Prescribing BERINERT: An Instructional Guide

BERINERT is a plasma-derived C1 Esterase Inhibitor (Human) indicated for the treatment of acute abdominal, facial, or laryngeal hereditary angioedema (HAE) attacks in adult and pediatric patients.

Please see full Prescribing Information.

Completing the Prescription and Insurance Verification Form

Patient Information

- Complete the First Name, Last Name, Address, City, State, Gender, D.O.B., Current Therapy, Home Phone, Preferred Phone, and Caregiver First and Last Name fields
- Include social security number only if required by insurance company

Insurance Information

- Indicate whether the patient has insurance
- If the patient does have insurance, the Primary Medical Insurance and Policy Number 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 BERINERT Connect℠, he or she must sign this section or contact BERINERT Connect℠ directly at 1-877-236-4423
  - Before patients elect or decline to enroll, they must read page 3
  - Please note that enrolling in BERINERT 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 BERINERT prescription to be left on an answering machine or voicemail, initial the appropriate statement
  - If the patient is not present to sign the form, please fax the form to BERINERT Connect℠ so that the prescription process can begin

Prescriber Information

- Complete the Prescriber's Name, Title and Specialty, State License Number, NPI #, If NP/PA section (if applicable), Address, City, State, Zip, Office Phone, Office Fax, and the name of the Office Contact

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 to the pharmacist filling the patient's prescription
- Sign to authorize the prescription

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

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

BERINERT Connect℠ pairs a case manager with a patient and HCP to provide a seamless experience from prescription through administration

- BERINERT Connect℠ starts the process with an introduction call to the patient that occurs within 2 business days from receipt of a fully completed patient's BERINERT Connect℠ Prescription & Service Request Form, which includes confirming the patient's contact and prescription delivery information

BERINERT Connect℠ Prescription & Service Request Form

Fax completed form to 1-866-415-2162 Phone 1-877-236-4HAE (1-877-236-4423)

BERINERT® C1 Esterase Inhibitor, Human

1 Patient Information

First Name XX	M.I. XX	Last Name XX		
Address XX		City XX	State XX	Zip XX
Gender ❑ M ❑ F	DOB XX	Current Therapy XX	SSN (last 4 digits only) XX	
Mobile Phone XX		Home Phone XX	Work Phone XX	
Email Address XX		Primary Language ❑ English ❑ Spanish ❑ Other (Please specify) XXX		
Caregiver First Name XXX	Last Name XXX	Phone Number XXX	Relationship to Patient XXX	

2 Insurance Information

Does patient have insurance? ❑ Yes ❑ No		Is patient eligible for Medicare? ❑ Yes ❑ No	
Primary Insurance XXxx	Insurance Phone # XXX	Policy # XXX	Group# XX
Policy Holder's Name XX		Relationship to Patient XX	
Policy Holder's DOB XX		Policy Holder's Employer (if available) XX	
Prescription Card ❑ Yes ❑ No	Pharmacy Plan Name XXXX	Pharmacy Plan Phone # XXX	
Policy ID XXX	Group # XXX	Rx Bin # XXX	Rx PCN # XXX
Secondary Insurance XXX	Insurance Phone # XXX	Policy # XXX	Group# XXX
Policy Holder's Name XXX		Relationship to Patient XXX	
Policy Holder's DOB XXX		Patient Guardian Name (if applicable) XXX	

I have read and agree to the Patient Services Authorization and Release of Health Information on page 3.(Signature and date may be required to receive certain services)

Patient Signature _____ Date XXX

XX
Initial Here

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

3 Prescriber Information

Prescriber's First Name XXX	Last Name XXX	Title and Specialty XXX		
Site Name XXX	Address XXX	City XXX	State XXX	Zip XX
Office Phone # XX	Office Fax # XX	Office Contact Name XXX	Office Contact E-mail XX	
State License # XXX	Tax ID# XX	NPI # XXX	If NP/PA, under direction of Dr. ❑ Yes ❑ No	

4 Prescription Information

Rx: BERINERT (C1 Esterase Inhibitor [Human])	**NDC:** 63833-825-02 (BERINERT C1 Esterase Inhibitor [Human]) 500 Units
Other drugs used to treat HAE: XXXX	ICD-10 Code ❑ D84.1 C1-INH deficiency ❑ Other (Please specify) XXXXX
Adverse reaction with previous HAE treatments? ❑ Yes ❑ No	If so, what brand caused AE? XXXXX
Known drug allergies? ❑ No ❑ Yes If yes, please list: XXXXXX	
Concurrent meds XXXXX	Prescription type ❑ Naïve ❑ Continuing therapy ❑ Restart
Weight (Specify kg or Lbs) ❑ kg ❑ lbs XXXX	Date recorded XXXX

Dose (20 IU/kg): XXX **Dispense:** ❑ 2 Doses ❑ 3 Doses ❑ Other XXX Doses **Number of Refills:** XXX

Administration: ❑ Train for Self-administration ❑ Other

❑ Pharmacy to provide anaphylactic kit per provider protocol **Must Select:** ❑ Dispense as Written ❑ Substitution Permitted

5 Prescriber Authorization *(Required)*

Prescriber certifies 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 BERINERT 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 BERINERT Connect℠ to transmit this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

☑ Dispense as written Prescriber Signature SIGN HERE _____ Date XXX

☑ Substitution allowed Prescriber Signature SIGN HERE _____ Date XXX

BERINERT Connect℠

BERINERT Connect℠ Prescription & Service Request Form

Provide to patient after prescription form is signed

BERINERT
C1 Esterase Inhibitor, Human

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 information, including but not limited to, 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), and any other information disclosed in connection with the Services (as defined below) ("Personal Health Information"), to CSL Behring and its representatives, agents, and contractors, including CSL Behring's support program(s) (collectively "CSL Behring Entities") for the purposes of:

(1) establishing eligibility for insurance benefits including but not limited to coverage for prescription drugs;
(2) evaluation and enrollment 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) enrollment in available patient services programs offered by CSL Behring Entities;
(4) communication 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 through CSL Behring Entities;
(6) evaluating the effectiveness of CSL Behring's support program(s); and
(7) any other related support, education, and assistance services related to my treatment with CSL Behring therapy and/or living with my disease (collectively, the "Services").

Further, I authorize any of the CSL Behring Entities to contact me by mail, telephone and/or SMS/text message, or e-mail for relevant follow-up to any of the aforementioned Services. CSL Behring Entities include but are not limited to brand specific support through hub service providers, pharmacy service providers, nurse self-infusion training providers and/or nurse adherence providers, as well as other entities under contract with CSL Behring to support these or similar aspects of the Services. I understand that these CSL Behring Entities may collect Personal Health Information from me for the purposes listed above, and that such collection is subject to CSL Behring's Privacy Policy.

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 also understand that CSL Behring Entities may receive compensation from CSL Behring in connection with the Services.

I understand that my pharmacy Providers, including those Providers who dispense free trials as part of the Services 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). If necessary or if requested by my prescriber, I authorize CSL Behring Entities to forward my prescription to a dispensing pharmacy on my behalf.

I understand that I may refuse to sign this authorization. I understand, however, that if I do not sign this authorization, I may not be able to receive Services 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, or eligibility for insurance benefits are not conditioned upon my agreement to sign this authorization. I understand that Services provided by CSL Behring are not insurance and that CSL Behring has the right to rescind, revoke or amend any service at any time without notice.

I understand that I am entitled to a copy of this authorization.

I understand that if CSL loans me durable medical equipment or other medical equipment through the Services, CSL reserves the right to seek reimbursement from me for all unreturned DME or equipment.

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 61501 King of Prussia, PA 19406 or by calling the CSL Behring Customer Affairs toll free number 1-888-508-6978 and that this cancellation will end my participation in CSL Behring Services and will not apply to any information already used or disclosed through this authorization before notice of the 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.

I understand that, under certain circumstances, by law I may have certain rights regarding CSL Behring's use of my or my minor child's data. I may have the right to receive information about what data CSL Behring has collected about me or my minor child. I may have the right to ask CSL Behring to delete certain personal information about me or my minor child, but only when CSL Behring does not have a legal reason for retaining such personal information. I understand that if I exercise these rights, I will be asked to verify my identity, that if someone else will exercise my rights on my behalf, that they will need to prove that they have your permission to do so. I understand that to exercise my rights, I may contact CSL Behring through https://privacyinfo.csl.com/ or toll free by phone at (833) 704-0018. For more information about how CSL Behring handles personal information, I understand that I can view CSL Behring's privacy policy at https://www.cslbehring.com/privacy-policy.

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