OPENDOORS®
Individualized care and support for patients like you®

OFEV® (nintedanib) capsules

OPEN DOORS® Patient Support Program Opt-In Form

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

For assistance or additional information, call
1-866-OPENDOOR (1-866-673-6366)

Upon your enrollment into the patient support program, the following services (collectively, the "services"), will be available to you:

- Nurse support via telephone 24 hours a day, 7 days a week to help answer any questions you may have about OFEV®
- Assistance to help you find potential social support resources in your area

If you elect to receive Boehringer Ingelheim Clinical Education, the services may also include any such educational class(es).

Clinical Educator Support on OFEV

Provided by Boehringer Ingelheim, Clinical Educators* can help you understand more about your disease and your treatment with OFEV (nintedanib) capsules to help you off to a good start. They will go over important safety information, including how your doctor can decide to manage certain side effects.

SELECT ONE (Required Field):

❑ **YES:** I would like to schedule an educational class with a Boehringer Ingelheim Educator.

❑ **NO:** I do not want to receive an educational class with a Boehringer Ingelheim Educator.

PATIENT INFORMATION

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 Authorization

I have read and agree to the patient certifications included in Section 3, which permit Boehringer Ingelheim Pharmaceuticals, Inc. to use and disclose my health information to provide Services to me.

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 Patient Authorization to Use and Disclose Health Information included in Section 4, which permits my physician, pharmacy and my health plan(s) 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

Optional Use and Disclosure of My Health Information

While Boehringer Ingelheim cannot provide me the Services unless I sign above, Boehringer Ingelheim would also like to use and disclose my Health Information (as defined in Section 3) 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.

*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.

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PRESCRIBER INFORMATION

SECTION 2: PRESCRIBER INFORMATION

Prescriber name _____ Site/facility name_____

Prescriber NPI # _____ Office contact name_____

Specialty _____ Office contact email _____

Address _____ Phone (_____)_____

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

Patient Diagnosis:

_____

SECTION 3: Patient Authorization Consent [To be completed by Patient or Caregiver/Legal Representative.]

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

I authorize Boehringer Ingelheim Pharmaceuticals, Inc., its affiliated companies, vendors, agents, and representatives (collectively, "Boehringer Ingelheim") to receive, use, and disclose my Health Information in order to:

I. Enroll me in the OPEN DOORS® Patient Support Program;

II. Provide my health care provider with information on my interactions with the OPEN DOORS® Patient Support Program;

III. Assist with analyses related to OFEV and the OPEN DOORS® Patient Support Program or any other patient support program administered by Boehringer Ingelheim;

IV. Provide me with other informational materials or surveys about my treatment experience with OFEV and the OPEN DOORS® Patient Support Program;

V. Contact my specialty pharmacy and health care provider on my behalf;

VI. If so elected in the prior page, to receive education from a Boehringer Ingelheim Clinical Educator, who may in turn share my Health Information with my doctor.

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 below, 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 Service 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 Authorization.

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SECTION 4: 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.

I direct and authorize my physician, pharmacy and my health plan(s) to use and disclose my protected health information (PHI) to Boehringer Ingelheim Pharmaceuticals, Inc., its affiliated companies, vendors, agents, and representatives (collectively, "Boehringer Ingelheim") and its partners, as necessary for Boehringer Ingelheim to provide the above services described in this form.

My PHI may include:

- Name and birthdate
- Address, telephone number and email address
- Information on my medical condition, as necessary
- Information about my health benefits or health insurance coverage

Reasons for sharing and using my PHI may include:

- Working with my health care plan to understand coverage for Boehringer Ingelheim products
- Applying to the BI Cares Patient Assistance Program
- Determining my eligibility and enrollment into financial assistance services, including co-pay assistance
- Coordinating my prescription through a pharmacy, infusion site and/or health care provider's office
- Providing treatment reminders and education

Once I sign this Authorization and my PHI is transmitted to Boehringer Ingelheim, I understand that the Health Insurance Portability and Accountability Act (HIPAA) may no longer protect or prohibit the redisclosure of the PHI disclosed to Boehringer Ingelheim. I understand that Boehringer Ingelheim has agreed to use and disclose my PHI only as described in Section 3 of this form. I can choose not to sign this Authorization, but if I do not sign, Boehringer Ingelheim will not be able to provide me with 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.

The length and terms of 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 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 PHI with Boehringer Ingelheim, but this will not affect PHI 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

I understand that I, as the patient or signer, have a right to receive a copy of this signed form.

Thank you for completing the form. We look forward to supporting you by providing helpful information and assistance.
Please fax to 1-844-880-OFEV (6338) or mail to: P.O. Box 5070 Louisville, KY 40255

Additional forms can be obtained by calling OPEN DOORS® at 1-866-OPENDOOR (1-866-673-6366) or visiting www.OFEV.com