REACH Start Form—INSTRUCTIONS

SKYCLARYS™ (omaveloxolone) capsules, 50 mg each

Phone: 1-844-98-REACH (1-844-987-3224) Fax: 1-844-806-1718

REACH
Reata Education, Access & Care Helpline

Reata Education, Access, and Care Helpline (REACH) is a centralized resource for patients and healthcare providers to receive information on insurance requirements and affordability options for prescribed Reata medicines.

THE COMPLETED AND SIGNED FORM MUST BE SUBMITTED BY A HEALTHCARE PROVIDER VIA

Fax: 1-844-806-1718

OR

Mail: Reata REACH, 11800 Weston Parkway, Cary, NC 27513

Instructions for Healthcare Provider

Please complete all sections on page 2, including:

- Patient information
- Insurance information
- Prescriber information
- Diagnosis
- Prescription information

A completed Start Form provides the required patient consent to allow REACH to discuss relevant healthcare information for a prescribed Reata medicine with a patient's healthcare provider, insurer, and Biologics, the exclusive specialty pharmacy for REACH.

To be eligible for all REACH services, your patient or their caregiver/authorized representative must complete and sign the patient consent section on page 3. Your patient is not required to enroll in REACH before you prescribe SKYCLARYS. However, their signed consent is required to access all program support services.

If the patient is not in the office while you are completing the Start Form, you may submit the form without patient signature. The REACH program will contact the patient to obtain consent via DocuSign or by mail.

QUESTIONS?

Visit www.ReataREACH.com or call 1-844-98-REACH

REACH Care Navigators are available

8 AM to 8 PM ET, Monday–Friday (except holidays)

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PATIENT INFORMATION

* Indicates a required field

*Patient First Name: *Last Name: Middle Initial:

*Patient Street Address: *Apt/Suite:

*City: *State: *ZIP Code: *Gender: *DOB:

*Patient Primary Phone (Mobile ☐): Voicemail Allowed: ☐ Yes ☐ No

Check Y/N: I authorize REACH to leave information regarding my prescription and insurance coverage on voicemail of number(s) provided

Secondary Phone (Mobile ☐):

Patient Email: Preferred Language:

Caregiver/Authorized Representative (Please complete this section ONLY if someone other than the patient will be interacting with REACH on program services)

Full Name of Caregiver/Authorized Representative: Relationship to Patient:

Caregiver/Authorized Rep Primary Phone: Caregiver/Authorized Rep Email:

INSURANCE INFORMATION

Include a copy of front and back of patient's medical and prescription benefit insurance cards, copy of insurance information from EMR, or complete the information below

Primary Insurance Name: ☐ No Insurance ☐ Medicare Part D

Member ID: Group #:

Policy Holder Name: DOB: Relationship to Patient:

Prescription Benefit Insurance Name: Phone #:

Member ID: Rx BIN: Rx PCN: Rx Group:

PRESCRIBER INFORMATION

*Prescriber Name: *Specialty:

*Practice Name:

*Street Address: *Suite/Apt: *Office Phone #:

*City: *State: *ZIP Code: Office Fax #:

*NPI #: *State License #:

Office Contact: Office Contact Phone #: Office Contact Email:

DIAGNOSIS

ICD-10 Code: ☐ G11.11 Friedreich's Ataxia ☐ Other (list ICD-10):

SKYCLARYS™ PRESCRIPTION INFORMATION

☐ SKYCLARYS™ (omaveloxolone) 50-mg capsules x 30-day supply (90 capsules) ☐ Other *Refills Authorized: #

Directions for use: ☐ Take 3 (50-mg) capsules by mouth once daily ☐ Other (please specify):

Prescriber Full Name:

X Prescriber Signature: **Date:**

By providing my signature I agree to the Prescriber Authorization language at the top of page 3.

PRESCRIBER AUTHORIZATION

I certify that (i) I am prescribing SKYCLARYS™ for the patient identified above and that the medication is medically necessary; (ii) I have provided the patient with a description of the Reata REACH program ("Program") and the patient has elected to participate; and (iii) the information provided herein is accurate to the best of my knowledge. I authorize Biologics Specialty Pharmacy as my designated agent and on behalf of my patient to forward the above statement of medical necessity and furnish any information on this form to the insurer of the above-named patient. I understand that (i) participation in the Program is not a guarantee of insurance coverage or reimbursement; and (ii) Reata reserves the right, at any time and without notice, to rescind, revoke, or amend the Program.

**Signature stamps not permitted. Please attach all prescriptions on Official State Prescription form if mandated by individual state laws.

PATIENT CONSENT: PLEASE READ, CHECK ALL BOXES THAT APPLY, SIGN, AND DATE

☐ By signing this Authorization to Release Health Information ("Authorization"), I authorize my healthcare providers (including my pharmacies), and my health plans and insurers [and their contractors] (collectively, the "Parties") to disclose to Reata, together with its parents and affiliate ("Manufacturer"), Biologics by McKesson, and its third-party business partners, vendors, and other agents ("Agents") (collectively, the "CORPORATION") my personal and medical information (my "Information"), including, but not limited to, any information about me on this enrollment form and/or about my medical treatment with SKYCLARYS™, for the purposes described below.

I understand that the purpose of this Authorization is to provide me with access to services provided by CORPORATION related to SKYCLARYS™ and/or my medical condition ("Program"), including: (i) enrollment in the Program; (ii) conducting benefits investigation and coordinating my insurance coverage, which may include allowing a Manufacturer field representative to access my information and engage with my healthcare providers directly, if necessary; (iii) if needed, determining my eligibility for and coordinating financial assistance, including the REACH Patient Assistance Program ("PAP"); (iv) providing me with educational materials about SKYCLARYS™; (v) facilitating quality and adverse event reporting activities; (vi) conducting data analytics, market research and Program-related business activities; (vii) contacting me by direct mail or electronic or telephonic means to the contact information on this form or to any future contact information provided by me or on my behalf in connection with carrying out the Program services, including adherence-related communications, reminders, and support, for which Biologics by McKesson and/or other Agents may receive financial remuneration from Manufacturer.

I understand that once my Information has been disclosed to CORPORATION, federal privacy laws may no longer protect the Information from further disclosure, but that CORPORATION intends to use and disclose my Information only in accordance with this Authorization or as otherwise allowed by law. I understand that I may refuse to sign this Authorization and that a refusal to sign will not affect my ability to obtain medical care, insurance coverage, or access to health benefits, including access to therapy. However, if I do not sign this Authorization, CORPORATION cannot provide me with Program services. I understand that I can revoke my authorization at any time by calling 1-844-98-REACH or by mailing a signed written statement with my name, address, and phone number to Reata REACH at 11800 Weston Parkway, Cary, NC 27513. Withdrawal of authorization will end further reliance on this Authorization and end my participation in the Program. I understand that such a revocation will not apply to uses or disclosures made before the Program receives and processes my statement of revocation. If I do not revoke the authorization, it will expire two (2) years from the date I sign below, or upon such earlier date as may be mandated by state law. By signing below,
I certify that I have read and understand the Authorization to Release Personal Health Information and agree to its terms. I understand that I am entitled to a copy of this Authorization upon request.

☐ I agree to be contacted by text messages ("texts"), placed by Reata or its agents or service providers (collectively, Reata) to the mobile phone number I have provided in the Patient Information Section of this Enrollment Form, which may contain promotional communications related to the services for which I am currently enrolled and/or my treatment. I certify that the number I am providing may be used to provide sensitive or confidential information. I acknowledge that standard text message rates may apply and that I may opt out of receiving such messages at any time by calling 1-844-98-REACH or replying "STOP" by text to any text from Reata, and that my consent to being contacted by text messages is not a condition for me to participate in Reata REACH or to purchase any products or services.

☐ I would also like to receive information from Reata via US mail or email, which may include disease state educational material, marketing information, and other information about SKYCLARYS™.

Patient Full Name (Print):

Caregiver/Authorized Representative Full Name (Print): Relationship to Patient:

X Signature: **Date:**

