Prescribing HAEGARDA: An Instructional Guide

HAEGARDA is indicated for routine prophylaxis to prevent Hereditary Angioedema (HAE) attacks in adolescent and adult patients.

HAEGARDA® C1 Esterase Inhibitor Subcutaneous (Human)

Please see full Prescribing Information.

Completing the Prescription and Service Request Form

Patient Information

- Complete the First Name, Last Name, Address, City, State, Gender, D.O.B., Preferred Phone, and Caregiver First and Last Name fields

Insurance Information

- Indicate whether the patient has insurance
- If the patient does have insurance, the Primary Medical Insurance and ID # fields must be completed
- It is recommended that you attach copies of both sides of the patient's pharmacy and insurance card(s)

Patient Signature

- Patient Services Authorization and Release of Health Information: If a patient wants to enroll in HAEGARDA Connect℠, he or she must sign this section or contact HAEGARDA Connect℠ directly at 1-844-423-4273
  - Before patients elect or decline to enroll, they must read section A on page 2
  - Please note that enrolling in HAEGARDA Connect℠ is not required for a patient to receive his or her prescription, but the patient must be enrolled to be eligible for financial assistance and other programs
  - To allow information regarding the HAEGARDA prescription to be left on an answering machine or voicemail, initial the appropriate statement
- Patient Marketing Authorization: If a patient wants to receive marketing materials for HAEGARDA, he or she must initial this section
  - Before a patient initials this section, he or she must read section B on page 2
  - Please note that electing or declining to receive these materials does not affect a patient's eligibility to receive HAEGARDA or enroll in HAEGARDA Connect℠

Prescriber Information

- Complete the Prescriber's Name, NPI #, Address, City, State, Phone Number, Fax Number, and Office Contact Name fields

Prescription Information and Prescriber Signature

- Indicate the ICD-10 code, any known patient allergies, patient weight, patient height, dosage strength, vial size, and units to administer twice weekly to the pharmacist filling the patient's prescription
- In order for the patient to be trained by a HAEGARDA nurse, an epinephrine auto-injector must be available during training. Please confirm that the patient has epinephrine available or provide a separate prescription for epinephrine
- Sign to authorize patient self-administration training through a HAEGARDA nurse
- Sign to authorize the prescription

Fax the completed form to HAEGARDA Connect℠ at 1-866-415-2162

- A Fax Receipt Confirmation will be provided from HAEGARDA Connect℠
- If any of the information is missing or incomplete, HAEGARDA Connect℠ will fax a Missing Information Form

HAEGARDA Connect℠ pairs a care coordinator with a patient and HCP to provide a seamless experience from prescription through administration

- HAEGARDA Connect℠ starts the process with an introduction call to the patient that occurs within 24 hours of receiving a patient's HAEGARDA Connect℠ Prescription & Service Request Form, which includes confirming the patient's contact and prescription delivery information
- HAEGARDA will be distributed only through specialty pharmacies

HAEGARDA Connect℠

HAEGARDA Connect℠ Prescription & Service Request Form

HAEGARDA® C1 Esterase Inhibitor Subcutaneous (Human)

Fax completed form to 1-866-415-2162 Phone 1-844-HAEGARDA (1-844-423-4273)

Patient Information

First name	M.I.	Last name		
Address		City	State	Zip
Gender ❑ M ❑ F	DOB	Age	SSN (last 4 digits only)	
Mobile phone	Home phone	Work phone		
Email address	Primary language ❑ English ❑ Spanish ❑ Other (Please specify)			
Caregiver first name	Last name	Phone number	Relationship to patient	

Insurance Information

Does patient have insurance? ❑ Yes ❑ No		Is patient eligible for Medicare? ❑ Yes ❑ No	
Primary insurance	Insurance phone number	Policy #	Group#
Policy holder's name		Relationship to patient	
Policy holder's DOB		Policy holder's employer	
Prescription card ❑ Yes ❑ No	Pharmacy plan name		Pharmacy plan phone #
Policy ID	Group #	Rx Bin #	Rx PCN #
Secondary insurance	Insurance phone number	Policy #	Group#
Policy holder's name		Relationship to patient	
Policy holder's DOB	Patient guardian name (if applicable)		

I have read and agree to the attached Patient Authorization Section A. Patient Services Authorization and Release of Health Information (Signature and date required to participate in HAEGARDA Connect℠)

Patient Signature _____ Date _____

Initial Here ☐ The initials to the left denote that I have read and agree to the attached Section B. Patient Marketing Authorization (participation optional).

Initial Here ☐ The initials to the left denote that I authorize HAEGARDA Connect℠ to leave information regarding my HAEGARDA prescription, insurance coverage, and Speciality Pharmacy Provider on my voicemail or alternate contact _____ (participation optional).

Prescriber Information

Prescriber's first name	Last name	Title and specialty		
State license #	NPI #	If NP/PA, under direction of Dr. ❑ Yes ❑ No	Site name	
Clinic/Hospital affiliation	Address	City	State	Zip
Deliver product to ❑ Office ❑ Patient's home ❑ Clinic	Clinic address	Office contact e-mail		
Office phone	Office FAX	Office contact	Office contact e-mail	

Prescription Information

Other drugs used to treat HAE:		ICD-10 Code ❑ D84.1 C1-INH deficiency ❑ Other (Please specify)	
Adverse reaction with previous HAE treatments? ❑ Yes ❑ No	If so, what brand caused AE?		
NKDA? ❑ Yes ❑ No	Known drug allergies	Concurrent meds	
Prescription type ❑ Naïve ❑ Continuing therapy ❑ Restart	Weight (Specify kg or lbs) _____ ❑ kg ❑ lbs Height ____ft ____in		Date recorded
Administer _____ units of HAEGARDA subcutaneously twice weekly (every 3 or 4 days)	Quantity to Dispense: ❑ _____ 2000 IU vial ❑ _____ 3000 IU vial		

Special instructions:

Special precautions (e.g. allergies)

Specialty pharmacy to provide anaphylactic kit per provider protocol.
Must select: ❑ Dispense as written ❑ Substitution permissible

Pharmacy: ❑ Dispense 1 month of drug, needles, silicone-free syringes, and other medical equipment necessary for administration

Keep at least ____ doses on hand at all times ❑ Refill for 1 year Number of refills ____

Epinephrine: Epinephrine must be available during HAEGARDA training administration due to a risk of anaphylaxis. Self-administration training will not be initiated unless epinephrine is available at the patient training location.

❑ I certify that I have a) given my patient a separate Rx for epinephrine injection, USP auto-injector 0.15 mg or 0.30 mg, and have instructed my patient to fill the prescription at their cost prior to the initiation of HAEGARDA injection training; or b) been informed by my patient that they have an epinephrine auto-injector which will be available at the time of HAEGARDA administration.

Date	Time	Date HAEGARDA is needed

Nursing Orders *(Signature required if training is ordered):*

HAEGARDA patients are eligible to receive injection training from company-funded HAEGARDA nurses.

☑ I request my patient be trained by a HAEGARDA nurse

My signature below indicates I am requesting HAEGARDA Connect℠ coordinate a HAEGARDA nurse to provide HAEGARDA self-administration training for my patient. This will include HAEGARDA administration training, or if necessary, administration of HAEGARDA during the training visit. I will receive information on my patient's infusion training via the fax number I provided above. This order is valid for one year.

Prescriber Signature SIGN HERE _____ Date _____

❑ First dose to be administered: ❑ In office ❑ at home

❑ I do not wish to have my patient trained by a HAEGARDA nurse. I will assume responsibility and arrangements for HAEGARDA injection training for this patient.

Prescriber Authorization *(Required)*

Prescriber attests that he/she has obtained consent to release the patient's health information to the CSL Behring Entities in conjunction with the Services working solely on behalf of the patient for the purposes of seeking reimbursement through CSL Behring HAEGARDA Connect℠; verifying insurance coverage; arranging for nursing services; and evaluating the patient's eligibility for alternate sources of funding, patient support services, and materials and product fulfillment via specialty pharmacies.

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

I authorize HUB to transmit this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

❑ Dispense as written ❑ Substitution allowed

Prescriber Signature SIGN HERE _____ Date _____

HAEGARDA Connect℠ Prescription & Service Request Form

Provide to patient after prescription form is signed

HAEGARDA® C1 Esterase Inhibitor Subcutaneous (Human)

A. Patient Services Authorization & Release of Health Information

By signing this authorization, I authorize my health plans, physicians and staff, other healthcare providers, and pharmacy providers (collectively, my "Providers") to disclose personal health information about me or my minor child, including information related to my or my child's medical condition, treatment, care management, and health insurance coverage and claims, any prescription (including fill/refill information), as well as information provided on this form (collectively, "Personal Health Information"), to CSL Behring and its representatives, agents, and contractors, including CSL Behring's HAEGARDA Connect℠ operated by Sonexus Health (collectively "CSL Behring Entities") for the purposes of (1) establishing eligibility for benefits; (2) evaluation and enrollment in one or more financial assistance program(s), such as a co-pay mitigation program and/or patient assistance programs (if one or more of such programs apply to my treatment with HAEGARDA); (3) enrollment in available patient services programs (4) communication about my treatment with my Providers, who may contact me directly to facilitate the dispensing of medication and scheduling shipments and refill reminders; (5) providing product support and adherence services; (6) evaluating the effectiveness of CSL Behring's HAEGARDA Connect℠ Program; and (7) any other related support, education, and assistance services related to my treatment with HAEGARDA (collectively, the "Services"). Further, I authorize any of the CSL Behring Entities to contact me by mail, telephone, or e-mail for relevant follow-up or to obtain any information not included in this authorization.

I understand that my pharmacy Providers may disclose to the CSL Behring Entities certain Personal Health Information regarding the dispensing of my HAEGARDA prescription and that such disclosure will result in remuneration to my pharmacy Provider(s). I understand that once my Personal Health Information is disclosed to the CSL Behring Entities under this authorization, it may no longer be protected by federal privacy laws and may be further disclosed by the CSL Behring Entities. However, I understand that the CSL Behring Entities will disclose my Personal Health Information for the limited purposes described above, or as I may further authorize in writing, or as permitted or required by law. I also understand that Sonexus Health, which operates HAEGARDA Connect℠ Program for CSL Behring, and my Providers, including pharmacies, may receive compensation from CSL Behring in connection with the Services. I understand that I may refuse to sign this authorization. I understand, however, that if I do not sign this authorization, I will not be able to receive Services through the HAEGARDA Connect℠ program.

I further understand that my treatment with HAEGARDA, payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this authorization. I understand that I am entitled to a copy of this authorization. I understand that I may change my mind and cancel this authorization at any time by writing a letter requesting such cancellation to HAEGARDA Connect, PO Box 368, Lewisville, TX 75067, or by calling the CSL Behring HAEGARDA Connect℠ toll free number 1-844-423-4273 but that this cancellation will end my participation in the HAEGARDA Connect℠ program and will not apply to any information already used or disclosed through this authorization before notice of the cancellation is received by my health plans or Providers. This authorization expires five (5) years from the date signed below, or earlier, if required by state law.

Please note that electing or declining to receive these materials does not affect a patient's eligibility to receive HAEGARDA or enroll in HAEGARDA Connect℠.

B. Patient Marketing Authorization

I further authorize the CSL Behring Entities to provide me information and/or contact me regarding education, training, and ongoing support on the use of HAEGARDA and that may be of interest to me.

I understand that the CSL Behring Entities may contact me by mail, telephone, or email. If I change my mind in the future and do not wish to receive information related to HAEGARDA or any related products or services or to be contacted occasionally for market research purposes, I understand that I may change my mind and cancel this authorization at any time by writing a letter requesting such cancellation to HAEGARDA Connect, PO Box 368, Lewisville, TX 75067, or by calling the CSL Behring HAEGARDA Connect℠ toll free number 1-844-423-4273 and will not apply to any information already used or disclosed through this authorization before notice of the cancellation is received by my health plans or Providers.

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www.CSLBehring-us.com **www.HAEGARDA.com** HGD-0067-JUN17

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