Genentech HINALEA BN44620 and HINALEA BN44621 Clinical Trial Form

By completing this form, you are requesting risdiplam in ☐ BN44620 ☐ BN44621 on behalf of your patient

1 **Complete all information below** and, sign and date

2 **Submit** via fax to Accredo Health Group, Inc. at: 1 (800) 216-6938

For any questions, please called Accredo Health Group, Inc. at 1 (855) 525-7995

Prescriber Order – To be completed by the prescriber

IxRS Patient Enrollment Number: _____ IxRS Batch Number: _____ Investigative Site Number: _____

Note: No refills are allowed. A new prescription form must be completed for each re-supply.

Step 1 Patient Information

First name: _____ Middle initial_____ Last name: _____ Gender: ☐Male ☐Female
Date of birth (MM/DD/YYYY):_____/_____/_____Preferred language:☐English ☐Spanish ☐Other:_____
Street: _____ Apt: _____ City:_____
State: _____ ZIP: _____ Home phone: (_____) _____ - _____
Caregiver Cell phone: (____)_____- _____ Caregiver Work phone: (____)_____- _____Caregiver email:_____
Caregiver contact name: _____ Relationship: _____ Alt. phone: (_____) _____ - _____
Alt. email: _____ ☐OK to leave message with alt. contact
☐ Drug and non-drug allergies: _____☐No Known Drug Allergies (NKDA)

Patient weight: _____lbs Divided by 2.2 = _____kg Date measured (MM/DD/YYYY): ____/____/_____

Step 2 Dose Determination

☐ **For patients at least 2 months of age and < 20 kg**

Age	Recommended Daily Oral Dose
2 months to < 2 years of age	0.20 mg/kg
≥ 2 years of age (< 20 kg)	0.25 mg/kg

_____ kg x _____ mg/kg= _____ mg daily
Patient Weight *Daily Dosage from Chart on the Left*

Determine volume of dose

_____ mg (from calculation above) ÷ 0.75 mg/mL = _____ mL dose per day

☐ **For patients ≥ 2 years of age and ≥ 20 kg, the dose is 5 mg (6.6 mL)**

Step 3 Prescription Information

Indicate the number of bottles per IxRS:

Enter the patient's age in months and weight in kg (to one decimal point) in IxRS then enter the number of bottles **displayed in the IxRS system** in the corresponding box below. ALMAC has been programmed with a formula to automatically calculate the number of bottles.

Drug	Number of bottles	Directions
Risdiplam 0.75 mg/mL oral solution		_____ mg (_____ mL) once daily ☐Oral ☐G-Tube/ NG-Tube

Step 4 Prescriber Information

First name: _____ Last name: _____
Office/Clinic/Institution name: _____
Street: _____ Suite:_____
City: _____ State: _____ ZIP:_____
State License Number: _____ Prescriber NPI:_____
Office phone: (_____) _____- _____Office fax: (____) _____ - _____Office email: _____

Step 5 Health Care Provider Certification

By signing this form, I certify: (a) The above therapy is for this patient. (b) You have received authorization from Genentech to provide this medicine to the patient listed above. (d) No action on these services will be taken until the parent/caregiver has been contacted.

Please complete concomitant medications on the next page

_____ Prescriber signature: Dispense as written

_____ Prescriber signature: Substitution permitted

_____ Date

PRESCRIBER MUST MANUALLY SIGN. Rubber stamps, signature by other office personnel for the prescriber,

and computer-generated signatures will not be accepted.

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Concomitant Medications

Medication	Dose	Frequency

Step 6 **Concomitant Medications Certification**

I certify that the medications indicated above are an accurate transcription of the patient's current medication

Completed by Signature **Date**
(Original signature required)