AFSTYLA® Antihemophilic Factor (Recombinant), Single Chain
Enrollment Form

PRINT AND FAX COMPLETED FORM TO 1-844-727-2757
FOR QUESTIONS, PLEASE CALL 1-800-676-4266

AFSTYLA Connect℠

AFSTYLA SUPPORT SERVICES

At CSL Behring, we believe everyone should have access to therapy. For AFSTYLA we provide support services to help you get the treatment you need. Please check the box below to select the service(s) you are interested in and complete this form. (See page 2 for service descriptions)

☐ **Co-Pay Assistance** ☐ **Free Trial** ☐ **Patient Assistance** ☐ **CSL Behring Assurance℠**

PATIENT Sections 1, 2 & 3 Must Be Completed for All Service Requests

1 Patient Information (REQUIRED)

Patient name _____ DOB ___/___/___ SSN (last 4 digits only) ____ ____ ____ ____ Sex ☐ M ☐ F

Street address _____ City _____ State _____ ZIP _____

Home phone _____ ☐ OK to leave message Mobile phone _____ ☐ OK to leave message Email _____

Current therapy status: ☐ Existing AFSTYLA patient ☐ Switch from another Factor VIII therapy _____ ☐ Other _____

2 Patient Insurance Information (REQUIRED) Please attach copies of both sides of patient's insurance card(s), if available.

☐ **Check if patient does <u>not</u> have insurance** (Patient must have insurance to be eligible for Free Trial and Assurance℠)

Primary insurance _____

Insurance phone _____ Policy # _____

Policyholder name _____ Policyholder DOB ___/___/___

Secondary insurance _____

Insurance phone _____ Policy # _____

Policyholder name _____

Policyholder DOB ___/___/___

Pharmacy plan _____ Group # _____ Policy # _____ Rx BIN # _____ Rx PCN # _____

3 Patient Authorization for Release and Use of Personal Health Information (REQUIRED)

I have read and understand the "Patient Authorization for Release and Use of Personal Health Information" section of the instructions on Page 2.
My signature also signifies that the information on this form is accurate and complete.

PATIENT SIGNATURE _____ Date _____

PARENT OR GUARDIAN SIGNATURE (for patients under 18 years old) _____ Date _____

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

Designated Individual (print name) _____ Relationship _____

PRESCRIBER

I AM REQUESTING: (please check appropriate box) ☐ **AFSTYLA FREE TRIAL PROGRAM** ☐ **AFSTYLA FREE TRIAL & PATIENT ASSISTANCE PROGRAM**

A Prescriber Information

Prescriber name _____ State license # _____ NPI # _____

Tax ID # _____ DEA _____ PTAN _____

Facility name _____ Facility address _____ City _____ State _____ ZIP _____

Office contact _____ Phone _____ Fax _____ Email _____

Ship to: ☐ Patient home ☐ Facility

B Prescription and Dosing Information

Rx: AFSTYLA For Prophylaxis
If you are requesting a Prophylactic trial, please fill out the below section.
All requests must be for a 4 week trial period.

- **Patients ≥12 years of age: 20–50 IU/kg body weight twice or three times per week.**
- **Patients <12 years of age: 30–50 IU/kg body weight twice or three times per week. More frequent or higher doses may be required in children.**

Patient weight _____ kg Dosage _____ IU/kg Frequency of dosing ☐ 2x/week ☐ 3x/week

☐ Other If other selected, please specify requested dosing frequency _____

Number of refills (If using pharmacy referral) _____ ☐ D66 Congenital Factor VIII Disorder

Rx: AFSTYLA On-Demand
If you are requesting an On-Demand trial dose, the request must be for 2 acute doses of AFSTYLA from a range of 10 – 50 IU/kg per dose.

- **Minor or Moderate Bleed:** Treat to 20 - 60 IU/dL to circulating factor
- **Major Bleed:** Treat to 60 - 100 IU/dL to circulating factor

Patient weight _____ kg Dosage _____ IU/kg Frequency of dosing _____

☐ D66 Congenital Factor VIII Disorder

No medical exceptions will be offered for the On-Demand dosing program.

C Prescriber Authorization (REQUIRED)

PRESCRIBER SIGNATURE _____ **DATE** _____

By signing above, I certify that:

- I have discussed with the above-named patient or the patient's legal guardian that CSL Behring sponsors a program through which CSL Behring will make a limited free supply of AFSTYLA available to the patient. The patient desires to participate in this CSL Behring program and receive the free product.
- I certify that the requested product is medically necessary for this patient and that the patient has no free trial history with this product.
- I have received the necessary written authorization from the patient or the patient's legal guardian to release to CSL Behring and its contracted agents, working solely on behalf of patient, the medical and/or other patient information included in this form relating to the patient referenced above for the purposes of participating in programs and services offered through AFSTYLA Connect℠, which may include any of the following:
  – participating in the AFSTYLA Trial Program
  – seeking reimbursement through AFSTYLA Connect
  – verifying insurance coverage and/or the evaluation of the patient's eligibility for alternate sources of funding
  – patient support services, including materials fulfillment, and product fulfillment via specialty pharmacies
- If I have requested free trial product, I will not directly or indirectly sell, resell, trade, barter or return for credit the requested product, or seek reimbursement for them from any source whatsoever, including any public or private third-party program.

CSL Behring

Enrollment Form Instructions

THANK YOU FOR YOUR INTEREST IN AFSTYLA CONNECT℠
PLEASE CALL **1-800-676-4266** WITH QUESTIONS

AFSTYLA SUPPORT SERVICES

At CSL Behring, we believe everyone should have access to therapy. For AFSTYLA we provide support services to help you get the treatment you need.

Co-pay Assistance: Patients meeting eligibility requirements* may receive up to $12,000 in Co-Pay support.

**Patient must have coverage for AFSTYLA under a private, commercial plan. Patients covered by state or federally funded programs are excluded (Medicare, Medicaid, PCIP, Tricare, SCHIPs, etc). Patient must be a resident of the United States. Product only is supplied per the Package Insert. Product must be purchased from a Specialty Pharmacy, Hemophilia Treatment Center, or Outpatient Hospital to be eligible. CSL Behring reserves the right to modify, limit, or discontinue all or any portion of the program without notice. Annual benefit may be up to $12,000 per enrollment year.*

Free Trial: Patients meeting eligibility requirements† can receive:

-One 30 day free trial of AFSTYLA if prescribed for prophylaxis ***OR***
-Two acute doses of AFSTYLA for on-demand trial. No medical exceptions will be offered for the on-demand dosing program.

†Only patients who have never previously received an AFSTYLA Free Trial are eligible. All insured patients are eligible for AFSTYLA Free Trial, including patients with Medicare and Medicaid. Free Trial product must be used on-label.

Benefit Investigation: We will contact an insurance carrier on a patient's behalf to obtain coverage and patient costs for AFSTYLA.

Assurance℠: The CSL Behring Assurance℠ program can help people who rely on AFSTYLA to continue to receive treatment if a lapse in commercial insurance coverage occurs. Call 1-800-676-4266 for more details.

PATIENT INSTRUCTIONS

1 Complete Sections 1 and 2 on the Enrollment Form.

2 Patient Authorization for Release and Use of Personal 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 information, including but not limited to, personal health information about me, including information related to my medical condition, treatment, care management, and health insurance coverage and claims, any prescription (including fill/refill information), and any other information disclosed in connection with the resources (as defined below) ("Personal Health Information"), to CSL Behring and its representatives, agents, and contractors (such as hub service providers, pharmacy service providers, nurse self-infusion training providers and/or nurse adherence providers and CSL Behring's support program(s) (collectively "CSL Behring Entities") for the purposes of the CSL Behring Entities:

(1) establishing my eligibility for insurance benefits including but not limited to coverage for prescription drugs;
(2) evaluating my eligibility for and enrolling me in one or more financial assistance program(s) offered by CSL Behring Entities, such as a co-pay mitigation program and/or patient assistance programs (if one or more of such programs apply to my treatment with a CSL Behring therapy);
(3) enrolling me in available patient services programs offered by CSL Behring Entities;
(4) communicating about my treatment with me or my Providers, including by contacting me directly to facilitate the dispensing of medication and scheduling shipments and refill reminders;
(5) providing product support and adherence services to me through CSL Behring Entities;
(6) evaluating the effectiveness of CSL Behring's support program(s);
(7) providing any other related support, education, and assistance services to me related to my treatment with CSL Behring therapy and/or living with my disease; and
(8) contacting me for marketing or market research purposes (collectively, the "Resources").

Further, I authorize any of the CSL Behring Entities to contact me by mail, email, telephone and by text message in connection with any of the Resources.

I understand that once my Personal Health Information or other personal information is disclosed to the CSL Behring Entities under this authorization, it may no longer be protected by state and/or 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 only for the limited purposes described above, or as I may further authorize in writing, or as permitted or required by law. I understand that data related to my enrollment in any CSL Behring program may be collected, analyzed, and shared among CSL Behring Entities.

I understand that my pharmacy Providers, including those Providers who dispense free trials as part of the Purposes or commercially-reimbursed doses of CSL Behring products, may disclose to the CSL Behring Entities certain Personal Health Information regarding the dispensing of my prescription and that such disclosure may result in remuneration to my pharmacy Provider(s).

I understand that I may refuse to sign this authorization. I also understand, however, that if I do not sign this authorization, I may not be able to receive Resources through CSL Behring Entities. I understand that my treatment with a CSL Behring therapy (other than participation in a free trial program), payment for treatment, insurance enrollment, and 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 CSL Behring c/o Patient Services P.O. Box 1587 Jeffersonville, IN 47130 or by calling 833-436-0021 and that this cancellation will end my participation in CSL Behring Resources. I also understand that my cancellation of the authorization will not invalidate any uses or disclosures of my Personal Health Information made before my notice of cancellation is received by CSL Behring Entities. This authorization expires five (5) years from the date signed, or earlier, if required by state law.

CSL Behring will not retain this data beyond the maximum period allowed by law.

Optional consent to receive marketing communications from CSL Behring Entities:

I understand that this consent is not required as a condition of signing the authorization or of receiving any products or Resources from CSL Behring:

☐ By checking this Opt-In box for Automated Marketing Calls and Text Messaging and signing this authorization, I am also consenting to CSL Behring and its service providers using my Personal Health Information to send me autodialed and prerecorded marketing calls and text messages at the telephone number(s) that I provide. I understand that I will have the ability to opt out from receiving marketing communications from CSL Behring Entities at any time.

Name: _____ Date: _____ Signature: _____

PRESCRIBER INSTRUCTIONS—Sections 1 and 2 MUST ALSO BE COMPLETED

1 Complete Prescriber Information in Section A of the Enrollment Form.

2 Complete the Patient's Dosing Information in Section B of the Enrollment Form, including confirmation of diagnosis code.

3 Read and Sign Prescriber Authorization in Section C of the Enrollment Form.