X4Connect™

Enrollment Form

XOLREMDI® (mavorixafor) capsules

Questions? Call 844-X4CNNCT (844-942-6628), M-F, 8am-8pm ET | = Health Care Professional (HCP) = Patient

HCP: Fax completed form, copies of insurance cards, list of current and previous medications (past 2 months), and genetic testing results/clinical information (if available) to: 877-914-0598

To ePrescribe* the prescription:
PANTHERx Specialty Pharmacy, 1120 Stevenson Mill Rd., Suite 400, Coraopolis, PA 15108, NPI: 1750843314
*If ePrescribe is used, you still need to fax this form with the items listed.

Patient Information

Name: _____ ☐ Male ☐ Female Last 4 Digits of SSN: _____

DOB (mm/dd/yyyy): ___/___/_____ Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Check & Provide Preferred Phone: ☐ Cell: _____ ☐ Home: _____ ☐ OK to leave message

Email: _____ Address: _____ City: _____ State: ___ Zip: _____

Caregiver Name†: _____ Relationship to Patient†: _____

Caregiver Phone†: _____ Caregiver Email†: _____ ☐ OK to leave message†

†Optional for patients over 18 years of age.

Patient Insurance Information – *Fax front/back copies of both insurance cards with completed enrollment form*

Is the patient insured? ☐ Yes ☐ No

Prescription Drug Plan: _____ Rx ID #: _____

Rx BIN #: _____ Rx PCN#: _____ Rx Group#: _____

Primary Medical Insurance: _____

Medical Insurance ID#: _____ Insurance Group #: _____

Policyholder Name: _____ Policyholder DOB (mm/dd/yyyy): ___/___/_____

Policyholder Relationship to Patient: _____

☐ If the patient has secondary medical insurance, please check this box and attach a copy of the secondary medical insurance card as well

Patient Authorization

Authorization to Share My Health Information

By signing below, I acknowledge that I have read and agree to the Consent to Share Protected Health Information and Enroll in X4Connect Program on pages 3 and 4 of this form:

Patient Sign

Patient Signature:

_____ Date (mm/dd/yyyy): ___/___/_____

Parent/Guardian Signature (if patient is a minor):

_____ Date (mm/dd/yyyy): ___/___/_____

☐ By checking this box, I authorize X4, and companies working with X4, to contact me by mail, email, fax, text messaging, and/or telephone regarding marketing purposes, disease and product information, as well as other potential topics of interest to me, customer surveys, or occasionally for market research. I understand that I am not required to provide this consent as a condition of receiving any X4 medicine or Patient Support Services.

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Patient Name: _____ DOB (mm/dd/yyyy): ___/___/_____

= HCP = Patient

Prescriber Information

Prescriber Name: _____ Prescriber Specialty: _____

NPI #:_____ State License #: _____ Practice Name: _____

Address: _____

City: _____State: ___ Zip: _____

Phone: _____ Fax:_____

Office Contact Name: _____

Role:_____ Contact Phone: _____

Contact Email: _____

Prescription Information – *Fax list of previous and current medications with completed enrollment form*

Has patient previously taken XOLREMDI? ☐ Yes ☐ No Patient's Current Weight: _____kg Date of Weight (mm/dd/yyyy): ___/___/_____

Diagnosis: ☐ WHIM Syndrome Other/ICD-10 Diagnosis Codes (List all that apply): _____

Product: XOLREMDI 100 mg capsules

Directions: ☐ Patients weighing >50 kg: 400 mg orally once daily; #120 capsules; 30-day supply
☐ Patients weighing ≤50 kg: 300 mg orally once daily; #90 capsules; 30-day supply
☐ Other: _____

Number of Refills: _____Medication allergies: ☐ NKDA ☐ Yes _____

Previous Medications (past 2 months; check all that apply or attach medication list): ☐ G-CSF ☐ Ig therapy ☐ Other: _____

Current Medications (check all that apply or attach medication list): ☐ G-CSF ☐ Ig therapy ☐ Other: _____

Quick Start Program

Patients who are prescribed XOLREMDI in accordance with the FDA-approved indication may be eligible for the X4Connect Quick Start Program to receive a free temporary supply of XOLREMDI in the event of an insurance-related delay.

☐ Yes, enroll my patient in the X4Connect Quick Start Program, if eligible.

Product: XOLREMDI 100 mg capsules

Directions: ☐ Patients weighing >50 kg: 400 mg orally once daily; #60 capsules; 15 day supply, up to 3 refills
☐ Patients weighing ≤50 kg: 300 mg orally once daily; #60 capsules; 20 day supply, up to 2 refills

Prescriber Authorization

I authorize X4 Pharmaceuticals, Inc. and its agents or contractors (collectively, "X4") on behalf of my patient, who has provided the necessary authorization, to (1) release any information on this form for the purpose of seeking reimbursement for XOLREMDI, (2) forward this prescription by fax or other mode of delivery, as required by applicable law, to the designated pharmacy, (3) assist in initiating or continuing XOLREMDI therapy, and (4) evaluate the patient's eligibility for X4's patient support programs administered by X4Connect, X4 Nurse Educators, and other contractors. I understand that X4Connect services are not intended to replace my medical treatment or care of the patient. I certify that the information provided, to the best of my knowledge, is complete and accurate, and that XOLREMDI is medically necessary and prescribed consistent with an FDA-approved indication. I acknowledge that I have assisted the patient in enrolling in X4Connect exclusively for purposes of patient care and not in consideration for, expectation of, or actual receipt of remuneration of any sort.

Special note: The prescriber must comply with applicable state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance of state-specific requirements could result in outreach to the prescriber.

For Quick Start Program: I understand that this medication is being provided free to the named patient by X4 and agree that neither I nor the patient will bill an insurer or any government healthcare program for the cost of this medication. The program may not be combined with another offer and is not eligible to patients without insurance or whose insurer has made a final coverage determination. Patients must be residents of the US and have a US mailing address.

HCP Sign

Prescriber Signature (no stamps): _____ ☐ Dispense as Written*
☐ Substitution Allowed Date (mm/dd/yyyy): ___/___/_____

X4 makes no representation that the information will comply with the requirements of any particular payer/insurer. The use of this information does not guarantee payment or that any payment received will cover your costs.

*Certain states require "brand medically necessary" or similar language to be handwritten by the prescriber if he/she has made this determination in his/her independent clinical judgment. The prescriber should comply with state-specific prescription requirements. Noncompliance could result in outreach to the prescriber.

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Patient Name: _____ DOB (mm/dd/yyyy): ___/___/_____

= HCP = Patient

Patient Consent

Consent to Share Protected Health Information and Enroll in X4Connect Program: X4 Pharmaceuticals ("X4"), through its X4Connect program, provides services such as prescription management, insurance navigation, financial assistance for eligible patients, referrals to third-party resources, drug shipment and refills outreach, support for adhering to my medication, disease and treatment related information, additional support services through X4Connect's Nurse Educators* and other related services (the "Program"). The Program services may change from time to time.

By signing this Consent, I authorize my healthcare provider(s), health insurer(s), pharmacy providers and other healthcare service providers ("Healthcare Entities") to share information, including protected health information relating to my medical condition, treatment, and insurance coverage ("My Health Information"), with X4 Pharmaceuticals, Inc., its affiliates and their employees (collectively, "X4"), as well as third-party companies working on X4's behalf, for the following purposes:

- Contact me by phone, text, mail, or email to provide information about the Program;
- Verify the accuracy of the information on this form and request additional financial and insurance information;
- Determine my eligibility for the Program and the specific services of the Program;
- Facilitate the provision of Program services to me;
- Share relevant disease and product-related information and materials, including, but not limited to through X4Connect's Nurse Educators*;
- Send enrollment information to my pharmacy via phone, email, postal mail, or fax; and/or
- As necessary to comply with applicable laws, including, without limitations, any safety reporting obligations.

I understand that X4 will not sell or trade my personal information to any third-party not related to the X4Connect program.

Once My Health Information has been disclosed to X4, I understand that federal privacy laws no longer protect it. However, X4 agrees to protect My Health Information by using and disclosing it only for purposes authorized in this Consent or as required by law or regulations. I understand that My Health Information includes, but is not limited to, my name, date of birth, and other personal information and identifiers (including my address), medical information and supporting records, including information about my health condition and treatment, and financial information (including information about my insurance) as well as other personal information collected by Healthcare Entities

*Personnel providing support as part of X4Connect are not employed by my healthcare professional and cannot render medical advice.

Cont'd on page 4

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Patient Name: _____ DOB (mm/dd/yyyy): ___/___/_____

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Patient Consent (cont'd)

about me or provided by me to X4. I understand that the pharmacy provider may receive remuneration from X4 in exchange for the health information and/or for any therapy support services provided to me.

I understand that I may refuse to sign this Consent. I further understand that my treatment (including with an X4 product), payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this Consent; but if I do not sign it or later cancel it, I will not be able to receive X4's patient program support.

I may cancel this Consent at any time by calling 844-X4CNNCT (844-942-6628). Canceling this Consent will end my consent to further disclosure of my health information to X4 by my Healthcare Entities after they are notified of my cancellation but will not affect previous disclosures by them pursuant to this Consent. Canceling this Consent will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance. This Consent will remain in effect until I cancel the Consent or five (5) years from the date signed unless a shorter period is required by state law.