Abeona Assist® Enrollment Form (to be completed by patient, QTC or Referring HCP)

Please fax completed form: 888-389-0390

Abeona Assist®
Your partner in navigation and support

A. Patient Information

First Name * _____ MI _____ Last Name * _____ DOB * _____

Gender ○ M ○ F Patient Preferred Language (if not English) _____

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

Email _____ Phone * _____ Preferred time to contact ○ AM ○ PM

B. Caregiver Information If Applicable

Caregiver 1 Name _____ Relationship to Patient _____ Phone _____

Caregiver 1 Email _____ Preferred time to contact ○ AM ○ PM OK to leave message? ○ Yes ○ No

Caregiver 2 Name _____ Relationship to Patient _____ Phone _____

Caregiver 2 Email _____ Preferred time to contact ○ AM ○ PM OK to leave message? ○ Yes ○ No

C. Insurance Information

Primary Insurance * _____ Policy ID # * _____ Group # _____

Primary Insurance phone _____ Policy holder _____ Relationship to Patient _____

Secondary Insurance _____ Policy ID # _____ Group # _____

Secondary Insurance phone _____ Policy holder _____ Relationship to Patient _____

D. Qualified Treatment Center (QTC) If Known

Treating HCP Name: First _____ Last _____ NPI # _____

QTC/Facility Name _____ Phone _____ Fax _____

Address _____ City _____ State _____ ZIP _____

E. Referring EB HCP Information If Known

Treating HCP Name: First _____ Last _____ NPI # _____

Practice Name _____ Phone _____ Fax _____

Address _____ City _____ State _____ ZIP _____

Office Contact Name and Title _____ Office Contact Phone _____

Office Contact Email _____ Preferred method of contact ○ Phone ○ Text ○ Email

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Provider Attestation

I hereby certify that I have obtained all necessary consents, authorizations and permissions from the patient or their authorized representative, as required by federal and state privacy laws, to share patient information with Abeona to assess the patient's eligibility to participate in Abeona Assist services, including benefit verification, and to enable Abeona Assist to contact the Patient directly about the Program. I acknowledge that I am under no obligation to recommend any Abeona Assist service, and I confirm that I have neither received nor will I accept any benefit, directly or indirectly, from Abeona or its representatives for recommending Abeona Assist. I will not seek reimbursement from any third party for services provided by Abeona or its agents, nor for any financial benefit received by the Patient through Abeona or its agents. To the best of my knowledge, the information provided on this form is accurate and complete. Furthermore, I understand that participation in Abeona Assist does not guarantee assistance and Abeona makes no guarantees regarding coverage or reimbursement for any items or services. I acknowledge that Abeona Assist reserves the right to modify or terminate the program at any time.

Provider Name _____ Provider Signature _____ Date _____

HIPAA Authorization

* Required for enrollment in the Abeona Assist Patient Support Program if the patient is not already enrolled, or it can be obtained by the Abeona Assist Patient Navigator Team.

I hereby authorize my healthcare providers, health insurance carriers, and pharmacies to disclose my identifiable health information, including my name, date of birth, address, telephone number, email, photos of my wound, health insurance, benefits, coverage limits, appeals, and health records and information related to my treatment, diagnosis, condition, medications, and lab tests (collectively, "Personal Information") to Abeona Assist in connection with the Abeona Assist program (the "Program"). I further authorize Abeona Assist to use and disclose my Personal Information for the following purposes:

1. to establish eligibility for the Program, and benefits and coverage benefits information;
2. to facilitate my participation in the Program, if determined eligible, including, but not limited to, the provision of products, supplies, or services by a third party including, but not limited to, hospital systems;
3. to enroll me in eligible patient support programs offered by the Program and/or Abeona Assist, including patient access support services and financial assistance eligibility, and register for any applicable product registration program required for my treatment;
4. to contact me to obtain my consent for Abeona Assist to use my Personal Information for certain other Abeona programs;
5. to communicate with me about the Program, surveys, market research, possible research opportunities, and products and services that may be of interest; and
6. for administration of the Program and related services, assessing and improving the Program, for research and product improvement, for other related business purposes, and as further described in the Abeona Therapeutics privacy policy available at https://www.abeonatherapeutics.com/privacy-policy.

I understand that I may choose not to sign this Authorization and that my treatment, plan payment, enrollment or eligibility for benefits will not be affected if I do not sign, but I may not be able to participate in the Program or receive some of the benefits of the Program.

Once my Personal Information is disclosed under this Authorization, it may be subject to redisclosure and no longer protected by federal privacy laws. This Authorization shall remain valid for a period of fifteen (15) years from the date of the Authorization signed, unless a shorter period is provided for by law or revoked in writing prior to that time. I understand that I may revoke this Authorization at any time by mailing a signed letter requesting such cancellation to Abeona Assist at 4060 Wedgeway Ct, Earth City, MO 63045, but that this revocation will not be effective for any use or disclosure made in reliance on this Authorization. Unless a shorter period is required by applicable state law, this Authorization does not expire until I am no longer enrolled in the Program or I am notified that I am ineligible for the Program.

Patient Name * _____ Patient Signature * _____ Date * _____

Parent/Legal Guardian Name _____ Parent/Legal Guardian Signature _____ Date _____

Relationship to Patient (If Other than Patient Signing) _____

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Patient Name * _____ Patient DOB * _____

Patient/Caregiver Consent to Enrollment in Program and Contact

* Required for enrollment in the Abeona Assist Patient Support Program if the patient is not already enrolled, or it can be obtained by the Abeona Assist Patient Navigator Team.

Please check each box, fill in the requested information, and sign at the bottom if you would like to be considered for Program financial assistance offerings. Contact Abeona Assist with any questions regarding Program eligibility and enrollment.

- ☐ I understand that if my insurance does not cover certain costs associated with my ZEVASKYN® (prademagene zamikeracel) therapy, I may be eligible to participate in the Abeona Assist Program. I grant permission to the Program to check my eligibility. I certify that my household income is $[_____] / year and there are [_____] individuals in my household. I recognize that as part of determining my eligibility for the Program, my household income may be subject to verification.
- ☐ I attest that the information I have provided in this form is accurate to the best of my knowledge. I understand that by enrolling in the Program, I agree to comply with the requirements of the Program. I understand that Abeona Assist makes no representation or guarantee concerning my eligibility to receive assistance. I understand that assistance may not be available in all areas.
- ☐ I attest that neither I nor anyone acting on my behalf will seek reimbursement for any financial support received as part of the Program from any government health care program or any other third-party insurer or payer, health savings account, or flexible spending account. I understand that the Program reserves the right to request additional documentation from me to determine eligibility, and may independently verify information provided. I understand that I must inform the Program if my financial circumstance, insurance, or any other eligibility criteria changes. I understand that Abeona reserves the right to amend or discontinue the Program, in whole or in part, at any time and without notice.
- ☐ I understand that I am enrolling in Abeona Assist (the "Program") to help facilitate access to my prescribed treatment including patient support programs subject to certain eligibility restrictions. By providing my phone number and/or email and signing this consent form, I consent to receive recurring, non-marketing calls, emails, and texts, including to my mobile phone, from Abeona Assist relating to the Program. I understand that calls and texts may be made using automated technology and/or a prerecorded message. I consent to receive calls and texts even if my phone number is on the national or state(s) do not call registry. I understand and agree that personal information transmitted by cell phone text and email cannot be secured against unauthorized access. Standard message and data rates may apply. I can cancel my enrollment in the Program by contacting Abeona Assist at 855-ABEONA-1.

Patient Name * _____ Patient Signature * _____ Date * _____

Parent/Legal Guardian Name _____ Parent/Legal Guardian Signature _____ Date _____

Relationship to Patient (If Other than Patient Signing) _____

Marketing Consent Optional

- ☐ By checking this box, I agree to receive marketing calls and texts from third parties authorized by or acting on behalf of Abeona Therapeutics ("Abeona") and its affiliates, including calls and texts made using automated technology and/or a prerecorded message, at the phone number provided regarding Abeona products, services, programs, or other topics of interest, to conduct market research, or to conduct surveys regarding the aforementioned.

  - I understand that my consent to receive marketing communications is not required as a condition of purchasing or receiving any goods or services from Abeona or to receive information or further contact from Abeona Assist, including receiving Patient Support services from Abeona Assist.
  - I understand that I may revoke my consent to receive marketing messages at any time by replying STOP or visiting the Privacy and Cookie Notice page on www.AbeonaTherapeutics.com, located at the bottom of the website. Once on the webpage, I can navigate to the 'Your Choice and Your Information' section and click on the provided link to access the Subject Request Form and manage my privacy preferences.

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