briumvi™ ublituximab-xiiy 150 mg/6 mL injection for IV patient support

BRIUMVI Patient Support
PO Box 2355
Morristown, NJ 07962

Phone: 1-833-BRIUMVI
(1-833-274-8684)
Fax: 877-639-2525

Hours of Operation:
Monday-Friday
8 AM to 8 PM EST

START FORM
(includes all program offerings from page 3)

1 Patient Information

First Name _____ Last Name _____

Date of Birth (MM/DD/YYYY) _____ Gender _____

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Address _____

City _____ State _____ ZIP _____

Email Address _____

Mobile Phone # _____

☐ OK to send text message (Message and data rates may apply)

Additional Phone # _____

Permanent US Resident?

☐ Yes ☐ No

Patient Authorization for Use and Disclosure of Personal Health Information

I have read and agreed to the Patient Authorization for Use and Disclosure of Personal Health Information on page 2.

Signature of Patient or Patient Representative _____ Date _____

In addition, I authorize the disclosure of my health information to the following authorized care partner:

Authorized Care Partner Name _____ Authorized Care Partner Phone _____

Relationship to Patient _____ Authorized Care Partner Email _____

BRIUMVI Copay Assistance Program

☐ **If eligible, I would like to enroll in the BRIUMVI Copay Assistance Program for commercially-insured patients. I have read and agreed to the program terms and conditions (see page 3).**

BRIUMVI Patient Assistance Program

BRIUMVI Patient Support provides product to eligible uninsured and underinsured patients at no charge. If you choose to apply for free product, checking the box below will prompt BRIUMVI Patient Support to verify your income.

☐ I have read and agree to the Terms and Conditions and the Fair Credit Reporting Act (FCRA) authorization on page 3.

Household Size (including yourself) _____

2 Patient Insurance

If available, please attach a copy of the front and back of the patient's medical and pharmacy insurance card to this form.

☐ **Please check this box if the patient has no insurance**

Primary Insurance	Primary Insurance Policy Holder	Primary Insurance Policy ID #	Group #	Primary Insurance Phone #
Secondary Insurance	**Secondary Insurance Policy Holder**	**Secondary Insurance Policy ID #**	**Group #**	**Secondary Insurance Phone #**

3 Prescriber Information

Prescriber First Name	Prescriber Last Name	Phone #	Fax #	NPI #
Address		**Suite #**	**Tax ID #**	**State License #**

City	State	ZIP	Office Contact Name	Office Contact Phone #	Office Contact Email

Diagnosis

☐ ICD-10 Code: G35 (MS) ☐ Other diagnosis code: _____

BRIUMVI Prescription

NDC: 73150-0150-06: 150 mg vial

Please Select All That Apply

☐ **First Infusion Rx:** 150 mg (1 vial) IV infusion

☐ **Second Infusion Rx:** 450 mg (3 vials) IV infusion (2 weeks later)

☐ **Subsequent Infusion Rx:** 450 mg (3 vials) infusion once every 24 weeks* (quantity sufficient) **Refill:** ____ times

*Administer the first subsequent infusion 24 weeks after the first infusion

Anticipated Infusion Date: _____ **Allergies:** _____

Send an electronic prescription if required by state law.

Infusion Options

How do you intend to procure and administer BRIUMVI? (Select only one)

In-Office

Site Name: _____

Address: _____

NPI: _____ Tax ID: _____

Product Procurement:

☐ Buy & Bill ☐ Specialty Pharmacy (SP) Preferred SP: _____

Referral to infusion site If referral infusion site is known, enter information below:

Site Name: _____

Address: _____ ZIP: _____

Phone: _____ Fax: _____

☐ Check if assistance is needed with locating an infusion site

Who should be contacted? ☐ Patient ☐ Prescriber

By signing this form, I certify: (a) I am a licensed healthcare provider and have prescribed the TG medicine identified above to the patient identified above based on my independent medical judgment; (b) I received the appropriate patient authorization to release the information above to TG Therapeutics, Inc., and BRIUMVI Patient Support together with their respective third-party service providers, contractors or affiliates, and the dispensing pharmacy for the purpose of assisting the patient with initiating or continuing therapy in accordance with my treatment decisions; (c) I will not attempt to seek reimbursement for free product provided to the patient; (d) I request BRIUMVI Patient Support to convey the prescription described herein to the authorized pharmacy; and (e) if the patient receives copay assistance under the BRIUMVI Copay Assistance Program, I understand that the patient's benefit will be paid directly to me/my office on behalf of my patient if I/my office is administering the TG medicine and I/my office will apply any amount received under the BRIUMVI Copay Assistance Program to satisfy the patient's obligation for the TG medicine prescribed.

Prescriber Signature Required (no stamps) _____ **Date** _____