if not English) _____ E-mail: _____

Preferred Communication Method: ❑ Phone Call ❑ E-mail ❑ Text Message

Caregiver Name (if applicable): _____ Caregiver Phone: (_____)_____

Patient Consent to Enrollment

I have read and agree to the Patient Consent to Enrollment included in Section 4, which permits Boehringer Ingelheim Pharmaceuticals, Inc. to use and disclose my health information to enroll me in the Services, and communicate with me about the Services, among other terms.

SIGN HERE _____

Patient signature/Legal representative Date

If signed by a legal representative:

_____

Print Name Relationship to Patient

Authorization to Use and Disclose Health Information

I have read and agree to the Authorization to Use and Disclose Health Information included in Section 5, which permits my specialty pharmacy, pharmacy, health insurer and health care provider to use, and disclose to Boehringer Ingelheim Pharmaceuticals, Inc., my protected health information in order to provide the Services.

SIGN HERE _____

Patient signature/Legal representative Date

If signed by a legal representative:

_____

Print Name Relationship to Patient

SECTION 2: Optional Use and Disclosure of My Health Information

❑ **Check here if you would like to participate in the OFEV Mentor Connections program**

Boehringer Ingelheim would also like to use and disclose my Health Information (as defined in Section 5) for the following purposes: (i) to contact me for marketing purposes or otherwise provide me with information about Boehringer Ingelheim's other products, services, and programs or other topics of interest; (ii) to conduct market research or otherwise ask me about my thoughts and experiences, and (iii) to develop new products, services, and programs. I may decide not to allow those uses and disclosures and still receive the Services. If I wish to allow these optional uses and disclosures of my Health Information, I will initial the box below.

INITIAL HERE _____ Yes, I agree to the optional uses and disclosures of my Health Information described immediately above.

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PATIENT NAME _____

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SECTION 3: PRESCRIBER INFORMATION

Prescriber name _____ Site/facility name _____

Prescriber NPI # _____ Office contact name _____

Specialty _____ Office contact email _____

Address _____ Phone (_____)_____

City: _____ State: _____ Zip Code: _____ Fax (_____)_____

SECTION 4: Patient Consent to Enrollment

Please read the following. If you agree, sign and date where indicated in Section 1 of page 1.

I hereby consent to Boehringer Ingelheim Pharmaceuticals, Inc., its affiliated companies, vendors, agents, and representatives (collectively, "Boehringer Ingelheim"):

- Enrolling me in the OPEN DOORS® Patient Support Program and the Boehringer Ingelheim Clinical Educator Program (together, the "Patient Programs") to provide me with the Services mentioned on page 1
- Providing my health care provider with information on my interactions with the Patient Programs
- Generating and using analyses related to OFEV and the Patient Programs or any other patient support program administered by Boehringer Ingelheim
- Providing me with other informational materials or surveys about my treatment experience with the Patient Programs

I understand and agree that Boehringer Ingelheim may contact me by mail, e-mail, 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 understand that the frequency of these messages will vary. By signing Section 1, I hereby agree that Boehringer Ingelheim may communicate with me via email and/or autodialed text message at the email address and/or mobile telephone number previously provided by me to Boehringer Ingelheim and/or my healthcare provider. I understand that my consent to receive email and/or text messages is not a condition of my obtaining other health care services from my healthcare provider. I understand and acknowledge that communications transmitted via unencrypted email, text message or over an open network may be inherently unsecure, and there is no assurance of confidentiality for information communicated in this manner. I also understand that emails and text messages have inherent privacy risks, especially when access to my computer or mobile device is not password protected. I further understand that my emails and text messages may be accessed by my employer, depending on the access I have provided to my employer. Nevertheless, I want Boehringer Ingelheim to communicate with me via email and/or text message as detailed herein.

I understand that messages transmitted pursuant to this Consent will be subject to Boehringer Ingelheim's Terms of Use and Privacy Statement. I understand that I will be able to revoke this consent (if it pertains to text messages) by replying "STOP" to a program text message or (if it pertains to email messages) by following the instructions in an email message to unsubscribe. For text messages, standard message and data rates may apply.

I further understand that my insurance enrollment, eligibility for insurance benefits, or payment for treatment including OFEV are not conditioned upon my signing this Consent. If I refuse to sign the Consent, or revoke my Consent later, I understand that this means I will not be able to participate in or receive the Services. This Consent is valid for 3 years from the date I signed or the date I last enrolled, whichever comes first, unless a shorter period is required by law.

I understand that I may cancel (revoke) this Consent at any time by mailing a request to P.O. Box 5070 Louisville, KY 40255 or by calling 1-866-673-6366. I understand that revoking this Consent will end further use and disclosures of my information by Boehringer Ingelheim except to the extent those uses and disclosures have been made in reliance upon this Consent and as permitted by applicable law. I am entitled to receive a copy of this Consent.

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PATIENT NAME _____

SECTION 5: Authorization to Use and Disclose Health Information

Please read the following. If you agree, sign and date where indicated in Section 1 of page 1.

By signing as instructed above, I direct and authorize my specialty pharmacy, pharmacy, health insurer and health care provider to use, disclose, exchange and share my protected health information ("Health Information") to Boehringer Ingelheim Pharmaceuticals, Inc., its affiliated companies, vendors, agents, and representatives (collectively, "Boehringer Ingelheim") as necessary for Boehringer Ingelheim to provide the Services, as well as other activities described in this form.

My Health Information may include:

- The information collected through this form, including name, birthdate, address, telephone number and email address
- Information on my medical condition, as necessary
- Information about my health benefits or health insurance coverage, including insurance identifiers

I hereby authorize Boehringer Ingelheim to use, disclose exchange and share my Heath Information for purposes of determining my participation in, and administering, the Services, which may include contacting me as well as my physician, specialty pharmacy, pharmacy and my health plan(s) or others.

Once I sign this Authorization and my Health Information is released, I understand that:

- Federal and state law may no longer protect or prohibit the redisclosure of the Health Information disclosed to Boehringer Ingelheim.
- I understand that certain vendors may receive payment from Boehringer Ingelheim in return for sharing my Health Information.
- I can choose not to sign this Authorization, but if I do not sign, Boehringer Ingelheim may not be able to provide me with all the Services described in this form. However, my health care providers and health insurer may not condition either my treatment or my payment, enrollment or eligibility for benefits on signing this form.
- This form is valid for 1 year from the date I signed or the date I last enrolled, whichever comes first, unless a shorter period is required by law.
- I understand that I have a right to receive a copy of this signed form.

I understand that I have the right to cancel this authorization. If I cancel, this means that my health care providers, pharmacies and health plans will no longer use or share my Health Information with Boehringer Ingelheim, but this will not affect Health Information already used or any further uses or sharing required by law. To cancel, I must send written notice to OPEN DOORS®. It can be sent by fax or by mail to the address below. The address is OPEN DOORS®, P.O. Box 5070, Louisville, KY 40255.

Who may be eligible for the OPEN DOORS® Patient Support Program and the Boehringer Ingelheim Clinical Educator Program?

- You must be a resident of the U.S. or the U.S. territories and be under the care of a licensed healthcare provider authorized to prescribe, dispense and administer medicine in the U.S.
- You must be prescribed OFEV® for one of its approved indications.

▶ WHAT HAPPENS NEXT?

When we receive your application, we will reach out to you via phone to discuss in further detail all the services available to you.