nemluvio™
(nemolizumab-ilto) for injection

NEMLUVIO® Specialty Pharmacy Enrollment Form

for Patients

Please fax the completed enrollment form to your preferred network specialty pharmacy.

Network Specialty Pharmacies

NEMLUVIO® (nemolizumab-ilto) is available through a limited distribution network of specialty pharmacies. Our specialty pharmacy network is contracted to provide enhanced service offerings, ensuring that patients are supported throughout the entire NEMLUVIO patient journey. Patients can scan the QR code to open the specialty pharmacy's website. Please save the contact information for your preferred specialty pharmacy. The specialty pharmacy will arrange for shipment.

AcariaHealth
Phone: 800-511-5144
Fax: 877-541-1503

Accredo Health Group, Inc.
Phone: 866-839-2162
Fax: 866-531-1025

Amber Specialty Pharmacy
Phone: 888-370-1724
Fax: 877-645-7514

BioPlus Specialty Pharmacy
Phone: 888-292-0744
Fax: 800-269-5493

CenterWell Specialty Pharmacy
Phone: 800-486-2668
Fax: 877-405-7940

CVS Specialty
Phone: 800-237-2767
Fax: 800-323-2445

Gentry Health Services
Phone: 844-443-6879
Fax: 844-329-2447

Lumicera Health Services
Phone: 855-847-3553
Fax: 855-847-3558

Optum Specialty
Phone: 855-427-4682
Fax: 877-342-4596

Senderra Pharmacy
Phone: 888-777-5547
Fax: 888-777-5645

Walgreens Specialty Pharmacy
Phone: 888-347-3416
Fax: 877-231-8302

Galderma Patient Services will call patients from: 1-855-636-5884. If unable to reach them, we will leave a voicemail. Patients are encouraged to check messages and return calls promptly.

This page is for NEMLUVIO patients.

Scan to explore GPS for NEMLUVIO

Please see full prescribing information at www.nemluvio.com.

US-NLV-2500075 (11/25)

nemluvio™ (nemolizumab-ilto) for injection

PLEASE REMEMBER Complete the ENTIRE form to avoid any delays and fax to your Preferred Network Specialty Pharmacy.

Attach front and back of insurance card. An incomplete enrollment form may delay the start of treatment.

☐ Copy of insurance card attached ☐ No insurance

ID | BIN | PCN | GROUP

Please select your preferred Specialty Pharmacy

☐ Already sent to Specialty Pharmacy?

☐ AcariaHealth Fax: 877-541-1503
☐ Accredo Health Group, Inc. Fax: 866-531-1025
☐ Amber Specialty Pharmacy Fax: 877-645-7514
☐ BioPlus Specialty Pharmacy Fax: 800-269-5493
☐ CenterWell Specialty Pharmacy Fax: 877-405-7940
☐ CVS Specialty Fax: 800-323-2445
☐ Gentry Health Services Fax: 844-329-2447
☐ Lumicera Health Services Fax: 855-847-3558
☐ Optum Specialty Fax: 877-342-4596
☐ Senderra Fax: 888-777-5645
☐ Walgreens Specialty Pharmacy Fax: 877-231-8302

1. Patient Information

To be fully completed by the healthcare provider and the patient or legal guardian before leaving the office. For information about how your information will be used, please see terms and conditions. By receiving services through GPS (Galderma Patient Services) for NEMLUVIO™ (nemolizumab-ilto), patient accepts all terms and conditions of the GPS for NEMLUVIO programs on page 5.

First Name | Middle Initial | Last Name | Date of Birth (MMDDYYYY) / / | Email | Sex: ☐ Male ☐ Female

Phone Number *Cell Phone (preferred); Home Phone (optional)* | Best Time to Contact | Address (No PO Box) | City | State | Zip

Guardian First Name *If patient is otherwise under the care of a guardian* | Guardian Last Name | Guardian Relationship | Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

2. Provider Information

☐ Allergist ☐ Dermatologist ☐ Immunologist ☐ Other: _____

Full Name | HCP Title

NPI Number | Practice Name/Affiliation

Office Contact Name | Supervising Physician (if applicable)

Provider/Office Email | Office Fax | Office Contact Phone

Address | City | State | Zip

3. Clinical Information To be completed by the HCP

Please list all previous treatments tried, failed, or patient is intolerant to. Be sure to include clinic notes to support your selection(s) for payers' prior authorizations.

Concurrent Medications

Other Disease Impacts *(physical, social, or psychosocial impairment)*

Patient Assistance Program (OPTIONAL):

The GPS for NEMLUVIO Patient Assistance Program ("PAP") is provided to NEMLUVIO patients who meet the eligibility criteria so they may begin or continue taking NEMLUVIO when they do not have adequate coverage for the product.

Number of people in household *Household = you, spouse and dependents* | Annual Household Income

Patient/Legal Guardian Signature

If not patient, relationship to patient | Date of Signature (MMDDYYYY)

Select Automatic Income Verification OR Self-Verification of Income:

Automatic Income Verification

☐ I hereby certify that I am providing authorization under the US Fair Credit Reporting Act to Galderma to obtain a consumer report from consumer reporting agencies and income verification services on me. I authorize Galderma to use such information for the purpose of estimating my income and determining if I qualify for PAP. This Authorization shall be valid until I exit the PAP Program or revoke this authorization. I understand that I may request the name of the consumer reporting agency or cancel this Authorization at any time by contacting GPS, but that this cancellation will not apply to any information already used or disclosed based on this Authorization. I also certify that I have read and consent to all the PAP Program Terms and Conditions.

Self-Verification of Income

☐ I attest that the income and number of people in my household are accurate and that Galderma may use this information to determine my eligibility for PAP. I understand that I may be removed from the Program if I fail to timely provide requested documentation of this information.

Patient Authorization and Additional Consents

By signing below, I acknowledge I have read and agree with the Patient Authorization on page 5, and that my personal health information will be collected, used, and disclosed to provide services in the GPS for NEMLUVIO Program consistent with the terms and conditions of the program. I know that I can withdraw my consent by contacting GPS for NEMLUVIO.

SIGN & DATE

Patient/Legal Guardian Signature | **Date of Signature** (MMDDYYYY) / / | If not patient, relationship to patient

☐ **For manufacturer and reimbursement support, I consent to the Galderma Communications Consent, found on page 5.**

☐ **I consent to receiving Text Messages per the consent on page 5.**

Any questions or need help? Please call: 1-855-636-5884

Please see full prescribing information at www.nemluvio.com.

US-NLV-2500075 (11/25)

nemluvio™
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Patient & Prescriber Information (all fields required)

Patient First Name | Middle Initial | Patient Last Name | Date of Birth (MMDDYYYY)

Patient Phone Number | Patient Address | City | State | Zip

Prescriber Name | Prescriber Address | City | State | Zip

NPI # | Prescriber State License # | Prescriber Phone Number | Prescriber Fax Number

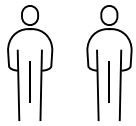
4. Prescription Information:

Prurigo Nodularis

Prurigo Nodularis Diagnosis:

- ☐ L28.1 Prurigo nodularis
- ☐ Other ICD-10-CM code _____

Affected Areas



☐ Patient has >20 nodules

Did this patient start NEMLUVIO on a sample?

☐ Yes ☐ No If yes, date sample product provided: ___/___/___

Weight (required):

☐ lb ☐ kg ___/___/___ Date (MMDDYYYY)

Known Drug Allergies ☐ NKDA

Please remember to fill out both prescription sections below.

Send dose to (as allowable by law): ☐ Patient's Home ☐ HCP Address

Network Specialty Pharmacy Prescription
NEMLUVIO 30 mg/0.49 mL single dose dual chamber pen (NDC 00299-6220-15)

Loading Dose:

☐ No, patient already on therapy

☐ **Yes, two 30 mg/0.49 mL pens (60 mg);**
SIG: Inject contents of 2 pens (60 mg), subcutaneously at week 0.
Dispense Qty: 2 pens

Maintenance Dose:

☐ **30 mg/0.49 mL pen;**
SIG: Inject contents of 1 pen (30 mg), subcutaneously every 4 weeks.
Dispense Qty: 1 pen Refills: 12, or ____

☐ **For patients > or = 90 kg/198.4 lb, two 30 mg/0.49 mL pens (60 mg);**
SIG: Inject contents of 2 pens (60 mg), subcutaneously every 4 weeks.
Dispense Qty: 2 pens Refills: 12, or ____

Prescriber Attestation

Prescriber must authorize these prescriptions and instructions by signing at the end of this section.

As the prescriber, I certify that NEMLUVIO is medically necessary for an FDA-approved indication for the previously identified patient and the information on this form is accurate to the best of my knowledge. I have reviewed the current full Prescribing Information for NEMLUVIO. I certify that I have obtained all necessary authorizations and consents as required by federal and state laws including HIPAA to disclose to Galderma, patient information including to facilitate insurance coverage for the product, initiating/dispensing therapy, and administering GPS for NEMLUVIO. I authorize Galderma and its affiliates, business partners, and agents to forward this prescription to the appropriate dispensing pharmacies, and I will comply with my state-specific prescription requirements, such as e-prescribing, state-specific prescription forms, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

SIGN & DATE

Prescriber Signature
(Dispense as Written/Brand Medically Necessary)

___/___/___ **Date of Signature** (MMDDYYYY)

SIGN

Prescriber Signature
(Substitution Permissible)

GPS for NEMLUVIO Free Goods Program: Quick Start/Bridge/PAP
NEMLUVIO 30 mg/0.49 mL single dose dual chamber pen (NDC 00299-6220-15)

Loading Dose:

☐ No, patient already on therapy

☐ **Yes, two 30 mg/0.49 mL pens (60 mg);**
SIG: Inject contents of 2 pens (60 mg), subcutaneously at week 0.
Dispense Qty: 2 pens

Maintenance Dose:

☐ **30 mg/0.49 mL pen;**
SIG: Inject contents of 1 pen (30 mg), subcutaneously every 4 weeks.
Dispense Qty: 1 pen Refills: 12, or ____

☐ **For patients > or = 90 kg/198.4 lb, two 30 mg/0.49 mL pens (60 mg);**
SIG: Inject contents of 2 pens (60 mg), subcutaneously every 4 weeks.
Dispense Qty: 2 pens Refills: 12, or ____

Prescriber Attestation

Prescriber must authorize these prescriptions and instructions by signing at the end of this section.

As the prescriber, I certify that NEMLUVIO is medically necessary for an FDA-approved indication for the identified patient and the information on this form is accurate to the best of my knowledge. I certify that any product received will not be offered to any other patient or for sale, trade, or barter, and no reimbursement claim will be submitted. I have reviewed the current full Prescribing Information for NEMLUVIO. I certify that I have obtained all necessary authorizations and consents as required by federal and state laws including HIPAA to disclose information to Galderma. I authorize Galderma and its affiliates, business partners, and agents to forward this prescription to the appropriate dispensing pharmacies, and I will comply with my state-specific prescription requirements, such as e-prescribing, state-specific prescription forms, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

SIGN & DATE

Prescriber Signature
(Dispense as Written/Brand Medically Necessary)

___/___/___ **Date of Signature** (MMDDYYYY)

SIGN

Prescriber Signature
(Substitution Permissible)

Any questions or need help? Please call: 1-855-636-5884

Please see full prescribing information at www.nemluvio.com.

US-NLV-2500075 (11/25)

nemluvio™
(nemolizumab-ilto) for injection

Patient & Prescriber Information (all fields required)

Patient First Name _____ Middle Initial _____ Patient Last Name _____ Date of Birth (MMDDYYYY) __/__/____

Patient Phone Number _____ Patient Address _____ City _____ State _____ Zip _____

Prescriber Name _____ Prescriber Address _____ City _____ State _____ Zip _____

NPI # _____ Prescriber State License # _____ Prescriber Phone Number _____ Prescriber Fax Number _____

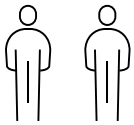
4. Prescription Information:

Atopic Dermatitis

Atopic Dermatitis Diagnosis:

- ☐ L20.9 Atopic dermatitis, unspecified
- ☐ L20.89 Other atopic dermatitis
- ☐ Other ICD-10-CM code _____

Affected Areas



☐ If <10% BSA; involvement of sensitive areas such as palms of hands, soles of feet, groin etc.

Investigator's Global Assessment Score (0-4) _____

Body Surface Area % _____ Date (MMDDYYYY) __/__/____

Did this patient start NEMLUVIO on a sample?

☐ Yes ☐ No **If yes, date sample product provided:** __/__/____

_____ ☐ NKDA
Known Drug Allergies

Please remember to fill out both prescription sections below.

Send dose to (as allowable by law): ☐ **Patient's Home** ☐ **HCP Address**

Network Specialty Pharmacy Prescription
NEMLUVIO 30 mg/0.49 mL single dose dual chamber pen (NDC 00299-6220-15)

Loading Dose:

☐ No, patient already on therapy

☐ **Yes, two 30 mg/0.49 mL pens (60 mg);**
SIG: Inject contents of 2 pens (60 mg), subcutaneously at week 0.
Dispense Qty: 2 pens

Maintenance Dose:

☐ **30 mg/0.49 mL pen;**
SIG: Inject contents of 1 pen (30 mg), subcutaneously every 4 weeks.
Dispense Qty: 1 pen Refills: 12, or ____

Prescriber Attestation
Prescriber must authorize these prescriptions and instructions by signing at the end of this section.

As the prescriber, I certify that NEMLUVIO is medically necessary for an FDA-approved indication for the previously identified patient and the information on this form is accurate to the best of my knowledge. I have reviewed the current full Prescribing Information for NEMLUVIO. I certify that I have obtained all necessary authorizations and consents as required by federal and state laws including HIPAA to disclose to Galderma, patient information including to facilitate insurance coverage for the product, initiating/dispensing therapy, and administering GPS for NEMLUVIO. I authorize Galderma and its affiliates, business partners, and agents to forward this prescription to the appropriate dispensing pharmacies, and I will comply with my state-specific prescription requirements, such as e-prescribing, state-specific prescription forms, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

SIGN & DATE

Prescriber Signature
(Dispense as Written/Brand Medically Necessary)

__/__/____
Date of Signature (MMDDYYYY)

SIGN

Prescriber Signature
(Substitution Permissible)

GPS for NEMLUVIO Free Goods Program: Quick Start/Bridge/PAP
NEMLUVIO 30 mg/0.49 mL single dose dual chamber pen (NDC 00299-6220-15)

Loading Dose:

☐ No, patient already on therapy

☐ **Yes, two 30 mg/0.49 mL pens (60 mg);**
SIG: Inject contents of 2 pens (60 mg), subcutaneously at week 0.
Dispense Qty: 2 pens

Maintenance Dose:

☐ **30 mg/0.49 mL pen;**
SIG: Inject contents of 1 pen (30 mg), subcutaneously every 4 weeks.
Dispense Qty: 1 pen Refills: 12, or ____

Prescriber Attestation
Prescriber must authorize these prescriptions and instructions by signing at the end of this section.

As the prescriber, I certify that NEMLUVIO is medically necessary for an FDA-approved indication for the identified patient and the information on this form is accurate to the best of my knowledge. I certify that any product received will not be offered to any other patient or for sale, trade, or barter, and no reimbursement claim will be submitted. I have reviewed the current full Prescribing Information for NEMLUVIO. I certify that I have obtained all necessary authorizations and consents as required by federal and state laws including HIPAA to disclose information to Galderma. I authorize Galderma and its affiliates, business partners, and agents to forward this prescription to the appropriate dispensing pharmacies, and I will comply with my state-specific prescription requirements, such as e-prescribing, state-specific prescription forms, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

SIGN & DATE

Prescriber Signature
(Dispense as Written/Brand Medically Necessary)

__/__/____
Date of Signature (MMDDYYYY)

SIGN

Prescriber Signature
(Substitution Permissible)

Any questions or need help? Please call: 1-855-636-5884

Please see full prescribing information at www.nemluvio.com.

Patient Authorization

I acknowledge that some healthcare providers, pharmacies and health insurers, and their service providers (collectively, "Providers") may use and disclose my information related to health insurance benefits, medical condition, treatment, and prescription details ("Health Information") and identifying information about me including information such as my name, address, and date of birth ("Identifying Information") with other Providers under my other existing HIPAA authorizations.

By signing the Patient Authorization on the Enrollment Form, I authorize Providers to use and disclose my Health Information and Identifying Information to Galderma, its affiliates, agents, and service providers, including patient support program service providers, (collectively, "Galderma") in connection with my participation in Galderma Patient Services for NEMLUVIO. Galderma may use my Health Information and/or Personal Information to provide me with various support services and information to help me access NEMLUVIO from Galderma including one or more of the following Galderma services (the "Services"):

1. Work with my insurance to identify eligibility/requirements and attempt to secure coverage for NEMLUVIO,
2. Assist with access including appeals, savings, educational, and support services and information associated with my therapy,
3. Enroll me into appropriate programs that help me gain access to NEMLUVIO, which was prescribed by my healthcare provider,
4. Participate in quality assurance activities such as surveys and feedback related to the Services or my treatment.

By signing this Authorization, my Providers may also disclose my Health Information and Identifying Information to Galderma so that Galderma may use it to help improve, develop, and evaluate Galderma Patient Services for NEMLUVIO, the Services, and other products, services, materials, and programs related to my condition or treatment.

In delivering the Services, Galderma may disclose my Health Information and Identifying Information to my Providers and certain financial assistance programs that may assist with my NEMLUVIO therapy payments. I understand Galderma and Providers may combine my records and information with information and data collected from other sources and use that aggregated information for the purposes listed above. I understand that my Providers may receive payment from Galderma for the use and disclosure of my Health Information/Identifying Information pursuant to this authorization and providing certain Services, such as but not limited to treatment reminders or training, based on my enrollment or participation.

Once I authorize the release of my records and information, I understand it may be redisclosed by the recipient and it may no longer be protected by federal or state health privacy laws or other applicable data protection laws or regulations.

I understand that this Authorization is voluntary and that I do not have to sign it to get treatment or for eligibility or enrollment in benefits from my Providers. I understand that my information will be used by Galderma in accordance with its privacy policy, located at https://www.galderma.com/us/your-privacy. I understand that I can revoke this Authorization at any time by calling 1-855-636-5884 or writing to GaldermaPatientServices@assistrx.com. I understand that I am entitled to receive a copy of this authorization after I sign it.

This Authorization will expire 5 years after I sign it, or earlier if required by law, unless I revoke it sooner. If this Authorization expires or is revoked, it will not impact my Providers' treatment or my insurance benefits. I also understand that if a Provider is disclosing my Health Information to Galderma on an authorized, ongoing basis, my revocation of this Authorization will be effective with respect to that Provider as soon as that Provider receives notice of my revocation. Revocation of this Authorization will not affect prior uses or disclosures of my Health Information.

Galderma Communications Consent

By checking the box on the GPS for NEMLUVIO Enrollment Form, I consent to the use by Galderma of my health and personal information to contact me and provide me with information, marketing materials, and clinical trial opportunities related to my condition or treatment and other information and offers that Galderma believes to be of interest to me. Galderma may contact me for these purposes by e-mail, mail, telephone, and if I have checked the "Text Message Consent" box on the Enrollment Form, pre-recorded or automated calls and texts.

I understand that I can review Galderma's privacy policy, available at **https://www.galderma.com/us/your-privacy**, for more information about Galderma's collection, use, and sharing of health and personal information. This consent will remain in effect until I cancel it. I understand that I may revoke this consent at any time, which I may do by calling 1-855-636-5884 or writing to GaldermaPatientServices@assistrx.com, and that if I revoke this consent, my revocation will not affect any actions taken by Galderma before receiving my revocation. I may request a copy of this consent. I understand that consent is not required for enrollment in the GPS for NEMLUVIO program.

Text Message Consent

By checking the box on the GPS for NEMLUVIO Enrollment Form, I consent to receive calls and texts from and on behalf of Galderma made with an auto dialer or prerecorded voice, including texts and calls for marketing and promotional purposes, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase or enrollment in the GPS for NEMLUVIO program. The number of messages will vary based on my program selections, and I may receive up to 5 per week. I also understand that message and data rates may apply and that I can text STOP to opt out and HELP for help. I agree to Galderma's Text Messaging Terms, available at **https://www.galdermaps.iassist.com/termsandconditions**.

Galderma Patient Services for NEMLUVIO General Terms & Conditions

Galderma Laboratories, L. P. ("Galderma") is the authorized U.S. distributor of NEMLUVIO® (nemolizumab-ilto) for injection. The GPS for NEMLUVIO Program ("Program") is operated by Galderma and its designated service provider(s). The purpose of the Program is to help ensure that eligible patients who have been prescribed NEMLUVIO have access and support related to their NEMLUVIO treatment journey.

These General Terms & Conditions are applicable to any and all of the services provided by Program, including, without limitation, the GPS for NEMLUVIO Quick Start Program, the GPS for NEMLUVIO Bridge Program, the GPS for NEMLUVIO Patient Assistance Program, the GPS for NEMLUVIO Replacement Program, and the GPS for NEMLUVIO Commercial Copay Program, and/or any and all other services provided by the

Program. By participating in and/or receiving any services from any part of the Program, you agree to all of these General and Additional Terms & Conditions.

All services provided by the Program are provided free of charge to eligible patients by Galderma and should not be billed to or have payment requested from any insurance provider, third-party plan, or charitable organization, except as permitted in connection with the GPS for NEMLUVIO Copay Program. Patients who receive NEMLUVIO through the Program must not sell or transfer NEMLUVIO to any third party.

Patient understands that health care providers, pharmacies, health insurers, and service providers may receive payment from Galderma for providing certain services, such as but not limited to treatment reminders or training, based on enrollment/ participation in the Program.

Patient understands that participation in the Program is not conditioned on any past, present, or future purchases or prescriptions, including any potential future fills of NEMLUVIO. Patients using NEMLUVIO are not required to enroll in the Program but must enroll if they wish to participate in and/or receive services from the Program. Patients may participate in most aspects of the program without signing a patient authorization; however, services available to such patients are different. Participation is void where prohibited by law.

To participate in and/or receive services from the Program, a patient must be:

- prescribed NEMLUVIO by a licensed US HCP;
- prescribed NEMLUVIO in accordance with its FDA-approved indication(s) and labeling;
- 18 years or older (for patients with prurigo nodularis) or 12 years or older (for patients with atopic dermatitis); and
- reside in the 50 United States or Washington DC.

By participating in the Program, you agree that HCPs, pharmacies and health insurers, and their service providers (collectively, "Providers") may disclose information about a Patient including information such as name, address, and date of birth ("Personal Information") to Galderma and its affiliates, agents, and service providers, including patient support program service providers, (collectively, "Galderma") in connection with your participation in the Program.

Patients also agree that any information collected through and/or related to your participation in one or more parts of the Program may be collected, stored, aggregated, used, and disclosed by Galderma for any purpose.

Patient agrees that Galderma may use their Personal Information in a manner in accordance with the terms of the privacy policy at **Your Privacy | Galderma US** including to provide the patient with various support services and information and to help improve, develop, audit, and evaluate the Program, its services, and other products, services, materials, and programs related to Patient's condition or treatment. Patient understands and agrees that Galderma may combine their records and information with information and data collected about other participants and from other sources and use that aggregated information for a variety of purposes. Additionally, by participating in the Program, health information and personal information will be collected, used, and disclosed by the Program consistent with the Program's service provider's Notice of Privacy Practices, available at https://www.assistrx.com/privacy-policy/.

Acceptance and participation in the Program constitute an agreement with Galderma in Texas. Patient (You) consents to the Program being governed by and interpreted in accordance with the substantive laws of the State of Texas without regard to its conflict of law principles. By enrolling in and/ or participating in the Program, Patient agrees that the services have a reasonable relationship to the State of Texas in that, among other things, and agree that the exclusive venue for any dispute arising out of participation in the Program is a state or a federal court of competent jurisdiction in Dallas County, Texas. By enrolling in and/or participating in the Program, you irrevocably and unconditionally submit to the exclusive jurisdiction of a state or a federal court in Dallas County, Texas.

Not all patients will be eligible for all or any services provided in the Program. Offers and services provided under the Program may not be the best offer or lowest cost service available to you. Participation in one or more services of the Program may be subject to limitations imposed by your health insurer, and state or federal law. Galderma reserves the right to modify, rescind, or discontinue this Program, any part(s) or service(s) provided under the Program, the Terms & Conditions of the Program, and the Additional Terms & Conditions of its services at any time without notification and for any reason. Galderma reserves the right to rescind or revoke a patient's participation in the Program and its service(s) at any time and for any reason including non-compliance with the General and/or Additional Terms & Conditions, suspected fraud, or non-responsiveness. Galderma may communicate changes to patients and their Providers by periodically updating the GPS for NEMLUVIO General and Additional Terms & Conditions.

To unenroll in the GPS for NEMLUVIO Program, call 1-855-636-5884 for further instructions. You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.FDA.gov/MEDWatch or call 1-800-FDA-1088 or call Galderma Special Services at 866-735-4137.

THIS IS NOT INSURANCE.

Additional Program Terms & Conditions

In addition to the GPS for NEMLUVIO General Terms and Conditions, by enrolling in and/or participating in the following programs, Additional Terms & Conditions will apply:

- Additional Terms & Conditions of the GPS for NEMLUVIO Quick Start Program
- GPS for NEMLUVIO Bridge Program Terms & Conditions
- GPS for NEMLUVIO Commercial Copay Program
- GPS for NEMLUVIO Replacement Program Terms & Conditions
- GPS for NEMLUVIO Injection Education & Training Program Additional Terms and Conditions

Full terms and conditions can be found at **https://galdermaps.iassist.com/termsandconditions** or by contacting GPS.

Healthcare providers may request Full GPS Program Terms & Conditions from their Galderma representative.