KalVista Cares™

Ekterly®
(sebetralstat) tablets 300 mg

EKTERLY®
Patient Start Form

KalVista Cares™ Patient Support Program

We offer personalized support that you and your patients can count on.

Benefits Investigation
Our Care Managers* evaluate your patients' insurance coverage and eligibility for various services.

Prior Authorization
We assist with prior authorization requests, reauthorizations, and appeals to help secure coverage.

Financial Assistance Options
If your patients are eligible, our Care Managers help enroll them in the KalVista Cares Co-Pay Assistance Program.**

Resources and Community Connections
KalVista Cares connects patients and their caregivers with important resources and a supportive community, empowering them throughout their healthcare journey.

Specialty Pharmacy Coordination and Triage
We work with the pharmacy and your patients' insurance to help ensure smooth access for your patients' treatment.

Questions about the KalVista Cares Patient Support Program?

Our team is available Monday through Friday, 8:30AM – 8PM ET 844-432-3322

Ways to enroll your patient

There are two simple ways to enroll your patient in the KalVista Cares patient support program.

Option 1: Online
Enroll online at www.kalvistacaresenroll.com or **scan** the code:

Option 2: Fax
Fax the completed Start Form to **844-432-9525**.

* Care Managers serve as the central point of contact for patients (and their caregivers) throughout their time on treatment. They complete all benefits verifications, and assist with financial needs.
** IMPORTANT NOTICE: This co-pay assistance program is intended only for eligible patients with commercial (private) insurance. Patients with government-funded insurance, such as Medicare, Medicaid, TRICARE, or any state or federal health insurance program, are not eligible to participate. Participation in the program is subject to eligibility requirements and program limits. The program may cover a portion or all of the patient's out-of-pocket costs, up to a maximum amount determined by the program. Terms and conditions may change from time to time, or the program may be discontinued at any time without notice. For the current terms and conditions, please visit https://www.kalvista.com/terms-conditions/ By participating, patients agree to comply with all terms and conditions.

KalVista Cares

EKTERLY® Patient Start Form

Enroll in one of two ways: www.kalvistacaresenroll.com **Fax:** 844-432-9525

Questions? Our team is available Monday through Friday, 8:30AM – 8PM ET 844-432-3322

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* Indicates required field.

1. Patient Information

* **Legal Name (First, Middle Initial, Last)**
* **DOB** (MM/DD/YYYY)
* **Gender** ☐ Male ☐ Female
* **Address**
* **Preferred Phone** ☐ Mobile ☐ Home ☐ Work
* **City** * **State** * **Zip**
Email
* **Preferred Language**
* **Patient Preferred Contact Method** ☐ Phone ☐ Text ☐ Email
Patient Representative/Caregiver Name (and relationship to patient)
Patient Representative/Caregiver Preferred Phone Number ☐ Mobile ☐ Home ☐ Work

2. Insurance Information If available, please attach copies of front and back of insurance card(s).

☐ No Insurance
* **Primary Insurer**
* **Policy ID** * **Group Number** * **Rx BIN** * **Rx PCN**
* **Phone** * **Subscriber Name** (and relationship to patient)
Secondary Insurer
Subscriber Name (and relationship to patient)
Policy ID **Group Number** **Rx BIN** **Rx PCN**
Phone

3. Prescriber Information

* **Prescriber Name (First & Last)**
Practice Name
* **Address**
Practice Phone
* **City** * **State** * **Zip**
State License
* **Tax ID**
* **NPI**
* **Office Contact Name** * **Office Contact Phone Number**
* **Office Fax Number** **Office Contact Email**

4. Prescription

☐ * **Patient diagnosis DX Code ICD-10-D84.1** ☐ **Other**

☐ * **Rx: EKTERLY tablets 300 mg.**
600mg - (2) 300mg tablets taken orally at the earliest recognition of an HAE attack with or without food.
Additional doses may be taken if needed up to 1200mg per day.

* **Quantity** 4-count blister pack
* **Number of Refills**
* **Current Prophylactic Therapy**
* **Previous Acute Therapy**

SIGN HERE

* **Dispense as written Prescriber Signature (No stamps)**
* **Date** (MM/DD/YYYY)

Quick Start Option

In the event of a delay in coverage authorization, Quick Start may be available for eligible newly prescribed patients. Quick Start prescriptions will ONLY be filled at the designated non-commercial pharmacy.

☐ * **Rx: EKTERLY tablets 300 mg.**
600mg - (2) 300mg tablets taken orally at the earliest recognition of an HAE attack with or without food.
Additional doses may be taken if needed up to 1200mg per day.

* **Quantity** 4-count blister pack
* **Number of Refills**

SIGN HERE

* **Substitution allowed Prescriber Signature (No stamps)**
* **Date** (MM/DD/YYYY)

Prescriber Authorization: I attest that I have obtained written permission, in the event it is required under applicable federal and/or state law, of my patient (or the patient's legal representative) for the release of my patient's Protected Health Information ("PHI") to KalVista Pharmaceuticals Inc. or its representatives or agents (collectively "KalVista") as may be necessary for the patient's participation in a program designed to assist patients in determining their insurance coverage for EKTERLY that I have elected to prescribe. I direct KalVista to convey, on my behalf, any prescription information delivered to KalVista for EKTERLY by any means under applicable law to the dispensing pharmacy chosen by or for the patient, to the patient's health insurance company, or to other third parties as may be necessary to assist this patient with filling his/her prescription for EKTERLY, with securing any insurance coverage for EKTERLY to which the patient is entitled, or other third parties to assist with patient assistance or reduced-cost medication. I understand I am to comply with the state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. I agree that KalVista may contact me for additional information relating to EKTERLY, including but not limited to via email, fax, and telephone. I authorize KalVista to transmit the above prescription to the pharmacy. In the event I have opted out of sharing data through the PDRP, I authorize KalVista and its representatives or agents to use my data as provided for in this Start Form and any authorization provided by my patient.

* Indicates required field.

5. Patient Authorization to Share Personal Health Information and KalVista Cares™ Enrollment

* **Legal Name (First, Middle Initial, Last)**

* **DOB** (MM/DD/YYYY)

I authorize any health plan, physician, health care professional, hospital, clinic, pharmacy provider or other health care provider (collectively, "Providers") to disclose my protected health information (as such term is defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations thereunder, as well as any other applicable federal or state law or regulation relating to personal information), including my contact information, personal information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription ("information"), to KalVista Pharmaceutical Company Limited, its affiliates and their representatives, agents, and contractors (collectively, the "Company" or "KalVista") and any third party engaged to assist KalVista in connection with the Company's provision of products, supplies, or services. I understand the Company will use or provide this information for the KalVista Cares Patient Support Program ("KalVista Cares") following purposes ("Services"): (1) to a specialty pharmacy to fulfill my prescription; (2) for KalVista Cares (if I agree below) to provide verification of insurance benefits and drug coverage, prior authorization support, financial assistance with co-pays, patient assistance programs, alternate funding sources, other related programs; (3) for communications with me, my prescribing physician or other Providers by mail, email, or telephone about my medical condition, treatment, care management, product information, health insurance, and providing me with related patient support communications; (4) for reporting safety and quality information to appropriate authorities, including communications with the U.S. Food and Drug Administration and other governmental authorities; (5) for internal uses by the Company, including evaluating the effectiveness of and improving KalVista Cares through data analysis and helping develop new products, services, and programs, as well as KalVista's general business, commercial, and administrative purposes; (6) to use and disclose my information to send communications and marketing materials to me and to contact me about participating in market research. I understand that certain pharmacy Providers may receive financial remunerations from the Company for the use and disclosure of my information for the purposes above. I understand that once disclosed to the Company, my information may no longer be subject to all the protections provided by federal and state privacy laws and regulations, including HIPAA. I understand that KalVista will only use my information for the purposes described above. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by sending written notice of revocation to KalVista Cares, KalVista Cares, 600 Emerson Rd, Suite 300, Creve Coeur, MO 63141. I understand that such revocation will not apply to any information already used or disclosed through this Authorization. This Authorization will expire within ten (10) years from today's date unless a shorter period is provided for by state law. I understand that I may refuse to sign this Authorization and that refusing to sign this Authorization will not change the way my physician, health insurance, and pharmacy or other Providers treat me. I also understand that if I do not sign this Authorization, I will not be able to receive KalVista Cares products, supplies, or services.

SIGN HERE

* **Patient Signature (I have read, understand, and agree to the release of my personal health information for the purposes described above)**

* **Date** (MM/DD/YYYY)

☐ **Signed by Patient** ☐ **Signed by Patient Representative/Caregiver**

☐ By signing above and checking this box, I certify that I expressly consent to receive text or SMS messages regarding enrollment updates and alerts from KalVista Cares or to receive telephone calls using an automated dialing system or pre-recorded messages at the telephone number that I provided above in Section 1, and I agree to notify KalVista Cares promptly if my number changes. I understand that message frequency varies by user and my wireless service provider's standard message and data rates may apply. I understand that I can opt out of future text messages at any time by texting STOP to 7177143709 from my mobile phone or texting HELP for additional support. If this box is left unchecked, I understand I will not receive text messages. Complete terms and privacy notice can be found at https://www.kalvista.com/privacy-policy/

KalVista Pharmaceuticals

For more information, visit Ekterly.com/HCP/KalVistaCares or call 844-432-3322. Please return completed form by fax to 844-432-9525.