

Once-weekly

REZZAYO™ 

(rezafungin for injection)

Support Program



Contact us for information and support:



1-866 REZZAYO (1-866-739-9296)

Hours: Monday-Friday, 8:30 AM to 8:00 PM, ET

Fax: 1-888-898-0033

Email: REZZAYO@Asembia.com

*INDICATION AND USAGE

REZZAYO™ (rezafungin for injection) is an echinocandin antifungal indicated in patients 18 years of age or older who have limited or no alternative options for the treatment of candidemia and invasive candidiasis. Approval of this indication is based on limited clinical safety and efficacy data.

Limitations of Use

REZZAYO™ has not been studied in patients with endocarditis, osteomyelitis, and meningitis due to *Candida*.

Please see additional Important Safety Information throughout and accompanying Prescribing Information for REZZAYO™ (rezafungin for injection).

REZZAYO™ Coverage and Process Support

Benefits Verifications

- Obtain patient specific insurance coverage for REZZAYO™
- Identify patient's cost-share responsibility (copay, co-insurance, deductible amounts)
- Verify prior authorization (PA) requirements, if any

Prior Authorization and Appeal Support

- Obtain prior authorization requirements when a PA is requested by the payer
- Receive copies of payer-specific forms and a sample letter of medical necessity, if needed
- Stay informed throughout the entire process with updates on the status and outcome of the PA or Appeal

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Melinta Therapeutics, LLC does not guarantee that coverage or payment will occur for any particular claim.

Materials provided through the REZZAYO Support Programs are for informational purposes only. This information does not guarantee coverage or payment. Codes, coverage and payment may vary from setting to setting, and from insurer to insurer. The provider submitting a claim is solely responsible for the accuracy of the codes submitted and for compliance with all coverage and reimbursement policies.

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REZZAYO™ Financial Support Programs

Copay Savings Program

- Copay support for eligible patients with private commercial insurance*
 - ✓ **Up to \$400 per 200 mg vial**
 - ✓ **Up to \$800 for 400 mg loading dose**
 - ✓ **No Out of Pocket Minimum**
- Patient must be 18 years of age or older and a US resident
- Patient must be treated in an outpatient setting of care
- There is no income requirement to qualify for the copay program

Patient Assistance Program (PAP)

Assistance program for uninsured patients demonstrating financial need:

- Patient must meet household income requirements
- Both inpatients and outpatients may be eligible for the Patient Assistance Program
- Patient must reside in the US

*A patient will not qualify if they have a prescription drug benefit through a government program (i.e. Medicaid, Medicare, Medicare Part D, Medigap, CHAMPUS, DOD, VA, TRICARE, or any state patient or pharmaceutical assistance program).

As a condition precedent of the co-payment or coinsurance support provided under this program, e.g., copay or coinsurance amounts paid to administering providers, participating patients and administering providers are obligated to inform insurance companies and third-party payers of any benefits they receive and the value of this program, as required by contract or otherwise.

Void where prohibited by law, taxed, or restricted. Additional terms and conditions may apply. Patients enrolled in the REZZAYO™ PAP are not eligible. Melinta Therapeutics, LLC may determine eligibility, monitor participation, and modify or discontinue any aspect of this program at any time.

Decisions to prescribe REZZAYO are made by providers working with their patients. The REZZAYO Support Programs provide information about REZZAYO and assistance in understanding its coverage and reimbursement. Patients who are not insured by a federal health care program and who meet certain other criteria may be eligible for financial assistance with their cost sharing obligations. More information is available through the REZZAYO Support Programs hotline.

Melinta Therapeutics, LLC does not guarantee and assumes no responsibility for the quality, availability or scope of the REZZAYO Support Programs services. Melinta Therapeutics, LLC reserves the right to rescind, revoke or amend this offer at any time without notice.

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Envision a new treatment path with REZZAYO™

REZZAYO™ offers a new option for continuity of echinocandin treatment in the outpatient setting

New Option: Discharge on REZZAYO™

Patient with invasive candidiasis

- Already on echinocandin therapy
- Otherwise dischargeable
- Needs to complete candidemia or invasive candidiasis treatment

Hospital outpatient department

Free-standing infusion center

Home infusion

Physician's office

REZZAYO™ can be administered in multiple outpatient settings of care

Simplified Echinocandin Dosing



REZZAYO™
(rezafungin for injection)

ONE IV infusion
once weekly, for
ONE hour¹

Recommended dose¹

400mg
400-mg
loading dose

200mg
200-mg dose
once weekly thereafter

- The safety of REZZAYO has not been established beyond 4 weekly doses
- If infusion-related reactions occur, the infusion may be slowed, or paused and restarted at a lower rate.

IMPORTANT SAFETY INFORMATION

Contraindications

REZZAYO™ is contraindicated in patients with known hypersensitivity to rezafungin or other echinocandins.

Warnings and Precautions

- **Infusion-related Reactions:** REZZAYO™ may cause infusion-related reactions, including flushing, sensation of warmth, urticaria, nausea, or chest tightness. If these reactions occur, slow or pause the infusion.
- **Photosensitivity:** REZZAYO™ may cause photosensitivity. Advise patients to use protection from sun exposure and other sources of UV radiation.
- **Hepatic Adverse Reactions:** Abnormalities in liver tests have been seen in clinical trial patients treated with REZZAYO™. Monitor patients who develop abnormal liver tests and evaluate patients for their risk/benefit of continuing REZZAYO™ therapy.

Adverse Reactions

Most common adverse reactions (incidence ≥ 5%) are hypokalemia, pyrexia, diarrhea, anemia, vomiting, nausea, hypomagnesemia, abdominal pain, constipation, and hypophosphatemia.

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Please see complete Indication on cover and accompanying full Prescribing Information