NutreStore™
[L-glutamine powder for oral solution]

Statement of Medical Necessity

Tel: 1-877-420-6493 Fax: 310-214-0075 www.nutrestore.com

1. Patient Information

Patient Name:_____ SSN: _____
DOB: _____/_____/_____ ❑ Male ❑ Female Parent/Legal Guardian:_____
Address: _____ City: _____ State: _____ Zip: _____
Preferred contact time and phone number: ❑ Day ❑ Evening
Daytime #: _____ Evening #: _____ E-mail: _____

2. Patient Insurance Information

Primary Insurance: _____ Phone #: _____
Cardholder Name:_____ ID#: _____Group #_____
Does patient have a prescription plan? ❑ Yes ❑ No Prescription plan:_____
ID#:_____Group # _____ Phone # _____

3. Patient Consent

Authorization for Release of Medical and Insurance Information

I hereby: (1) authorize Emmaus Medical, Inc., (EM) and any third parties working with EM (collectively, "EM") to contact my healthcare provider, pharmacy, insurance company or other third-party payors about my medical, financial, insurance or third party payor information, if applicable (my "Information"), and to use and disclose this Information, and (2) authorize those parties to disclose (i.e., release) all such Information to EM to assist in obtaining coverage for NutreStore™. This authorization expires 10 (ten) years from my signature date unless I notify EM in writing that I withdraw it earlier. I understand I also need to sign a separate "Patient Authorization" form (attached hereto) concerning the use and disclosure of my Information and I agree to sign that form. I understand my Prescriber is responsible for choosing which prescription products are right for me based on my particular diagnosis.

Patient/Legal Guardian Signature _____ Date _____

4. Prescription Information

NutreStore ™ [L-glutamine powder for oral solution] 5 grams packets #168
Sig: 1 (one) packet 6X daily
Refill: 3 (three) NDC#42457-001-84

5. Statement of Medical Necessity (Prescriber to complete)

Does the patient have Short Bowel Syndrome? ❑Yes ❑ No
What is the patient's underlying condition? ❑ Intrinsic Bowel disease ❑ Vascular disease ❑ Trauma ❑ Other
Has the patient had a bowel resection? ❑ Yes ❑ No Date of surgery: _____
Length of remaining small intestine: ❑<90 cm ❑90-200 cm ❑>200 cm Is the colon in continuity? ❑ Yes ❑ No Comment _____
Is the patient receiving parenteral nutrition? ❑ Yes ❑ No If yes, approximate weekly volume: _____ (mL) _____days/week
Date of parenteral nutrition initiation: _____
Is the patient on specialized nutritional support other than parenteral nutrition? ❑ Yes ❑ No
What is the patient's current weight? _____lbs

6. Prescriber Information

Prescriber's Full Name: _____ Med. Lic. #:_____
DEA: _____NPI#: _____Tax ID#: _____
Office/Clinic/Institution: _____
Address: _____
City: _____ State:_____ Zip: _____
Phone: (_____)_____ Fax: (_____)_____

Prescriber Certification

I certify that the information in this Statement of Medical Necessity is accurate to the best of my knowledge, that the prescribed therapy is medically necessary for the treatment of Short Bowel Syndrome, and that I am aware of the risks and benefits associated with the use of NutreStore™. I authorize EM to be my designated agent (1) to provide any information on this form to the insurer of the named patient and (2) forward the above prescription, by fax or by other mode of delivery to the pharmacy designated by the named patient.

Print Prescriber's Name:_____Date: _____

Prescriber Signature X_____

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[L-glutamine powder for oral solution]

PATIENT AUTHORIZATION

Patient's Name: _____

Address: _____

SSN: _____ DOB: _____/_____/_____

Authorization to use and disclose medical, financial and insurance information

By signing below, I hereby:

1) authorize Emmaus Medical, Inc. (EM), and any third parties working with EM to help EM (collectively, "EM") to contact my healthcare provider, pharmacy, insurance company or other third-party payors (collectively, "Third Parties") about my medical, financial, insurance or third party payor information, including but not limited to any confidential HIV-related information, if applicable, and information to verify the accuracy of the information I provided in the Statement of Medical Necessity (my "Information") for the purposes described below;

(2) authorize the Third Parties to use and disclose (i.e., to release) my Information to EM for the purposes described below;

(3) authorize EM to use and disclose my Information for those same purposes;

(4) authorize EM to disclose Information back to the Third Parties for those same purposes;

(5) authorize EM and Third Parties to disclose Information about me between and among each other for those same purposes.

Purposes for which my Information may be used and disclosed

By signing below, I authorize the use and disclosure of my Information (which includes any confidential HIV-related information, if applicable), for the following purposes:

- to provide me with free medical and clinical information and patient educational materials about my condition, treatment options, products and other offerings;
- to assist me in obtaining insurance coverage for my prescription drug, including support for appeals and help with required documentation needed by insurance companies, and provide me with information about alternative payment options, including any applicable patient assistance programs that may be in place;
- to help me locate a pharmacy to fill my prescription, if applicable, and to help facilitate dispensing of my prescription;
- to provide me with information about compliance with the treatments my healthcare provider has prescribed and to have healthcare specialists follow-up with me about my treatment compliance;
- to monitor the status of my insurance reimbursement, prescription dispensing and treatment compliance and advise my healthcare provider, pharmacy,

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PATIENT AUTHORIZATION (CON'T)

insurance company or other third-party payors of such status;

- to conduct surveys to measure my patient satisfaction with the dispensing of my prescription; and
- for such other purposes as may be required or permitted by applicable law.

Authorization to forward prescription to pharmacy

By signing below, I authorize EM and the Third Parties to send, via fax, email or other mode of delivery, my prescription to the pharmacy of my choosing.

Terms of this Authorization

This authorization expires 10 (ten) years from the date below. I understand that:

(1) I can revoke this authorization by notifying EM in writing and the revocation is not effective as to actions any party took in reliance on the authorization;

(2) once my Information is disclosed to third parties under this authorization some of it may not be protected;

(3) I can refuse to sign this form (but then EM cannot assist me);

(4) EM reserves the right to, at any time and without notice:

(a) modify the Statement of Medical Necessity form,

(b) modify or discontinue any or all aspects of this authorization, and

(c) terminate any assistance provided by EM;

(5) I have the right to receive a copy of this form; and

(6) my prescribing physician is responsible for choosing which prescription products are right for me based upon my particular diagnosis.

Check the box below for more information

☐ I authorize EM and the Third Parties to send me up-to-date medical and promotional information on my prescription drug and additional EM services and products which may be of interest to me.

I have read and understand the terms of this Patient Authorization. I authorize Emmaus Medical, Inc. to use or disclose my Information in the manner described above.

_____ _____

Patient Signature Date

_____ _____

Legal Guardian/Parent Signature (If Applicable) Date