vykat XR (diazoxide choline) extended-release tablets

Start Form

Instructions for HCP:

- Complete sections 1-5 of this form. If requesting Quick Start, please indicate in section 6.
- Prescriber to sign and date section 5, or submit a separate Rx.
- Fax all three (3) pages of this completed form to **1-877-914-0788**.

SOLENO one™

① Prescriber Information

Prescriber Name: _____ Prescriber Specialty: _____

Institution/Practice Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ ZIP: _____

NPI: _____ Tax ID: _____ Medicaid Number: _____

Contact Name: _____ Contact Phone: _____ Fax Number: _____

② Patient Information

Full First Name, Middle Initial: _____ Last Name: _____

Date of Birth (MM/DD/YYYY): _____ Gender: ◯ Male ◯ Female

Address: _____ City: _____ State: _____ ZIP: _____

Group Home/Residential Service Provider? ◯ Yes ◯ No If yes, facility and contact name: _____

Mobile Phone: _____ Alternate Phone: _____

Email Address: _____ Preferred Language: ◯ English ◯ Spanish ◯ Other: _____

Parent/Legal Guardian Name (First/Last): _____ Relationship: _____

Parent/Legal Guardian Mobile Phone: _____ Parent/Legal Guardian Email: _____

By signing here, I am providing program authorization as outlined in section 8 on page 3. If unsigned, Soleno One™ will contact for e-consent.

PATIENT or CAREGIVER SIGN HERE

_____ _____ _____

Patient/Parent/Legal Guardian Signature Date Printed Name

③ Insurance Information

Does the patient have insurance? ◯ Yes (complete this section) ◯ No (skip this section)

Please complete the information below or provide copies of insurance card(s), front and back, for primary and secondary insurance.

Primary Rx Insurance Company: _____

Primary Rx Insurance Phone: _____ Primary Member ID: _____

Primary Cardholder Name: _____ Cardholder Date of Birth (MM/DD/YYYY): _____

Patient's Relationship to Cardholder: ◯ Self ◯ Child ◯ Spouse ◯ Other: _____

④ Clinical Information

Provide patient's diagnosis code:

◯ Q87.11: Prader-Willi syndrome

Confirmed diagnosis based on:

◯ Genetic Testing

◯ Clinical Presentation

◯ Other ICD-10 Code: _____

Code Description (required):

_____

_____

Does the patient have hyperphagia? ◯ Yes ◯ No

Height: _____ ft _____ in

Weight: _____ ◯ kg ◯ lb

Date height/weight taken (MM/DD/YYYY): _____

Current Medications: (list or attach current medications list) _____

_____

◯ No Known Allergies ◯ Known Allergies: _____

Please provide relevant chart notes and lab results, if available, to aid in prior authorization process.

Questions about filling out this form? Please call 1-833-SOLENO-1 (1-833-765-3661).

⑤ Prescription for VYKAT™ XR (diazoxide choline) extended-release tablets

Patient's Full Name: _____ Date of Birth (MM/DD/YYYY): _____

COMPLETE THE Rx BELOW:
- Select dosing regimen based on patient's weight
- Indicate maintenance refills (if applicable)
- Sign and date below the Rx chart

–OR–

SUBMIT A SEPARATE Rx IF:
- Your patient's dosing regimen varies from recommended dosing, or
- Your state law requires it

Please indicate submission method:

◯ Separate Rx attached

◯ Rx submitted electronically to PANTHERx Rare Pharmacy
1120 Stevenson Mill Rd, Ste 400, Coraopolis, PA 15108
NCPDP#: 3997117W

REMINDER: Check fasting plasma glucose (FPG) and HbA1c, and optimize blood glucose in patients who have hyperglycemia, before initiating treatment.

IMPORTANT:

◯ Please check this box if your patient is currently taking fluvoxamine or any other strong CYP1A2 inhibitor as this will impact the VYKAT XR titration schedule. A Soleno One pharmacy team member will contact you to share the necessary modifications before the VYKAT XR prescription is filled.

		MONTH 1		MONTH 2		MONTH 3 ONWARD	
Rx	**WEIGHT RANGE**	**Titration Step 1** *(Weeks 1 and 2)*	**Titration Step 2** *(Weeks 3 and 4)*	**Titration Step 3** *(Weeks 5 and 6)*	**Target Maintenance Dose** *(Weeks 7 and 8)*	**Target Maintenance Dose**	
◯	**20 to <30 kg**	**Once-Daily Dose:** 25 mg **Dispense:** 25 mg 1 tab PO QD #14	**Once-Daily Dose:** 50 mg **Dispense:** 25 mg 2 tabs PO QD #28	**Once-Daily Dose:** 75 mg **Dispense:** 75 mg 1 tab PO QD #14	**Once-Daily Dose:** 100 mg **Dispense:** 75 mg 1 tab PO QD #14 25 mg 1 tab PO QD #14	**Once-Daily Dose:** 100 mg **Dispense:** 75 mg 1 tab PO QD #30 25 mg 1 tab PO QD #30	**# of Refills:**
◯	**≥30 to <40 kg**	**Once-Daily Dose:** 75 mg **Dispense:** 75 mg 1 tab PO QD #14	**Once-Daily Dose:** 150 mg **Dispense:** 75 mg 2 tabs PO QD #28	**Once-Daily Dose:** 150 mg **Dispense:** 150 mg 1 tab PO QD #14	**Once-Daily Dose:** 150 mg **Dispense:** 150 mg 1 tab PO QD #14	**Once-Daily Dose:** 150 mg **Dispense:** 150 mg 1 tab PO QD #30	**# of Refills:**
◯	**≥40 to <65 kg**	**Once-Daily Dose:** 75 mg **Dispense:** 75 mg 1 tab PO QD #14	**Once-Daily Dose:** 150 mg **Dispense:** 75 mg 2 tabs PO QD #28	**Once-Daily Dose:** 225 mg **Dispense:** 150 mg 1 tab PO QD #14 75 mg 1 tab PO QD #14	**Once-Daily Dose:** 225 mg **Dispense:** 150 mg 1 tab PO QD #14 75 mg 1 tab PO QD #14	**Once-Daily Dose:** 225 mg **Dispense:** 150 mg 1 tab PO QD #30 75 mg 1 tab PO QD #30	**# of Refills:**
◯	**≥65 to <100 kg**	**Once-Daily Dose:** 150 mg **Dispense:** 75 mg 2 tabs PO QD #28	**Once-Daily Dose:** 225 mg **Dispense:** 75 mg 3 tabs PO QD #42	**Once-Daily Dose:** 300 mg **Dispense:** 150 mg 2 tabs PO QD #28	**Once-Daily Dose:** 375 mg **Dispense:** 150 mg 2 tabs PO QD #28 75 mg 1 tab PO QD #14	**Once-Daily Dose:** 375 mg **Dispense:** 150 mg 2 tabs PO QD #60 75 mg 1 tab PO QD #30	**# of Refills:**
◯	**≥100 to <135 kg**	**Once-Daily Dose:** 150 mg **Dispense:** 150 mg 1 tab PO QD #14	**Once-Daily Dose:** 300 mg **Dispense:** 150 mg 2 tabs PO QD #28	**Once-Daily Dose:** 375 mg **Dispense:** 150 mg 2 tabs PO QD #28 75 mg 1 tab PO QD #14	**Once-Daily Dose:** 450 mg **Dispense:** 150 mg 3 tabs PO QD #42	**Once-Daily Dose:** 450 mg **Dispense:** 150 mg 3 tabs PO QD #90	**# of Refills:**
◯	**≥135 kg**	**Once-Daily Dose:** 150 mg **Dispense:** 150 mg 1 tab PO QD #14	**Once-Daily Dose:** 300 mg **Dispense:** 150 mg 2 tabs PO QD #28	**Once-Daily Dose:** 450 mg **Dispense:** 150 mg 3 tabs PO QD #42	**Once-Daily Dose:** 525 mg **Dispense:** 150 mg 3 tabs PO QD #42 75 mg 1 tab PO QD #14	**Once-Daily Dose:** 525 mg **Dispense:** 150 mg 3 tabs PO QD #90 75 mg 1 tab PO QD #30	**# of Refills:**

PRESCRIBER SIGN HERE

Prescriber Signature (no stamps) Date Prescriber Name

Questions about filling out this form? Please call 1-833-SOLENO-1 (1-833-765-3661).

Patient's Full Name: _____ Date of Birth (MM/DD/YYYY): _____

⑥ Quick Start Program Referral — *Only complete if requesting Quick Start Program enrollment*

Quick Start: This program provides up to an initial 28-day supply of VYKAT XR to eligible patients who encounter an extended insurance authorization process and whose prescriber believes a delay in therapy could lead to negative clinical outcomes.

Prescriber must check below to enroll patient, if eligible, in the VYKAT XR Quick Start Program:

◯ I authorize the pharmacy to dispense, using the Rx written in section 5 of this form, attached, or provided electronically, per program business rules.

⑦ Prescriber Attestation & Authorization

By completing and faxing this form, I certify that the person named on this form is my patient, the information contained in this form is complete and accurate to the best of my knowledge, and that treatment with VYKAT XR (diazoxide choline) extended-release tablets is medically necessary. I certify that the patient has authorized me under HIPAA and state law to disclose of their information to Soleno Therapeutics, Inc. and its agents (together, "Soleno") for Soleno to provide the patient support services described in this paragraph.

I understand that the information I provide on this form will be used by the Soleno One patient support program for the purposes of verifying and navigating my patient's insurance coverage and eligibility, coordinating the dispensing of my patient's prescription medicine, and providing eligible Soleno One support services to my patient, including contacting my patient for these purposes. I authorize Soleno One to transmit my patient's prescription for VYKAT XR to the appropriate specialty pharmacy on behalf of my patient.

I agree that I may be contacted for additional information as needed related to the patient's VYKAT XR treatment and/or coordination of care. I understand that I am under no obligation to prescribe any Soleno products.

Cut here to provide the consent language to your patient, if desired.

⑧ Patient Consent & Authorization (Optional)

Soleno Therapeutics ("Soleno") provides comprehensive patient support services through its Soleno One™ patient support program to eligible individuals prescribed VYKAT™ XR (diazoxide choline) extended-release tablets. By signing this form, I authorize the collection, use, and disclosure of my personal information as outlined below.

Authorization to share my information with Soleno: I authorize my healthcare providers, including physicians, pharmacies, and health insurance plans (collectively, "Providers"), to share my personally identifiable health and insurance information with Soleno Therapeutics, Inc. and its affiliates, business partners, vendors, and service providers (collectively, "Soleno"). This information includes but is not limited to details about my medical condition, treatment, and prescriptions (including fill/refill data); insurance benefits, coverage claims, and other health-related information; and information provided in this consent form (my "Information").

Authorization to support access to VYKAT XR: Soleno may use my Information to: facilitate my access to VYKAT XR through patient support programs, administer those programs, verify and navigate insurance benefits, and coordinate prescription fulfillment with pharmacies. Soleno is further authorized to use my Information to provide assistance programs for treatment management; administer and analyze the effectiveness of the patient support program, including data analysis and compliance reviews; and fulfill legal and regulatory requirements. I understand that my pharmacy may receive payment from Soleno in exchange for providing support services or sharing my information.

Authorization to contact me and provide information: I authorize Soleno to provide me with information about Soleno products, services, research or other topics of interest, and to conduct market research or otherwise ask me about my experience with or thoughts about such topics. I understand and agree that Soleno may use my Information to contact me by mail, email, fax, telephone call, or text message for these purposes. I may opt out of text messages at any time by replying STOP. Standard message and data rates may apply. I understand and agree that my Information may also be used by Soleno to help develop new products, services, and programs.

Once my Information is disclosed to Soleno, it may no longer be protected by federal privacy laws. However, Soleno will safeguard my information and use it only as authorized or required by law. Soleno will not sell or transfer my Information to any unrelated third party for marketing purposes.

I understand that signing this form is not required to receive medical treatment, health insurance benefits, or other healthcare services, but I will not be able to participate in Soleno One patient support services without it. I may cancel this authorization at any time by notifying Soleno in writing at 1120 Stevenson Mill Rd, Ste 400, Coraopolis, PA 15108 or by calling 1-833-765-3661, option 1. Cancellation will not affect previous disclosures or action based on this consent. Unless revoked earlier, this authorization will expire five (5) years from the date signed or as required by state or local law. I may request a copy of this authorization form or review Soleno's privacy practices by visiting https://soleno.life/privacy-policy/.

Fax all three (3) pages of this completed form to 1-877-914-0788.

For more information, including full prescribing information, visit VykatXR.com or call 1-833-SOLENO-1 (1-833-765-3661)**.**

SOLENO THERAPEUTICS