First Steps is a fertility drug patient assistance program for self-pay patients only. Eligible patients may receive up to 25%, 50%, or even 75% off their medications. To learn more about First Steps, please visit www.designrxfirststeps.com.

FIRST STEPS ENROLLMENT FORM

Phone (855)672-9260 Fax (855)672-9262
www.designrxfirststeps.com Email:firststeps@envisionrx.com

PATIENT INFORMATION

LAST NAME:

FIRST NAME:

DATE OF BIRTH:

GENDER: Female

PREFERRED EMAIL ADDRESS FOR CONTACT:

PROVIDER EMAIL ADDRESS:

PHARMACY EMAIL ADDRESS:

HOME PHONE:

MOBILE PHONE:

STREET ADDRESS:

CITY, STATE, ZIP CODE:

TREATMENT

Are you currently undergoing treatment with a fertility specialist? If yes, please provide physician's name.

Yes ☐ No ☐ Physicians Name _____

Have you ever received products through DesignRx First Steps in the past? Yes ☐ No ☐

I have been prescribed the following:

☐ Follistim ☐ Ganirelix ☐ Pregnyl

Fax or mail your income verification form to DesignRx First Steps:

We will need to know the annual adjusted gross income for the entire household. The following are acceptable income documents that we can use to validate your income:

- 1040 Form
- 1040 Form Married filing separately. Need a form from both filers
- 1040 A Form
- 1040 - A Form (MFS)
- 1040 -EZ form
- Hardship Letter & Income Documents

How many people live in your household?

Patient Signature and Authorization:

My signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge, and that I have read, understand, and agree to the terms of this enrollment form and the attached Authorization to Use and Disclose health and other personal information.

Patient Signature Date Patient Name

General Authorization to Use and Disclose Health and Other Personal Information

I, _____, or my personal representative, hereby authorize my physician and his/her staff to disclose my health and other personal information, including, but not limited to, the information on this form, to DesignRx, LLC and its agents and representatives including any company that helps administer the DesignRx Assist Program (collectively "DesignRx") so that DesignRx may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers (collectively, "Third Parties") in order to:

(1) contact me about participating in the DesignRx Assist Program;

(2) provide me with materials relating to the DesignRx Assist Program;

(3) verify the accuracy of the information I provide in my application for the DesignRx Assist Program;

(4) provide support services that can assist me with obtaining access to the DesignRx Assist Program products;

(5) for such other purposes as may be required or permitted by applicable law.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to DesignRx in order to assist DesignRx in accomplishing the purposes described above.

☐ I do not authorize the use or disclosure of any information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health or substance abuse.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected by federal and/or state privacy laws. However, I understand that DesignRx will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized personal representative's) separate written consent.

I understand that I am not required to sign this authorization and such refusal will not affect my ability to receive DesignRx Program products, my ability to obtain treatment, or my eligibility for benefits but it will limit my ability to participate in the DesignRx Assist Program.

I understand that this authorization will remain in effect for one year from the date of my signature, unless I revoke it earlier in writing by mailing my revocation to DesignRx, LLC/EnvisionRxOptions, 2181 East Aurora Road, Suite 201, Twinsburg, OH 44087, via facsimile at 855-672-9262, or via email at firststeps@envisionrx.com.

If I revoke this authorization, DesignRx will stop using and disclosing my information once it is received and logged by DesignRx. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation nor will the revocation apply to disclosures made in reliance on this authorization. I understand that revoking my authorization will also limit my ability to participate in the DesignRx Assist Program.

A copy of this authorization is valid as an original. I also understand that I have the right to receive a copy of this authorization.

Patient name (please print): _____ Date: ___/___/_____

Signature of patient (or personal representative): _____

Printed Name and Authority/relationship of personal representative (if applicable):

_____