RYSTIGGO® (rozanolixizumab-noli) Injection For Subcutaneous Use Start Form

FAX: 1-833-FAX-UCB1 (1-833-329-8221) | ENROLL ONLINE: ONWARDhcp-enroll-RYSTIGGO.com | EMAIL: ucbonward@rxallcare.com | QUESTIONS? CALL: 1-844-ONWARD1 (1-844-669-2731)

Services Requested: ☐ Benefit Investigation ☐ Financial Assistance ☐ PA Appeal Support ☐ Care Coordinator Support
☐ Claim Denial Support ☐ Patient Assistance Program (PAP) - Consent Required: see page 4

Step 1: Patient Information * Required field

☐ New to Therapy ☐ On Therapy

First Name* | Middle Initial | Last Name*

Date of Birth* (MM/DD/YYYY) | Phone Number* ☐ Home ☐ Cell | Gender: M ☐ F ☐ Other ☐

Street Address* | Apt#

City | State | ZIP* | Preferred Language: ☐ English ☐ Spanish ☐ Other

Communication Preference: ☐ Email ☐ Phone ☐ Text | Email

☐ Please check here to authorize ONWARD Care Coordinators to leave detailed messages (which may include health information) on you/your caregiver's voicemail.

Caregiver Information
By providing this information, you authorize ONWARD™ to communicate with this person regarding your health condition and services provided by the program.

First Name | Last Name | Relationship to Patient

Phone ☐ Home ☐ Cell | Primary Point of Contact: ☐ Patient ☐ Caregiver

Email | ☐ Caregiver is authorized legal representative of the patient

STEP 2: Insurance Information * Required

NOTE: *You may attach copies of the front and back of the patient's insurance card(s) in lieu of completing this section.*

☐ Check here if patient does not have insurance	PRIMARY INSURANCE	SECONDARY INSURANCE	OTHER
INSURANCE PROVIDER			
INSURANCE PHONE#			
CARDHOLDER NAME			
RELATIONSHIP TO PATIENT			
MEMBER ID			
GROUP#			
BIN#			
PCN#			

STEP 3: Prescriber/Rendering Provider Information * Required field

Prescriber First Name* | Prescriber Last Name*

Specialty | NPI#* | Tax ID#

Rendering Provider | Rendering Provider NPI

Practice/Clinic Name

Address*

City | State | ZIP

Office Phone#* | Office Fax#

Office Contact Name | Office Contact Email

Office Contact Phone# | Office Contact Communication Preference: ☐ Phone ☐ Email

STEP 4: Product Acquisition and Preferred Site of Care

Method of Acquisition

☐ Buy & Bill ☐ Specialty Pharmacy

Preferred Specialty Pharmacy

☐ CVS Specialty® ☐ KabaFusion ☐ PANTHERx Rare

RYSTIGGO® is available via a limited network which includes CVS Specialty, KabaFusion, and PANTHERx Rare.

Provide benefit coverage for the following site(s) of care (check all that apply)**:**

☐ In Office ☐ Home Infusion ☐ Ambulatory Infusion Center ☐ Hospital Outpatient

Site of Care Name _____ NPI# _____

Address _____ City _____ State _____ Zip _____

Preferred Site of Care:

☐ Check here if patient has already been referred.

☐ Please provide assistance locating in-network infusion site options

STEP 5: Clinical Information * *Required field*

ICD-10 Diagnosis* ☐ G70.00 ☐ G70.01 ☐ Other _____ MGFA Classification (I, II, III, IV, V): _____

MG-ADL Score _____ Date of Assessment _____

AChR Antibody Test: ☐ Positive ☐ Negative ☐ Not Known MuSK Antibody Test: ☐ Positive ☐ Negative ☐ Not Known

Current Therapies:

☐ Eculizumab ☐ Rituximab

☐ Efgartigimod ☐ IVIG

☐ Ravulizumab ☐ SCIG

☐ Oral Corticosteroids ☐ PLEX

☐ Acetylcholinesterase Inhibitors

☐ Other _____

Non-steroidal ISTs

☐ Azathioprine

☐ Cyclophosphamide

☐ Cyclosporine

☐ Methotrexate

☐ Tacrolimus

☐ Mycophenolate

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☐ Other _____

Non-steroidal ISTs

☐ Azathioprine

☐ Cyclophosphamide

☐ Cyclosporine

☐ Methotrexate

☐ Tacrolimus

☐ Mycophenolate

Medical Allergies: _____ ☐ No allergies

STEP 6: Prescription Information

Patient First & Last Name _____ Date of Birth (MM/DD/YYYY) _____

Prescriber to indicate prescribed RYSTIGGO® dose:

MEDICATION	PATIENT WEIGHT	DOSING PER WEIGHT BAND	STRENGTH/DOSAGE	DIRECTIONS FOR ADMINISTRATION	QTY	REFILLS
RYSTIGGO (rozanolixizumab-noli)	_____ kg	☐ Patient weight <50 kg	420 mg/3 mL NDC: 50474-981-83	Use 1 vial via subcutaneous infusion once weekly for 6 weeks	6 vials	
	Date Weight Taken (MM/DD/YYYY) _____	☐ Patient weight ≥50 kg to <100 kg	560 mg/4 mL NDC: 50474-982-84	Use 1 vial via subcutaneous infusion once weekly for 6 weeks	6 vials	
		☐ Patient weight ≥100 kg	840 mg/6 mL NDC: 50474-983-86	Use 1 vial via subcutaneous infusion once weekly for 6 weeks	6 vials	

Infusion Order: ☐ I authorize the dispensing pharmacy to coordinate home health infusion nurse visits as necessary.

- I authorize home nurse visits to provide education related to infusion therapy, disease state, and subcutaneous nurse administration of RYSTIGGO, including dosing as per prescription orders.

Supplies Order: ☐ I authorize the dispensing pharmacy to provide supplies required to administer RYSTIGGO appropriate to the administration site of care.

Attestation and Signature

By signing below, I certify: 1) This information is accurate to the best of my knowledge; 2) I am disclosing this information to UCB, their affiliates, agents, representatives, business partners, and service providers (together "UCB") to help enable treatment for this Patient; 3) The Patient is aware of, has consented to, and has directed my disclosure of their information to UCB so that UCB may contact the Patient to further enable services for those purposes and that such consent and direction applies to disclosures made through the duration of the Patient's therapy; 4) I will not seek reimbursement from any third party for the support UCB provides.

☐ **Check For Prescribers Only:** In addition, I certify that the therapy is medically necessary, and I am licensed to prescribe the prescription medication identified in this form, the prescription complies with my state-specific prescribing requirements and I appoint UCB as my agent for the limited purposes of conveying this prescription by any means under applicable law only to a dispensing pharmacy or infusion provider. PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN AND DATE. RUBBER STAMPS AND SIGNATURE BY OTHER OFFICE PERSONNEL FOR THE PRESCRIBER WILL NOT BE ACCEPTED.

PRINT FIRST AND LAST NAME: _____

Signature* _____ Dispense as Written (Date)* _____