IDELVION®, Coagulation Factor IX (Recombinant), Albumin Fusion Protein (rIX-FP)

Enrollment Form

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

IDELVION Connect℠

IDELVION SUPPORT SERVICES

At CSL Behring, we believe everyone should have access to therapy. For IDELVION 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** ☐ **Benefit Investigation** ☐ **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 IDELVION patient ☐ Switch from another Factor IX 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 AUTHORIZATION FOR DATA PRIVACY CONSENT (REQUIRED)

I have read and understand the "AUTHORIZATION FOR DATA PRIVACY CONSENT" section of the instructions on Page 2. My signature also signifies that the information on this form is accurate and complete.

PATIENT SIGNATURE _____ Date _____

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

Designated Individual (print name) _____ Relationship _____

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

PRESCRIBER

I AM REQUESTING: (please check appropriate box) ☐ **IDELVION FREE TRIAL** ☐ **IDELVION FREE TRIAL & BENEFIT INVESTIGATION**

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: IDELVION For Prophylaxis

If you are requesting a Prophylactic trial dose, the request must be for once weekly dosing for 4 weeks.

- **Patients <12 years of age:** 40–55 IU/kg body weight every 7 days
- **Patients ≥12 years of age:** 25–40 IU/kg body weight every 7 days

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

☐ D67 Congenital Factor IX Disorder

Rx: IDELVION On-Demand

If you are requesting an On-Demand trial dose, the request must be for 2 acute doses of IDELVION from a range of 30 – 100 IU/kg per dose. (max 100 IU/kg per dose)

- **Minor or Moderate Bleed:** Treat to 30 - 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 _____

☐ D67 Congenital Factor IX 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 IDELVION 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 IDELVION Connect, which may include any of the following:
  - participating in the IDELVION Trial Program
  - seeking reimbursement through IDELVION 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
Biotherapies for Life®

Enrollment Form Instructions

THANK YOU FOR YOUR INTEREST IN IDELVION SUPPORT SERVICES
PLEASE CALL **1-800-676-4266** WITH QUESTIONS

IDELVION SUPPORT SERVICES

At CSL Behring, we believe everyone should have access to therapy. For IDELVION 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 IDELVION 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 either:

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

†Only patients who have never previously received an IDELVION Free Trial are eligible. All insured patients are eligible for IDELVION Free Trial, including patients with Medicare and Medicaid. Free Trial product must be used per package insert.

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

Assurance℠: The CSL Behring Assurance℠ program can help people who rely on IDELVION 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 Read AUTHORIZATION FOR DATA PRIVACY CONSENT—Sign Section 3 on the Enrollment Form.

DATA PRIVACY CONSENT FOR CSL Behring's Support Services:

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.

II 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 my 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.

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.