# ANDEMBRY Referral Form

ANDEMBRY Referral Form must be submitted to ANDEMBRY Connect℠
Fax: **866-415-2162** Phone: **1-844-423-4273**

ANDEMBRY® garadacimab-gxii

## Patient Information *(REQUIRED*)*

☐ Check here if information is included on additional pages

| | | | | |
|---|---|---|---|---|
| First name | M.I. | Last name | | |
| Address | | City | State | Zip |
| Date of Birth | Gender ☐ M ☐ F | Primary phone # | Alternative phone # | |
| Email address | | Primary language ☐ English ☐ Spanish ☐ Other (Please specify) _____ | | |
| (If applicable) Caregiver first name | | Last name | Phone # | |
| Relationship to patient | | | | |

## Prescriber Information *(REQUIRED*)*

| | | | |
|---|---|---|---|
| Prescriber full name | State license # | PTAN # | NPI # |
| Tax ID | Facility name | Address | |
| City | State | ZIP | |
| Office contact name | Office phone # | Office fax # | |
| Email | | | |

## Prescription Information *(REQUIRED*)*

| | |
|---|---|
| Drug allergies | ICD-10 Code: ☐ D84.1 Defects in the complement system, C1 esterase inhibitor (C1-INH) deficiency<br>☐ Other (Please specify) |

Known drug allergies? ☐ Yes ☐ No If yes, please list:

**Dosing:** Dosing of ANDEMBRY: Administer ANDEMBRY as an initial loading dose of 400 mg subcutaneously as two 200-mg injections on the first day of treatment followed by a monthly dose of 200 mg. Pharmacy to include ancillary supplies. First dispense to include ANDEMBRY and ancillary supplies for 1 month.
ANDEMBRY **is available in 200 mg/1.2 mL solution. No exceptions to dosing quantity. Refill for 1 year.**

**Please select options below:**

☐ Dispense loading dose of 400 mg subcutaneously on first dispense
☐ Dispense monthly dose of 200 mg subcutaneously monthly
☐ Refill for 1 year OR number of refills _____

**QuickStart prescription (optional). Please select options below:**

☐ Dispense loading dose of 400 mg subcutaneously on first dispense
☐ Dispense monthly dose of 200 mg subcutaneously monthly
☐ Refill for one month* _____

*Patients with commercial insurance may be eligible for up to two (2) QuickStart refills.
Patients with government insurance may be eligible for one (1) QuickStart refill.

## Prescriber Authorization *(REQUIRED*)*

By signing and dating, I certify that I have obtained consent to release the patient's health information to CSL Behring Entities for the purposes of verifying insurance coverage; arranging for nursing services; participating in the ANDEMBRY QuickStart Program; and evaluating the patient's eligibility for additional patient support services and product fulfillment via specialty pharmacies. I am to comply with my state-specific prescription requirements such as e-prescribing, state-specific prescription form, and fax language. Non-compliance with state-specific requirements could result in outreach to me. I authorize CSL Behring Entities to transmit this prescription to the appropriate pharmacy designated by the patient utilizing the patient's benefit plan.

**QuickStart:** I attest that the person listed is my patient for whom I have prescribed a CSL Behring product in accordance with the labeled indication of the product. If I have prescribed a QuickStart dispense above, I acknowledge that this patient is being enrolled into the ANDEMBRY QuickStart Program. I acknowledge and agree not to submit a third-party insurance claim or other claim for payment for QuickStart product or for services rendered in association with its administration, including Medicare Parts A, B, and D, Medicare Advantage Plus, Medicaid, Medicaid Managed Care, Veterans Administration (VA), TRICARE, State Children's Health Insurance Plans (SCHIPS), and Preexisting Condition Insurance Plans (PCIPS). Furthermore, I acknowledge that CSL Behring reserves the right, in its sole discretion, to discontinue the QuickStart Program or the provision of QuickStart product to this patient at any time.

☐ Dispense* as written Prescriber Signature SIGN HERE _____ Date *(REQUIRED*)* _____

☐ Substitute† allowed Prescriber Signature SIGN HERE _____ Date *(REQUIRED*)* _____

* Dispense As Written / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute.

† May Substitute / Product Selection Permitted / Substitution Permissible. CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" .
ATTN: New York and Iowa providers, please submit electronic prescription

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## Insurance Information *(REQUIRED*)*

**HCP may send in copies of the patient insurance cards with the referral form**

| | | |
|---|---|---|
| Does patient have insurance? ☐ Yes ☐ No | Insurance name | |
| **Does Patient have Primary insurance?** ☐ Yes ☐ No | Insurance phone # | Policy # / Member ID |
| Group # | Rx Bin # | Rx PCN # |
| Policy holder's name | Relationship to patient | |
| Policy holder's Date of Birth | Policy holder's employer (if available) | |
| Prescription card ☐ Yes ☐ No | Pharmacy plan name | Pharmacy plan phone # |

| | | |
|---|---|---|
| **Does Patient have Secondary insurance?** ☐ Yes ☐ No | Insurance name | |
| Insurance phone # | Policy # / Member ID | |
| Group # | Rx Bin # | Rx PCN # |
| Policy holder's name | Relationship to patient | |
| Policy holder's Date of Birth | Policy holder's employer (if available) | |
| Prescription card ☐ Yes ☐ No | Pharmacy plan name | Pharmacy plan phone # |

## Patient Consent

- Before patients elect or decline to enroll, they must read the Patient Services Authorization & Release of Health Information on page 4
- Please note that enrolling in ANDEMBRY Connect℠ is not required for a patient to receive their prescription, but the patient must be enrolled to be eligible for financial assistance and other programs
- Please inital appropriate consent to allow information regarding your ANDEMBRY prescription to be left on your answering machine or voicemail

I have read and agree to the Patient Services Authorization and Release of Health Information on page 4. (Signature and date may be required to receive certain services)

☐ (Optional) I have read and understand the Opt-In for Automated Marketing Calls and Text Messages in the Patient Authorization on page 4 and hereby agree to receive these types of communications from CSL Behring

SIGN HERE _____ Date *(REQUIRED*)* _____

Patient Signature*

* Patient must sign the patient services authorization and release of health information to participate in ANDEMBRY Connect℠ Support services

**Initial Here** _____

The initials to the left denote that I authorize/ ANDEMBRY Connect℠ to leave information regarding my ANDEMBRY prescription, insurance coverage, and Specialty Pharmacy Provider on my voicemail or alternate contact _____ (participation optional).

## Nursing Support

Injection training and product support is available through our **dedicated nursing team at ANDEMBRY Connect**

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## 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 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").

(8) contacting me for marketing or market research purposes

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. CRP1501301