BRINSUPRI Prescription

Brinsupri™ (brensocatib) tablets, 10 mg • 25 mg | inLighten™ Patient Support

Fax: (844) 960-5300 or email: brinsupri@inlightensupport.com

To prevent delays, please:

1. Complete all required fields (marked with an asterisk) on pages 1 and 3

2. Include scanned copies of both sides of the patient's pharmacy insurance card(s)

HEALTHCARE PROFESSIONAL & PRESCRIPTION INFORMATION

Patient Information:

*Patient First Name: _____ *Patient Last Name: _____

*DOB: _____ *Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Unknown

*Physical Address (no PO boxes): _____

*Physical City: _____ *Physical State: _____ *Physical ZIP: _____ *Mobile Phone: _____

Prescriber Information:

*Prescriber First Name: _____ *Prescriber Last Name: _____

*Practice Name: _____ Specialty: _____

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

*Phone: _____ Extension Line: _____ *Fax: _____ *NPI #: _____

Office Contact Name: _____ Office Contact Phone: _____

Office Contact Email: _____ Best Time to Contact Office: ☐ AM ☐ PM

This Prescription does not need to be sent to a pharmacy because it was already sent directly to a:
☐ SP checked below ☐ VA pharmacy ☐ 340B entity

BRINSUPRI is fulfilled by 3 in-network pharmacies. Check box below to indicate preference. ☐ No Preference
☐ Amber Specialty Pharmacy ☐ Maxor Specialty Pharmacy, A VytlOne Company ☐ PANTHERx Rare Pharmacy

Diagnosis (ICD-10-CM Code): ☐ J47.0 Bronchiectasis, with acute lower respiratory infection ☐ Other: _____
☐ J47.1 Bronchiectasis, with acute exacerbation ☐ J47.9 Bronchiectasis, uncomplicated

Current medications: _____

Known drug allergies: _____

Official Prescription Information

Product: BRINSUPRI

Quantity: 30-day supply

Dosing Info: ☐ BRINSUPRI 10 mg (take 1 tablet orally once daily) ☐ BRINSUPRI 25 mg (take 1 tablet orally once daily)

☐ 11 refills ☐ Other: _____

New York prescribers, please submit prescription on an original NY State prescription blank. The prescriber is to comply with his or her state-specific form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber. ***Substitution permitted?** ☐ Yes ☐ No

Prescriber Certification

I certify that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. By submitting this form, I certify that I am the prescriber who has prescribed BRINSUPRI to the previously identified patient, that the patient authorized the disclosure of their personal health information to Insmed, that I provided the patient with a description of the *inLighten™ Patient Support* program, and that the patient has given permission to be contacted by Insmed regarding the *inLighten Patient Support* program. I authorize the *inLighten Patient Support* program to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

***Prescriber Signature** _____ ***Date:** _____

No stamped signatures accepted

Please see Indication and Important Safety Information for BRINSUPRI on page 2 and accompanying full Prescribing Information.

Questions?
Phone: **833-LIGHT-00 (833-544-4800)**

SAFETY INFORMATION

INDICATION

BRINSUPRI is indicated for the treatment of non-cystic fibrosis bronchiectasis (NCFB) in adult and pediatric patients 12 years of age and older.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Dermatologic Adverse Reactions

Treatment with BRINSUPRI is associated with an increase in dermatologic adverse reactions, including rash, dry skin, and hyperkeratosis. Monitor patients for development of new rashes or skin conditions and refer patients to a dermatologist for evaluation of new dermatologic findings.

Gingival and Periodontal Adverse Reactions

Treatment with BRINSUPRI is associated with an increase in gingival and periodontal adverse reactions. Refer patients to dental care services for regular dental checkups while taking BRINSUPRI. Advise patients to perform routine dental hygiene.

Live Attenuated Vaccines

It is unknown whether administration of live attenuated vaccines during BRINSUPRI treatment will affect the safety or effectiveness of these vaccines. The use of live attenuated vaccines should be avoided in patients receiving BRINSUPRI.

ADVERSE REACTIONS

The most common adverse reactions ≥2% in the ASPEN trial included upper respiratory tract infection, headache, rash, dry skin, hyperkeratosis, and hypertension. The safety profile for adult patients with NCFB in WILLOW was generally similar to ASPEN, except for a higher incidence of gingival and periodontal adverse reactions.

Less Common Adverse Reactions

Liver Function Test Elevations

In ASPEN, there was an increase from baseline in average ALT, AST, and alkaline phosphatase levels at all time points from Week 4 through Week 56 in both BRINSUPRI 10 mg and 25 mg arms compared to placebo. The incidence of ALT >3X upper limit of normal (ULN) was 0%, 1.2%, and 0.9%; the incidence of AST >3X ULN was 0.2%, 0.3%, and 0.5%; and the incidence of alkaline phosphatase >1.5X ULN was 2.5%, 4.1%, and 4.0% in patients treated with placebo and BRINSUPRI 10 mg and 25 mg, respectively.

Skin Cancers

In ASPEN, the incidence of skin cancers among patients treated with BRINSUPRI 10 mg and 25 mg was 0.5% and 1.9%, respectively, compared to 1.1% in placebo-treated patients.

Alopecia

In ASPEN, the incidence of alopecia among patients treated with BRINSUPRI 10 mg and 25 mg was 1.5% and 1.6% respectively, compared to 0.4% in placebo-treated patients.

USE IN SPECIFIC POPULATIONS

Pregnancy: There are no clinical data on the use of BRINSUPRI in pregnant women.

Lactation: There is no information regarding the presence of BRINSUPRI and/or its metabolite(s) in human milk, the effects on the breastfed infant, or the effects on milk production. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for BRINSUPRI and any potential adverse effects on the breastfed child from BRINSUPRI or from the underlying maternal condition.

Pediatric use: The safety and effectiveness of BRINSUPRI for the treatment of NCFB have been established in pediatric patients aged 12 years and older. Common adverse reactions in pediatric patients aged 12 years and older enrolled in ASPEN were consistent with those in adults. The safety and effectiveness of BRINSUPRI have not been established in pediatric patients younger than 12 years of age.

Please see full Prescribing Information.

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PP-BRIN-US-00334 08/2025

Patient Support Program Enrollment Form

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To prevent delays, please:

1. Complete all required fields (marked with an asterisk) on pages 1 and 3

2. Include scanned copies of both sides of the patient's pharmacy insurance card(s)

PATIENT INFORMATION

*Patient First Name: _____ *Patient Last Name: _____ *MI: _____

*DOB: _____ *Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Unknown

*Physical Address (no PO boxes): _____

*Physical City: _____ *Physical State: _____ *Physical ZIP: _____

*Mailing Address: _____ ☐ Same as Physical Address

*Mailing City: _____ *Mailing State: _____ *Mailing ZIP: _____

*Mobile Phone: _____ Home Phone: _____ Patient Email: _____

Preferred Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

Preferred Contact Language: ☐ English ☐ Spanish ☐ Other: _____

Authorized Alternate Contact (or parent/guardian) First Name: _____ Last Name: _____

Alternate Contact Phone: _____ Relationship to Patient: _____

Authorization for Use and Disclosure of My Health Information: I have read and agree to the Authorization for Use and Disclosure of My Health Information on page 4. By signing below, I authorize the disclosure of my PHI to the *inLighten Patient Support* program as described in the Authorization for Use and Disclosure of My Health Information on page 4.

***Patient Signature 1** _____ ***Date:** _____

PATIENT / LEGAL REPRESENTATIVE IF PATIENT IS <18 YEARS (PUERTO RICO <21)

Patient Support Program Enrollment and Data Collection Consent: I have read and agree to the Patient Support Program Enrollment and Data Collection Consent on page 4. By signing below, I agree to enroll in the *inLighten Patient Support* program and consent to processing of my Health Information as described in the Patient Support Program Enrollment and Data Collection Consent on page 4.

***Patient Signature 2** _____ ***Date:** _____

PATIENT / LEGAL REPRESENTATIVE IF PATIENT IS <18 YEARS (PUERTO RICO <21)

If signed by legal representative:

Printed name: _____ Relationship to patient: _____

Prescription Insurance Information (Please Fax a Copy of Insurance Card)

Primary Pharmacy Insurance:

*Prescription Coverage Plan Name: _____

Beneficiary/Cardholder: _____ Relationship to Cardholder: _____

*Primary Insurance ID #: _____ *Group #: _____

*BIN: _____ *PCN: _____ *Phone: _____

*Primary Rx Plan Type: ☐ Private/Commercial ☐ Medicare Advantage ☐ Medicare Part D ☐ Medicaid ☐ TRICARE ☐ Other

Secondary Pharmacy Insurance:

Secondary Prescription Coverage Plan Name: _____

Beneficiary/Cardholder: _____ Relationship to Cardholder: _____

Secondary Insurance ID #: _____ Secondary Group #: _____

Secondary BIN: _____ Secondary PCN: _____ Secondary Phone: _____

Secondary Rx Plan Type: ☐ Private/Commercial ☐ Medicare Advantage ☐ Medicare Part D ☐ Medicaid ☐ TRICARE ☐ Other

Patient Does Not Have Insurance ☐

Please see Indication and Important Safety Information for BRINSUPRI on page 2 and accompanying full Prescribing Information.

Questions?
Phone: **833-LIGHT-00 (833-544-4800)**

PATIENT AUTHORIZATION

Authorization for Use and Disclosure of My Health Information

I authorize my health care providers, including the pharmacies I use and my health plan(s), to disclose to Insmed (the manufacturer of my prescription) and its affiliates, agents, contractors, and any other person or entity assisting Insmed in the administration of the *inLighten Patient Support* program, my personal information (e.g., my name, gender, date of birth, address) and information about my health, including the information provided by my health care provider on any Patient Enrollment Form (collectively, "My Health Information"), for the following purposes (collectively, the "Patient Support Program Purposes"):

- To facilitate my participation in the *inLighten Patient Support* program;
- To investigate, verify, and determine my insurance coverage;
- To provide financial assistance and support to facilitate access to my medications as prescribed by my health care provider;
- If applicable, to facilitate a voluntary training session educating on device use and successful treatment initiation;
- To determine my initial and continuing eligibility for other assistance programs;
- To use My Health Information to contact me by phone, mail, e-mail, or text message to request further information, discuss the enrollment process, send me educational materials related to and administer my participation in the *inLighten Patient Support* program, evaluate treatment progress and/or the effectiveness of the *inLighten Patient Support* program;
- For Insmed's internal business purposes of continuous improvement, including ongoing quality control, data analysis, product development, marketing, and research. This may include the use or development of automated tools and processes, such as those related to artificial intelligence; and
- To help ensure the accuracy and completeness of any forms, applications, or other documentation provided to Insmed by me or on my behalf

I understand that my pharmacy provider may receive financial remuneration from Insmed in exchange for My Health Information and/or for any therapy support services provided to me. I also understand that once My Health Information has been disclosed under this Authorization, federal privacy laws may no longer protect it and My Health Information may be subject to further disclosure. I further understand that if I decline to sign this Authorization, that will not affect my eligibility for health plan benefits or treatment by my health care providers, but I will not be able to participate in the *inLighten Patient Support* program. I understand I have the right to revoke this Authorization for any and all purposes at any time by notifying my health care provider in writing.

If I revoke this Authorization, I understand that my health care provider will stop making disclosures of My Health Information to the *inLighten Patient Support* program. However, I also understand that the uses and disclosures of My Health Information previously made by my health care provider to the *inLighten Patient Support* program in reliance on this Authorization will not be deemed invalid. This Authorization expires ten (10) years from the date of my signature, unless I revoke it or the expiration date is specified or mandated to be shorter by applicable state law. I understand that I am entitled to a copy of this Authorization once signed.

Patient Support Program Enrollment and Data Collection Consent

I agree to enroll in the *inLighten Patient Support* program provided by Insmed and verify that the information in the "Patient Information" section of this form is accurate and complete. I also agree that Insmed and its data processors, affiliates, agents, contractors, and any other person or entity assisting Insmed in the administration of the *inLighten Patient Support* program (which may include but not be limited to co-pay administrators, fulfillment/logistics partners, and patient educators) may collect, use, and disclose information about me, my finances, and my health, which may include my sensitive data and consumer health data, as listed below (collectively, "My Information"), for the Purposes defined in the Authorization for Use and Disclosure of My Health Information:

- Individual health conditions, treatment, diseases, or diagnosis;
- Social, psychological, behavioral, and medical interventions;
- Health-related surgeries or procedures;
- Use or purchase of prescribed medication;
- Bodily functions, vital signs, symptoms, or measurements related to health;
- Diagnoses or diagnostic testing, treatment, or medication;
- Data that identifies me as a consumer seeking health care services; and
- Health-related data that have been derived or inferred from the above.

I understand that I am not required to consent to processing of My Information for these purposes. However, I understand that if I do not consent, I will not be able to participate in the *inLighten Patient Support* program, as collection of My Information is necessary for Insmed to facilitate my participation. I understand I have the right to withdraw my consent to participate in the *inLighten Patient Support* program at any time. I also understand that, depending on where I live, applicable state law may grant me the right to request restrictions on Insmed's collection, use, and disclosure of My Information. If I withdraw my consent, I understand that the uses and disclosures of My Information previously made in reliance on this Consent will not be deemed invalid. To withdraw my consent to participate in the *inLighten Patient Support* program or to request restrictions on the collection, use, or disclosure of My Information, I understand that I may call 833-544-4800 or write to Insmed Incorporated, Attn: *inLighten Patient Support* program, 700 US Highway 202/206, Bridgewater, NJ 08807.

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PP-BRIN-US-00334 08/2025