Program Enrollment Form for Referring Physicians

Phone: 1-833-888-6378 • Fax: **1-844-999-6378** • Email: **mybluebirdsupport@bluebirdbio.com**

How to initiate enrollment for your patient into my bluebird support

- Please complete all required fields to initiate enrollment for your patient into **my bluebird support** and return via fax to **my bluebird support** at 1-844-999-6378.

Fields with an * are required information to initiate enrollment.

PATIENT INFORMATION

Patient Name

First* _____ Last* _____

Date of Birth (MM/DD/YYYY)* _____ Gender* ◯ Male ◯ Female Preferred Language (if not English) _____

Address* _____ City* _____ State* _____ Zip Code* _____

Phone* _____ Email Address* _____

Caregiver Name (required if patient is <18 years old)_____ Relationship to Patient _____

Qualified Treatment Center Name (if known) _____

INSURANCE INFORMATION

Please include a copy of the front and back of all of the patient's insurance card(s), if available.

Primary Insurance Name* _____ Plan Phone Number_____ Policy Number*_____

Group Number _____ Policyholder Name _____ Relationship to Patient _____ Policyholder Date Of Birth _____

Secondary Insurance Name* _____ Plan Phone Number_____ Policy Number*_____

Group Number _____ Policyholder Name _____ Relationship to Patient _____ Policyholder Date Of Birth _____

ENROLLING PHYSICIAN INFORMATION

First Name* _____ Last Name* _____ Physician Practice Name* _____

Address* _____ City* _____ State* _____ Zip Code* _____

Phone* _____ Fax* _____ Email* _____

DEA Registration Number* _____ NPI Number* _____ Tax ID Number* _____

Treatment Name* _____ Primary Diagnosis/ICD-10-CM Code* _____

Office Contact Name* _____ Phone Number* _____ Email* _____

Healthcare Provider Signature* _____ **Date (MM/DD/YYYY)*** _____

Healthcare Provider Name* _____

I certify to the following: (a) I have obtained the patient's authorization for the disclosure of the patient's information on this form to bluebird bio, Inc. and its agents (collectively "bbb"), for purposes of benefits verification, to assess the patient's eligibility for participation in **my bluebird support**, and for coordination in assessing the patient for eligibility for therapy; (b) I allow bbb to utilize my information provided in this enrollment form, including NPI/Tax ID, for the purpose of conducting the patient's benefits verification (c) I understand that I am under no obligation to recommend any bluebird bio product and I have not received and will not receive any benefit from bluebird bio for recommending a bluebird bio product; (d) the information contained in this form is accurate to the best of my knowledge; (e) I understand bluebird bio does not guarantee assistance and reserves the right to revise or cancel programs at any time; (f) I have reviewed and understand bluebird bio's Privacy Policy.

PATIENT SECTION MAY BE COMPLETED BY PATIENT IF PRESENT DURING TIME OF SUBMISSION

If patient is not present and the following sections of this form cannot be completed at submission, **my bluebird support** will reach out directly to the patient to complete enrollment. If patient is under the age of 18, the patient's legal representative should fill out patient sections of the form.

CONTACT OPT-IN TO BE COMPLETED BY PATIENT/CAREGIVER (OPTIONAL)

Preferred Method of Contact ☐ Phone ☐ Email ☐ Text

OPT-IN TO RECEIVE my bluebird support TEXT MESSAGES (Optional)

☐ By checking this box, I acknowledge that I have read bluebird bio's Privacy Policy (https://www.bluebirdbio.com/privacy-policy) and **my bluebird support's** texting Terms of Service (https://mybluebirdsupport.com/text-terms-of-service). I have read the Opt-in information below and by checking the box hereby provide my consent to receive support program text messages from **my bluebird support** at the telephone number(s) I provided. I understand that I am not required to provide this consent as a condition of purchasing or receiving any goods or services from bluebird bio. I may text "STOP" to opt out at any time. I may text "HELP" for help at any time. I understand message and data rates may apply. Message frequency varies. If I have any questions about my text plan or data plan, I must contact my wireless provider.

PATIENT/CAREGIVER CERTIFICATION - ALL FIELDS BELOW TO BE COMPLETED BY PATIENT (OPTIONAL)

- I certify that the personal information that I provide to **my bluebird support**, the support program from bluebird bio, Inc., is true and complete.
- I certify that all plans and programs through which I obtain healthcare coverage are listed above. I further certify I am a resident of the United States
- I understand that changes in my insurance provider, insurance coverage, or financial situation may affect my eligibility for certain **my bluebird support** program services and I agree to immediately notify my Patient Navigator at 1-833-888-6378 if any of these change (i.e., if I start to receive benefits from a federal or state government funded program, such as Medicare or Medicaid)
- I understand that enrollment in **my bluebird support** is not required in order to access a bluebird gene therapy
- I acknowledge and agree to these terms and conditions of **my bluebird support**
- I understand that bluebird bio does not guarantee coverage or reimbursement for applicable products. Coverage and reimbursement decisions are made by insurance companies following the receipt of claims

_____ _____

Signature of Patient or Legal Representative (if patient is under 18 Years of Age)† **Date (MM/DD/YYYY)**

_____ _____

Print Name of Patient or Legal Representative (if patient is under 18 Years of Age) **Relationship to Patient**

†By signing on behalf of the patient, as representative or guardian, I attest that I am legally authorized to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient (such as power of attorney or legal court order) may be requested.

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize and request that my treating physicians, health insurance plan(s), pharmacies or other health care providers (collectively "Health Care Providers") disclose my protected health information including medical, laboratory, and/or pharmacy records related to my diagnosis of, eligibility for therapy to treat and treatment of my medical condition relevant to a bluebird bio gene therapy, and other social determinants of health to bluebird bio and its affiliates (collectively "bluebird"), its contractors and business partners. This authorization is made for the purpose of enrolling me in bluebird's patient services program, providing me with patient services, and administering the patient services program. I understand that bluebird bio, its contractors and business partners may use and disclose my protected health information for the activities described in this authorization, including but not limited to communicating with my Health Care Providers to administer bluebird bio's Patient Services programs and for general operational purposes.

I understand that I have the right to revoke this authorization, in writing, at any time, except where disclosures have already been made based upon my original authorization. This authorization shall remain valid for a period of ten (10) years from the date the Authorization is signed, unless a shorter period is provided for by state law or revoked in writing prior to that time. I understand that I need to send a written request to revoke my authorization to a designated person/office at the specific Health Care Provider(s) or Insurers who provide information to bluebird bio.

I understand that it is possible that information used or disclosed with my permission pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that signing this authorization is voluntary. My treatment, payment, or eligibility for benefits is not conditioned upon my authorization of this disclosure. I acknowledge, however, that if I do not sign this authorization, I will not be able to participate in bluebird patient services programs.

I understand that certain parties, such as my pharmacy provider, may receive remuneration (payment) from bluebird bio in connection with the activities described in this authorization.

I understand I will receive a copy of this authorization upon completion of enrollment.

Signature of Patient or Legal Representative (if patient is under 18 Years of Age)*† _____ **Date (MM/DD/YYYY)*** _____

Print Name of Patient or Legal Representative (if patient is under 18 Years of Age)* _____ **Relationship to Patient** _____

†By signing on behalf of the patient, as representative or guardian, I attest that I am legally authorized to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient (such as power of attorney or legal court order) may be requested.

Patient/Caregiver Consent to Receive Marketing and Promotional Communications (optional)

- I consent to receiving communications by mail, email, or telephone (if I authorized) about bluebird bio products, services, and programs or other topics of interest. I authorize bluebird bio to contact me to conduct market research or otherwise ask me about me or my loved one's experience with or thoughts about such topics. I understand and agree that any information that I provide may be used by bluebird bio to help develop new products, services, and programs
- I understand that this Consent to Receive Marketing and Promotional Communications is not required to enroll in **my bluebird support** and is not required as a condition of purchasing any goods or services
- I understand that bluebird bio will not sell or transfer my personal data to any unrelated third party for marketing purposes without my express permission
- I have reviewed and understand bluebird bio's Privacy Policy
- I may opt out of marketing-related emails by clicking the "Unsubscribe" link at the bottom of each such email. To stop receiving other communications from bluebird bio, please contact us at privacy@bluebirdbio.com with your request
- This marketing consent expires after ten (10) years, or such shorter timeframe required by applicable law, from the day I sign it as indicated by the date next to my signature unless otherwise canceled earlier as set forth above
- I understand I will receive a copy of this form after completing enrollment

Signature of Patient or Legal Representative (if patient is under 18 Years of Age)† _____ **Date (MM/DD/YYYY)** _____

Print Name of Patient or Legal Representative (if patient is under 18 Years of Age) _____ **Relationship to Patient** _____

†By signing on behalf of the patient, as representative or guardian, I attest that I am legally authorized to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient (such as power of attorney or legal court order) may be requested.