PRESCRIPTION REFERRAL FORM

IgIQ® RESOURCE CENTER — BENEFITS INVESTIGATION REQUEST

FAX: 1-866-720-4373 • TOLL-FREE: 1-877-355-IGIQ (4447)
EMAIL: IgIQ@sonexushealth.com

Please complete the form. Submit via fax or email (only via encrypted file). Upon completion, the results of the Benefits Investigation will be faxed or emailed to you.

Hizentra®
Immune Globulin Subcutaneous (Human) 20% Liquid

SECTION A PATIENT INFORMATION

Name _____
Contact Phone _____
Patient Address (no PO Boxes) _____
City _____ State _____ ZIP _____
Sex ☐ F ☐ M Date of Birth _____
Email _____
Diagnosis (ICD-10) _____
Parent/Guardian Name (if applicable) _____
Parent/Guardian Contact Phone _____

SECTION B PATIENT INSURANCE INFORMATION

(Fax copy of insurance card[s] or provide the information)

Primary Insurance _____
Prescriber Participating Status (check one) ☐ Network ☐ Out of Network
Policyholder's Name _____
Employer _____
Insurance Phone _____
Group Number _____ Policy Number _____
Plan Provider ID Number _____

Secondary Insurance _____
Prescriber Participating Status (check one) ☐ Network ☐ Out of Network
Policyholder's Name _____
Employer _____
Insurance Phone _____
Group Number _____ Policy Number _____
Plan Provider ID Number _____

☑ **Patient's In-Network Provider:** The IgIQ Resource Center will contact the patient's insurer to confirm coverage options for Hizentra, including in-network Specialty Pharmacies. If more than one pharmacy is in network, IgIQ will select an INN SP unless your preference is indicated below. If your preferred specialty pharmacy is out of network, IgIQ will contact your office. Results from the completed benefits investigation will be sent to your office via fax or email.

Preferred Specialty Pharmacy _____

SECTION C TREATMENT SETTINGS

Initial Treatment Setting: ☐ Prescriber Office ☐ Home
☐ Begin treatment in clinical setting – transition to home

Patient Training:
If patient requires training, do you want the Specialty Pharmacy to train the patient? ☐ Yes ☐ No

Would you like the SP to contact you regarding nursing notes/pharmacy progress reports on the status of this SCIg patient? ☐ Yes ☐ No

SECTION D PRESCRIPTION ORDER FOR HIZENTRA

Upon request, the IgIQ Resource Center can send this prescription to the Specialty Pharmacy or service.

Please complete dosing schedule Rx and ancillary supplies section:

Previous Ig Therapy (if applicable) _____
Patient Weight (kg) _____ **Height** _____
Dosing Schedule: (refer to PI for dosing instructions)
Dose/kg _____ **Total dose/week** _____ (in grams) (_____ total mLs)
To be infused into _____ subcutaneous sites every _____ days
Total grams of Hizentra requested _____ grams
(Based on number of weeks requested and patient body weight)

☐ Ensure that patient titrates to maximum volume and flow rate per prescribing information

Ancillary Supplies:
If the Ancillary Supplies section is left blank, infusion supplies will be selected for the patient

☐ Patient does not need a pump
SC Needle Length(s): ☐ 4mm ☐ 6mm ☐ 9mm ☐ 12mm ☐ 14mm
_____ Refills (as allowed by state or payor requirement)

☐ No known drug allergies
☐ Drug allergies _____
☐ Pharmacy to provide anaphylactic kit per provider protocol
☐ Concomitant medications _____
(Use separate page to list additional concomitant medications)

Premedication ☐ **Yes** ☐ **No**
☐ Acetaminophen (oral): ***Adult dose:*** _____ ***Pediatric dose:*** _____
☐ Diphenhydramine (oral): ***Adult dose:*** _____ ***Pediatric dose:*** _____

Emergency medications:
☐ Epinephrine 1:1000 intramuscular: ***Adult dose:*** _____ ***Pediatric dose:*** _____
(Administer intramuscularly as needed for severe anaphylactic reaction times one dose; may repeat one time)
☐ Diphenhydramine ☐ IV ☐ IM ***Adult dose:*** _____ ***Pediatric dose:*** _____

Prescriber's Full Name _____
Tax ID # _____ DEA # _____
SLN _____
NPI _____
Practice or Facility Name: _____
Address _____
City _____ State _____ ZIP _____
Office Contact _____
Phone _____ Fax _____
Patient's Specialty Pharmacy/Current Home Care _____

PLEASE NOTE: TWO SIGNATURES ARE REQUIRED

☑ **DISPENSE AS WRITTEN:** Exact terminology may be based on state regulations. Please provide state-specific prescription language here:

_____

PRESCRIBER SIGNATURE: (REQUIRED TO PROCESS PRESCRIPTION)

_____ Date _____

PRESCRIBER AUTHORIZATION (REQUIRED)

I certify that Hizentra is medically necessary for this patient. I will be supervising the patient's treatment accordingly. Non-approval of Hizentra may result in further deterioration of patient's health and/or hospitalization. By signing below, I certify that I have received the necessary authorization from the patient to release the medical and/or patient information referenced on this form relating to the above referenced patient to CSL Behring and its contracted agent or contractors working solely on behalf of the patient for the purpose of seeking reimbursement through the CSL Behring IgIQ Resource Center, verifying insurance coverage and/or the evaluation of the patient's eligibility for alternate sources of funding, patient support services, including materials fulfilment, and product fulfilment via specialty pharmacies.

PRESCRIBER AUTHORIZATION SIGNATURE:

_____ Date _____

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 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), as well as information provided on this form (collectively, "Personal Health Information"), to CSL Behring and its representatives, agents, and contractors, including Sonexus Health (collectively "CSL Behring Entities") for the purposes of (1) establishing eligibility for benefits; (2) evaluation and enrollment in one or more financial assistance program(s), such as a co-pay mitigation program and/or patient assistance programs (if one or more of such programs apply to my treatment with one or more CSL Behring products); (3) enrollment in available patient services programs; (4) communication about my treatment with my Providers, who may contact me directly to facilitate the dispensing of medication and scheduling shipments and refill reminders; (5) providing product support and adherence services; (6) evaluating the utilization and effectiveness of CSL Behring's patient support programs; and (7) any other related support, education, and assistance services related to treatment with CSL Behring products (collectively, the "Services"). Further, I authorize any of the CSL Behring Entities to contact me by mail, telephone/SMS text message, or e-mail for relevant follow-up or to obtain any appropriate information not included in this authorization.

I understand that my pharmacy Providers may disclose to the CSL Behring Entities certain Personal Health Information regarding the dispensing of CSL Behring product prescription and that such disclosure will result in remuneration to my pharmacy Provider(s). I also understand that Sonexus Health and my Providers, including pharmacies, may receive compensation from CSL Behring in connection with the Services. I understand that once my Personal Health Information is disclosed to the CSL Behring Entities under this authorization, it may no longer be protected by 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 for the limited purposes described above, or as I may further authorize in writing, or as permitted or required by law. I understand that I may refuse to sign this authorization. I understand, however, that if I do not sign this authorization, I will not be able to receive Services.

I further understand that my treatment with CSL Behring products, payment for treatment, insurance enrollment, or 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 Sonexus Health, PO Box 368, Lewisville, TX 75067, or by calling this toll free number (1-800-676-4266) but that this cancellation will end my participation in the Services and will not apply to any information already used or disclosed through this authorization before notice of the cancellation is received by my health plans or Providers. This authorization expires five (5) years from the date signed below, or earlier, if required by state law.

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE:

_____ Date _____

RELATIONSHIP TO PATIENT (IF APPLICABLE): _____

Biotherapies for Life® CSL Behring

PLEASE DO NOT FAX THIS SIDE

Important Safety Information

Hizentra is indicated for:

- Treatment of primary immunodeficiency (PI) in adults and pediatric patients 2 years and older.
- Maintenance therapy in adults with chronic inflammatory demyelinating polyneuropathy (CIDP) to prevent relapse of neuromuscular disability and impairment.
  - Limitation of use: maintenance therapy in CIDP has been systematically studied for 6 months and for a further 12 months in a follow-up study. Continued maintenance beyond these periods should be individualized based on patient response and need for continued therapy.

For subcutaneous infusion only.

WARNING: Thrombosis may occur with immune globulin products, including Hizentra. Risk factors may include: advanced age, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling vascular catheters, hyperviscosity, and cardiovascular risk factors.

For patients at risk of thrombosis, administer Hizentra at the minimum dose and infusion rate practicable. Ensure adequate hydration in patients before administration. Monitor for signs and symptoms of thrombosis and assess blood viscosity in patients at risk for hyperviscosity.

Hizentra is contraindicated in patients with a history of anaphylactic or severe systemic reaction to human immune globulin (Ig) or components of Hizentra (eg, polysorbate 80), as well as in patients with immunoglobulin A deficiency with antibodies against IgA and a history of hypersensitivity. Because Hizentra contains L-proline as stabilizer, use in patients with hyperprolinemia is contraindicated.

IgA-deficient patients with anti-IgA antibodies are at greater risk of severe hypersensitivity and anaphylactic reactions. Thrombosis may occur following treatment with Ig products, including Hizentra.

Monitor patients for aseptic meningitis syndrome (AMS), which may occur following treatment with Ig products, including Hizentra. In patients at risk of acute renal failure, monitor renal function, including blood urea nitrogen, serum creatinine and urine output. In addition, monitor patients for clinical signs of hemolysis or pulmonary adverse reactions (eg, transfusion-related acute lung injury [TRALI]).

Hizentra is derived from human blood. The risk of transmission of infectious agents, including viruses and, theoretically, the Creutzfeldt-Jakob disease (CJD) agent and its variant (vCJD), cannot be completely eliminated.

The most common adverse reactions (observed in ≥5% of study subjects) were local infusion-site reactions, as well as headache, diarrhea, fatigue, back pain, nausea, extremity pain, cough, upper respiratory tract infection, rash, pruritus, vomiting, upper abdominal pain, migraine, arthralgia, pain, fall, and nasopharyngitis.

The passive transfer of antibodies can interfere with response to live virus vaccines and lead to misinterpretation of serologic test results.

Please see accompanying full prescribing information for Hizentra.

To report SUSPECTED ADVERSE REACTIONS, contact the CSL Behring Pharmacovigilance Department at 1-866-915-6958 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.