Hizentra®
Immune Globulin Subcutaneous (Human) 20% Liquid

FREE TRIAL PROGRAM REQUEST FORM

Biotherapies for Life® CSL Behring

FAX: 1-866-720-4373 • TOLL-FREE: 1-877-355-4447

Please complete the form. Submit via fax. For internal use only. Upon request, Hizentra Connect℠ can send a separate prescription referral to the Specialty Pharmacy or service provider.

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)
CIDP: (please check) ☐ G61.81
PI: (please specify) _____

Parent/Guardian Name (if applicable) _____

Parent/Guardian Contact Phone _____

SECTION B PATIENT INSURANCE INFORMATION

Patients must have active insurance in order to participate in the free trial program. (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 _____

SECTION C PRESCRIPTION ORDER FOR HIZENTRA

☑ **Pharmacy to dispense Hizentra prefilled syringes.**

– Please specify here to order vial(s) _____

Previous Ig Therapy (for prior 3 months) _____

Patient Weight (kg) _____ **Height** _____ ft _____ in

Dosing Schedule: (refer to PI for dosing instructions)

Dose/kg _____ **Total dose/week** _____ (in grams) (_____ total mLs)

Infuse subcutaneously every _____ days

Pharmacy to dispense 4 week supply unless 6 week biweekly dose is specified.

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

Date of last IVIg infusion _____

For CIDP Patients: Therapy to be initiated 1 week after last IVIg infusion
For PI Patients: Refer to prescribing information for timing to initiate therapy

☑ **Ancillary Supplies:**

If the ancillary supplies are not otherwise specified, the program pharmacy will select supplies for the patient. You may be contacted for additional prescription orders if the ancillaries require updates or replacements.

Allergies: *Please utilize KORU supplies

☐ No known drug allergies

☐ Drug allergies _____

☐ Concomitant medications _____

(Use separate page to list additional concomitant medications)

Prescriber Information:

Prescriber's Full Name _____

NPI _____

SLN _____

Tax ID # _____ DEA # _____

Practice or Facility Name _____

Address _____

City _____ State _____ ZIP _____

Office Contact _____

Phone _____ Fax _____

PRESCRIBER AUTHORIZATIONS

Signature required.

By signing below, 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 Hizentra 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 treatment history with this product or has not been treated with this product in the last 12 months.
- 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 Hizentra Connect, which may include any of the following:
  - Participating in the Free Trial Program
  - Seeking reimbursement through Hizentra 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.

PRESCRIBER SIGNATURE:

_____ Date _____

Please see other side for additional information and to record required patient or guardian signature.

SELF-ADMINISTRATION TRAINING:

Must check one. Signature required if training is ordered.

Patients in the Free Trial Program are eligible to receive self-administration training from a Free Trial Program registered nurse at no charge. If nurse training is ordered, epinephrine must be available at the patient training location or self-administration training will not be initiated.

☐ I certify that I have a) given my patient a separate Rx for epinephrine injection, USP Auto-Injector 0.15 mg or 0.30 mg, and have instructed my patient to fill the prescription at their cost prior to the initiation of Hizentra self-administration training; or b) been informed by my patient that they have an epinephrine auto-injector which will be available at the time of Hizentra administration.

PRESCRIBER SIGNATURE:

_____ Date _____

My signature above indicates that I am requesting Hizentra Connect coordinate my patient's Hizentra self-administration training from Free Trial Program. Up to three for Primary Immunodeficiency and five for Chronic Inflammatory Demyelinating Polyneuropathy training visits are offered.* This will include Hizentra administration training, or if necessary, administration of Hizentra during the training visit. I will receive information on my patient's self-administration training via the fax number I provided above. This order is valid for one year.

☐ I do not wish to have my patient trained through Free Trial Program. I will assume responsibility and arrangements for Hizentra self-administration training for this patient.

PATIENT-SIGNED DATA PRIVACY CONSENT FOR CSL BEHRING'S SUPPORT PROGRAMS:

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.

I 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 your 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.

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE:

_____ Date _____

RELATIONSHIP TO PATIENT (IF APPLICABLE): _____

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.

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