Prescribing HAEGARDA: An Instructional Guide

HAEGARDA is a plasma-derived concentrate of C1 Esterase (Human) (C1-INH) indicated for routine prophylaxis to prevent Hereditary Angioedema (HAE) attacks in patients 6 years of age and older.

HAEGARDA® C1 Esterase Inhibitor Subcutaneous (Human)

Please see full Prescribing Information.

Completing the Prescription and Referral 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 the Patient Services Authorization & Release of Health Information on page 3
  - 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
  - If the patient is not present to sign the form, please fax the form to HAEGARDA Connect℠ so that the prescription process can begin

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 case manager 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 & Referral 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 & Referral 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

❑ Check here if information is included on additional pages

First name	M.I.	Last name		
Address		City	State	Zip
DOB	Gender ❑ M ❑ F	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 #	Relationship to patient	

Insurance Information

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

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)

(Optional) ❑ I have read and understand the Opt-In for Automated Marketing Calls and Text Messages in the Patient Authorization on page 3 and hereby agree to receive these types of communications from CSL Behring.

SIGN HERE ❯ _____

Patient Signature **Date** ***(REQUIRED)***

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

Prescriber Information

Prescriber's first name	Last name	Title and specialty		
Site name	Address	City	State	Zip
Office phone #	Office FAX #	Office contact	Office contact e-mail	
State license #	Tax ID#	NPI #	If NP/PA, under direction of Dr. ❑ Yes ❑ No	

Prescription Information

Other drugs used to treat HAE:	**ICD-10 Code:** ❑ D84.1 Defects in the complement system, C1 esterase inhibitor (C1-INH) deficiency ❑ Other (Please specify)
Adverse reaction with previous HAE treatments? ❑ Yes ❑ No	If so, what brand caused AE?
Known drug allergies? ❑ No ❑ Yes If yes, please list:	
Concurrent meds	Prescription type: ❑ Naïve ❑ Continuing therapy ❑ Restart
Weight (Specify kg or lbs) ❑ kg ❑ lbs / Date recorded	Epinephrine: Self-administration training by HAEGARDA Nurses will not be initiated unless epinephrine is available at the patient training location. ❑ My patient has a prescription for epinephrine. Epinephrine #2 pack ❑ 0.15mg ❑ 0.3mg ❑ Refills: _____ Inject IM as needed for anaphylaxis reaction. May repeat x1 in 5 to 15 minutes if symptoms persist. SP to provide at first dispense.
Dosing of HAEGARDA: 60 IU/kg twice weekly HAEGARDA is available in 2000 IU and 3000 IU vials Administer _____ units of HAEGARDA subcutaneously twice weekly (every 3 or 4 days)	
Special instructions:	Specialty pharmacy to provide anaphylactic kit per provider protocol. Must select: ❑ Dispense as written ❑ Substitution permissible
Special precautions:	
❑ Refill for 1 year OR number of refills _____	
Pharmacy: Dispense 1 month of drug, needles, silicone-free syringes, and other medical equipment necessary for administration.	
Pharmacy: Deliver product to patient's home / Date / Time	

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.

First dose trained by nurse in: ❑ in office ❑ at home Ongoing nurse visits will provide my patient and/or his/her caregiver with training on the proper self-administration of HAEGARDA.

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 injection training via the fax number I provided above. This order is valid for one year.

Prescriber Signature SIGN HERE ❯ _____ Date *(REQUIRED)* _____

❑ 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 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 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 Prescriber Signature SIGN HERE ❯ _____ Date *(REQUIRED)* _____

❑ Substitution† allowed Prescriber Signature SIGN HERE ❯ _____ Date *(REQUIRED)* _____

*Dispense As Written / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute

†May Substitute / Product Selection Permitted / Substitution Permissible. CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution"

ATTN: New York and Iowa providers, please submit electronic prescription

HAEGARDA Connect℠ Prescription & Referral Form

Provide to patient after prescription form is signed

HAEGARDA®
C1 Esterase Inhibitor
Subcutaneous (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, 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 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 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, 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 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 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.

1020 First Avenue, PO Box 61501, King of Prussia, PA 19406-0901 USA
www.CSLBehring.com **www.HAEGARDA.com** USA-HGD-0522-APR24

CSL Behring

HAEGARDA Connect℠ QuickStart Program

QuickStart Form must be submitted to HAEGARDA Connect with a completed HAEGARDA Prescription and Referral Form.

HAEGARDA®
C1 Esterase Inhibitor Subcutaneous (Human)

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

Healthcare Provider Information *(REQUIRED)*

Prescriber name		Facility name		
Address		City	State	Zip
Office contact	Office phone #	Office fax #	Email	
State license #	NPI #	Tax ID	DEA	PTAN

Prescription Information *(REQUIRED)*

Ship to: ❑ Patient's Home ❑ Healthcare Provider *(Drug cannot be shipped to any inpatient facility.)*

Patient name	DOB	Weight *(Specify kg or lbs)* ❑ kg ❑ lbs		
Address		City	State	Zip

HCP facility name *(Complete if shipping to an HCP address different from above)*

Address		City	State	Zip
Office contact	Office phone #	Office fax #	Email	

Date of most recent therapy	Drug allergies

Dosing of HAEGARDA: 60 IU/kg twice weekly
HAEGARDA is available in 2000 IU and 3000 IU vials. No exceptions to dosing quantity.

Administer _____ units of HAEGARDA subcutaneously twice weekly (every 3 or 4 days).
Pharmacy to include ancillary supplies.
First dispense to include HAEGARDA and ancillary supplies for 14 day fill.

Refills: Patient may receive up to 2 additional months of QuickStart. Refill dispenses will only be dispensed in a 14 day supply of HAEGARDA with ancillary supplies. Not all patients will be eligible for refills. Refills are only authorized in the event of a delay in commercial therapy.

Site of Care: ❑ Home ❑ Facility

Directions

Special instructions

Special precautions

Nurse-facilitated self infusion training to support the QuickStart Program is available upon completion of nursing orders located on the HAEGARDA Referral Form.

Prescriber Attestation *(REQUIRED)*

By signing and dating, I attest that the person listed is my patient for whom I have prescribed a CSL Behring product in accordance with the labeled use of the product. I acknowledge that this patient is applying for therapy assistance and does not have access to commercially available CSL Behring product at this time. I acknowledge and agree not to submit a third-party insurance claim or other claim for payment for this product or for services rendered in association with its administration, including Medicare Parts A, B, and D, Medicare Advantage Plans, Medicaid, Medicaid Managed Care, Veterans Administration (VA), TRICARE, State Children's Health Insurance Plans (SCHIPS), and Preexisting Condition Insurance Plans (PCIPs). Furthermore, I acknowledge that CSL Behring reserves the right, in its sole discretion, to discontinue at any time its QuickStart Program provision of product to this patient. I certify that I have received the necessary authorization from the patient to release the medical and/or patient information on this form to CSL Behring and its contracted agent or contractors, working solely on behalf of the patient, for the purpose of participating in the HAEGARDA QuickStart Program.

Prescriber Signature SIGN HERE _____ Date *(REQUIRED)* _____

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