SAGE CENTRAL ENROLLMENT FORM

FAX: 833-564-SAGE (833-564-7243)
PHONE: 844-4-SAGERX (844-472-4379), M-F, 8AM-8PM ET
EMAIL: support@sagecentralsupport.com

For additional assistance, call the phone number above. Healthcare Providers complete required fields on **PAGE 4**.

SAGE CENTRAL® PATIENT SUPPORT

Zulresso® (brexanolone) injection IV for intravenous use 100mg/20mL

How to complete the form

To enroll in Sage Central, follow the steps below.

1. Read the *Authorization to Share Personal Health Information* on page 2, then sign below to provide consent.
2. Check the box to receive marketing communications. (Optional)
3. Complete sections **A** and **B**.
4. Make a photocopy of both sides of your insurance card for your healthcare provider to send in with your form.

What happens next

Once your form is received by Sage Central, you will receive a call within 1-2 business days.

- This call from a Sage Central Navigator will come from an **844 area code** and may say "Patient Support"
- If you miss this call, please call Sage Central at the number above

Once the information needed from your insurance provider is confirmed, a Sage Central Navigator will be in touch.

PATIENT AUTHORIZATION

I have read and understand the *Authorization to Share Personal Health Information* ("Patient Authorization") on page 2, and consent to the terms.
A signature is required in order to be enrolled in Sage Central.

SIGN HERE

PATIENT SIGNATURE	TODAY'S DATE (MM/DD/YYYY)

CARE PARTNER(S) INFORMATION

In addition, I authorize the disclosure of my health information to the following designated individual(s) (optional):

NAME	RELATIONSHIP	PHONE NUMBER	EMAIL ADDRESS
NAME	RELATIONSHIP	PHONE NUMBER	EMAIL ADDRESS

Consent for Marketing Calls and Text Messages

☐ By checking this box on the Sage Central Enrollment Form, I consent to receive marketing calls and text messages from My Healthcare Entities and/or Sage (as defined in the Patient Authorization on page 2), including calls and texts made with an autodialer or prerecorded voice, at the telephone number(s) I have provided. I understand that my consent is not required as a condition of receiving information or materials about Sage or My Healthcare Entities or purchasing any goods or services from Sage or My Healthcare Entities. I understand that message and data rates may apply and that all carriers may not be supported. Privacy Policy at https://www.sagerx.com/privacy-policy/.

For help, text [HELP] to (844) 472-4379; to stop texts, type [STOP] to (844) 472-4379.

SECTION A: PATIENT INFORMATION

PATIENT FULL NAME (FIRST, MIDDLE INITIAL, LAST)		
DOB (MM/DD/YYYY)		
ADDRESS		
CITY	STATE	ZIP
EMAIL ADDRESS		
PREFERRED LANGUAGE		
MOBILE PHONE NUMBER	HOME PHONE NUMBER	WORK PHONE NUMBER

PREFERRED PHONE NUMBER:
☐ Mobile phone number ☐ Home phone number ☐ Work phone number

BEST TIME TO CALL:
☐ Morning ☐ Afternoon ☐ Evening

☐ Check if it is okay to leave a message.

SECTION B: INSURANCE INFORMATION

☐ Check if patient has no insurance.

POLICYHOLDER NAME (FIRST, MIDDLE INITIAL, LAST)	
POLICYHOLDER DOB (MM/DD/YYYY)	RELATIONSHIP TO PATIENT
PRIMARY INSURANCE	POLICY ID NUMBER
INSURANCE PHONE NUMBER	GROUP NUMBER
SECONDARY INSURANCE (IF APPLICABLE)	POLICY ID NUMBER
INSURANCE PHONE NUMBER	GROUP NUMBER

Pharmacy coverage

PRESCRIPTION INSURANCE	POLICY ID NUMBER
INSURANCE PHONE NUMBER	Rx GRP NUMBER
Rx BIN NUMBER	Rx PCN NUMBER

Read the entire form and **FAX PAGES 1 AND 4,** once completed, to Sage Central at **833-564-SAGE (833-564-7243).**

Please see Select Important Safety Information on page 3
Please read the patient Medication Guide, including information about serious side effects, in the full Prescribing Information available at Zulresso.com

Visit **SageCentralSupport.com** for more information about Sage Central.

Sage Therapeutics™

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AUTHORIZATION TO SHARE PERSONAL HEALTH INFORMATION

I understand that Sage Central is a patient support program offered by Sage Therapeutics, Inc. to help eligible patients obtain financial assistance and access other patient support programs provided by Sage Central.

By signing below, I give my permission for my health care providers, health plans, and pharmacy ("My Healthcare Entities") to share with Sage Therapeutics, Inc., its present and future affiliates, vendors and other companies working with and on behalf of Sage Therapeutics, Inc. (collectively, "Sage"), personal information relating to my medical condition, treatment, and health insurance coverage ("My Information") so that Sage may: 1) obtain information on insurance coverage for my treatment; 2) review my eligibility for benefits from my health plan or other programs for my treatment; 3) coordinate treatment logistics with my healthcare setting for my treatment; 4) facilitate my access to Sage Central and additional patient support programs provided by Sage Central; 5) manage patient support programs provided by Sage Central; 6) access my credit information and information derived from public and other sources to estimate my income as part of the determination of eligibility for financial assistance; 7) de-identify My Information and combine it with other de-identified data for purposes of research and publication; and 8) contact me to: (i) evaluate the effectiveness of Sage Central and other patient support programs provided by Sage Central; (ii) conduct market research; (iii) arrange for my receipt of educational, promotional, and/or marketing materials about Sage Central and additional patient support programs provided by Sage Central, or about other Sage products and services; and (iv) help advance Sage's internal business objectives, including quality control and assessment. I specifically authorize Sage and My Healthcare Entities to use My Information to contact me for non-marketing purposes by mail, email, fax, telephone call, and text message, including by using an automatic telephone dialing system or prerecorded voice, at the number(s) and address(es) provided on the Sage Central Enrollment Form, and to use that same information to contact me by mail, email and fax for the marketing purposes described above.

I understand that, once My Information has been disclosed to Sage, federal privacy law may no longer protect the information. I also understand, however, that Sage intends to protect My Information by using and disclosing it only for purposes authorized in this Authorization or as required by law. I understand that my pharmacy and health insurers may receive remuneration (payment) from Sage in exchange for sharing My Information with Sage to facilitate the patient support programs and other purposes described in this Authorization.

I understand that I may refuse to sign this Authorization, and that refusing will not affect my treatment, insurance enrollment, or eligibility for insurance benefits, but it will make me ineligible to participate in Sage's support programs. If I do sign, I may cancel this Authorization at any time by mailing a letter to: Sage, 7751 Brier Creek Parkway, Suite 200, Raleigh, NC 27617 or emailing support@sagecentralsupport.com. I understand that canceling this Authorization will not invalidate reliance on this Authorization to use or disclose My Information prior to Sage's receipt of my notice of cancellation.

This Authorization expires ten (10) years from the date next to my signature, unless I revoke it sooner, or unless a shorter timeframe is required by applicable law. I understand I have a right to receive a copy of this Authorization after it is signed.

Read the entire form and **FAX PAGES 1 AND 4**, once completed, to Sage Central at **833-564-SAGE (833-564-7243).**

Please see Select Important Safety Information on page 3
Please read the patient Medication Guide, including information about serious side effects, in the full Prescribing Information available at Zulresso.com

Sage Therapeutics™

SAGE CENTRAL® PATIENT SUPPORT

Zulresso® (brexanolone) injection IV for intravenous use 100mg/20mL

What is ZULRESSO?

ZULRESSO is a prescription medicine used in adults to treat a certain type of depression called Postpartum Depression.

SELECT IMPORTANT SAFETY INFORMATION

These are not all the side effects of ZULRESSO.

ZULRESSO can cause serious side effects, including:

- **Excessive sedation and sudden loss of consciousness.** ZULRESSO may cause youto feel very sleepy (excessive sedation) or pass out (loss of consciousness). Your healthcare provider should check you for symptoms of excessive sleepiness every 2 hours while you are awake.
  - During your infusion, tell your healthcare provider right away if you feel like you cannot stay awake during the time you are normally awake or if you feel like you are going to pass out. Your healthcare provider may lower your dose or stop the infusion until symptoms go away
  - You must have a caregiver or family member with you to help care for your child(ren) during your infusion
- Because of the risk of serious harm resulting from excessive sedation or sudden loss of consciousness, ZULRESSO is only available through a restricted program called the ZULRESSO REMS.

ZULRESSO can cause other serious side effects, including:

- **Increased risk of suicidal thoughts or actions.** ZULRESSO and other antidepressant medicines may increase suicidal thoughts and actions in some people 24 years of age and younger. **Pay close attention to and tell your healthcare provider right away if you have any of the following symptoms, especially if they are new, worse, or worry you:**
  - Attempts to commit suicide, thoughts about suicide or dying, new or worse depression, other unusual or sudden changes in behavior or mood

Keep all follow-up visits and call your healthcare provider between visits as needed, especially if you have concerns about symptoms.

The most common side effects of ZULRESSO include:

- Sleepiness, dry mouth, passing out, flushing of the skin or face

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

Before receiving ZULRESSO, tell your healthcare provider about all your medical conditions including if you drink alcohol, have kidney problems, are pregnant or think you may be pregnant, or are breastfeeding or plan to breastfeed. It is not known if ZULRESSO will harm your unborn baby. If you become pregnant during treatment, talk with your healthcare provider about enrolling with the National Pregnancy Registry for Antidepressants at 1-844-405-6185.

While receiving ZULRESSO, avoid the following:

- Driving a car or doing other dangerous activities after your ZULRESSO infusion until your feeling of sleepiness has completely gone away
- Do not drink alcohol

Tell your healthcare provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements. ZULRESSO and some medicines may interact with each other and cause serious side effects.

Especially tell your healthcare provider if you take other antidepressants, opioids, or Central Nervous System (CNS) depressants (such as benzodiazepines).

Please read the patient Medication Guide, including information about serious side effects, in the accompanying full Prescribing Information.

Read the entire form and **FAX PAGES 1 AND 4**, once completed, to Sage Central at **833-564-SAGE (833-564-7243).**

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For Healthcare Providers only

Are you authorized to prescribe and oversee the treatment with ZULRESSO at the certified Healthcare Setting identified in Section D?

YES You are the patient's **PRESCRIBING PHYSICIAN**. Please complete **Section A** below. If you know the REFERRING provider, please provide that information in **Section B**.

☐ I am the Prescribing Physician and will be overseeing the treatment with ZULRESSO for the patient identified in Section D.

NO You are the patient's **REFERRING PROVIDER**. Please complete **Section B** below. If you know the PRESCRIBING physician, please provide that information in **Section A**.

☐ I am referring the patient identified in Section D for treatment with ZULRESSO at the Healthcare Setting listed in Section D.

SECTION A: PRESCRIBING PHYSICIAN

PRESCRIBING PHYSICIAN NAME		
PRESCRIBING PHYSICIAN NPI NUMBER		
PRESCRIBING PHYSICIAN EMAIL		
OFFICE CONTACT		
OFFICE ADDRESS		
CITY	STATE	ZIP
PHONE NUMBER	FAX NUMBER	

SECTION B: REFERRING PROVIDER

REFERRING PROVIDER NAME		
REFERRING PROVIDER NPI NUMBER	REFERRING PROVIDER CREDENTIALS	
REFERRING PROVIDER EMAIL		
OFFICE CONTACT		
OFFICE ADDRESS		
CITY	STATE	ZIP
PHONE NUMBER	FAX NUMBER	

☐ By checking this box, I attest that, based on my clinical judgment, ZULRESSO is medically necessary for the treatment of postpartum depression for the patient identified in Section D, and the information provided on the Sage Central Enrollment Form is complete, current, and accurate to the best of my knowledge.

By signing below, I certify that I have obtained the patient's authorization to release the information contained in this form and such other information as may be required by Sage Therapeutics, Inc. and its employees or agents to enroll the patient and administer the patient support programs provided by Sage Central.

SIGN HERE

PRINTED NAME	DATE (MM/DD/YYYY)
SIGNATURE	

Note: Patient Authorization is required to enroll in Sage Central. If Patient Authorization is not obtained prior to submission of this enrollment form, the Referring Provider or Prescribing Physician, signing above, authorizes Sage Therapeutics, Inc. to reach out to the patient identified in Section D for completion.

SECTION C: DIAGNOSIS (This section is required.)

Select all that apply.

☐ ICD-10 Code: F53.0 ☐ Other _____

SECTION D: CERTIFIED HEALTHCARE SETTING INFORMATION (This section is required.)

If you are the Referring Provider, enter your preferred healthcare setting location here. However, if you need assistance finding a ZULRESSO REMS certified Healthcare Setting for the patient identified in this section, check the appropriate box in the first line and leave the fields related to the Healthcare Setting blank.

☐ I need assistance finding a ZULRESSO REMS certified Healthcare Setting for this patient. ☐ Work directly with the patient to find a ZULRESSO REMS certified Healthcare Setting.

PATIENT FULL NAME			DOB (MM/DD/YYYY)
PATIENT WEIGHT (LB)	DATE OF DELIVERY (MM/DD/YYY)	ZIP	
HEALTHCARE SETTING – INCLUDING SPECIFIC DEPARTMENT/LOCATION			
ADDRESS	CITY	STATE	ZIP
PHONE NUMBER	FAX NUMBER		

Read the entire form and **FAX PAGES 1 AND 4,** once completed, to Sage Central at **833-564-SAGE (833-564-7243)**.

Please see Select Important Safety Information on page 3

For more information,please see Full Prescribing Information including Boxed Warning available at ZulressoHCP.com

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