RUCONEST SOLUTIONS
Expertise. Delivered personally.

# Patient Enrollment Form

**Fax completed forms to: 1-855-423-5757**

RUCONEST®
C1 esterase inhibitor (recombinant)

## 1. Patient Information

☐ **Attach copy of demographic/face sheet OR complete below**

Name ..... ☐ Male ☐ Female SSN # ..... DOB .....

Check Preferred Phone # ☐ Work # ..... ☐ Home # ..... ☐ Cell # .....

Email ..... Preferred Language .....

Address ..... City/State/ZIP .....

Caregiver Name (first, last) ..... Relationship to Patient ..... Phone # ..... ☐ Ok to Leave Message

## 2. Patient Insurance Information

☐ **Attach all insurance and prescription cards OR complete below**

### Medical Insurance Card

Plan Name .....

Plan Phone # .....

Policy Holder Name .....

Member ID # .....

Group # .....

### Prescription Drug Card

PBM/Plan Name .....

Plan Phone # .....

Member ID # .....

BIN # .....

PCN # ..... Group # .....

## 3. Prescriber Information

Provider Specialty: ☐ Allergy ☐ Immunology ☐ Dermatology ☐ Primary Care ☐ Emergency Room ☐ Other

Provider Name ..... NPI # ..... TIN # .....

Medicaid Provider ID # ..... State License # ..... PTAN # .....

Site Name .....

Address ..... City/State/ZIP .....

Phone # ..... Fax # .....

Contact Name ..... Role ..... Phone # .....

## 4. Specialty Pharmacy Nursing Orders

### Self-administration Training

☐ **I am prescribing a visiting RN to provide education on self-administering RUCONEST, including dosing and titration as per prescriber order**

☐ IV access maintenance: peripheral IV normal saline (NS) flush (2-3 mL) (if indicated) or optional

☐ NS pre/post-infusion

☐ Central line/port ☐ PowerPort
☐ PICC line ☐ Other .....

☐ Flush with NS 5 mL to 10 mL. Post-infusion flush with heparin (100 units per mL) 3 mL to 5 mL (if indicated) or optional

☐ Other .....

### Nursing Infusion Services

☐ **I am prescribing a visiting RN to provide on-demand infusion services, including dosing and titration as per prescriber order**

Location of RN visit

☐ Home

☐ Physician office

☐ Other .....

Visit frequency (based on medication order and dosage order) and patient's/caregiver's ability to self-administer .....

☐ My patient has an Rx for epinephrine

Sign Here **PRESCRIBER** ..... Date .....

## 5. Prescription

**Preferred Specialty Pharmacy:**
☐ Accredo ☐ CVS Caremark ☐ Option Care

Patient Name .....

DOB .....

☐ ICD-10-CM D84.1 (HAE) ☐ Other .....

**Prescription: RUCONEST 2100 IU/vial injection**

Patient weight ..... kg (1 kg = 2.2 lb) ..... lbs Date of weight .....

**Dose: (50 IU/kg, max 4200 IU per dose)** ..... **(IU)** ☐ Refills .....

**Each shipment includes:**

☐ 4 doses (8 vials) ☐ 8 doses (16 vials) ☐ ..... doses ( ..... vials)

**Directions:** Administer ..... IU (max 4200 IU) as a slow IV injection over 5 minutes prn. No more than 2 doses within a 24-hour period

**Dispense infusion supplies with each prescription**

**Dispense: One (1) vial of Sterile Water for Injection 14 mL per 2100 IU vial of RUCONEST**

**Peripheral IV access supplies**

☐ Quantity: QS, NS Sodium Chloride 0.9% (10 mL Syr)

**Or**

**Port IV access** ☐ Central line/port ☐ PICC line ☐ PowerPort ☐ Other .....

☐ Quantity: QS, NS Sodium Chloride 0.9% (10 mL Syr)

☐ Quantity: QS, Heparin Flush

☐ 10 U 5/10 mL Syr **Or** ☐ 100 U 5/10 mL Syr

☐ Quantity: QS, Huber Needles

☐ 22 G x 1.0" Safe **Or** ☐ 1.5" Safe

**Special Instructions** ..... ☐ Patient has epinephrine prescription

Drug/Non-Drug Allergies ..... ☐ No Known Allergies Concurrent Medications .....

Sign Here

☐ **Dispense as written** **PRESCRIBER** ..... Print ..... Date .....

☐ **Substitution permitted** **PRESCRIBER** ..... Print ..... Date .....

I appoint Pharming Healthcare, Inc., RUCONEST SOLUTIONS, its affiliates, and their representatives on my behalf to convey this prescription described herein to the dispensing pharmacy. I understand that I may not delegate signature authority.

## 6. Optional Prescription for Bridge to Therapy Program for RUCONEST

Patient Name .....

DOB .....

☐ ICD-10-CM D84.1 (HAE) ☐ Other .....

**Prescription: RUCONEST 2100 IU/vial injection**

Patient weight ..... kg (1 kg = 2.2 lb) ..... lbs Date of weight .....

**Dose: (50 IU/kg, max 4200 IU per dose)** ..... **(IU)**

☐ 2 doses (4 vials) ☐ ..... doses ( ..... vials) ☐ Refills .....

**Directions:** Administer ..... IU (max 4200 IU) as a slow IV injection over 5 minutes prn. No more than 2 doses within a 24-hour period

**Dispense infusion supplies with each prescription**

**Dispense: One (1) vial of Sterile Water for Injection 14 mL per 2100 IU vial of RUCONEST**

**Peripheral IV access supplies**

☐ Quantity: QS, NS Sodium Chloride 0.9% (10 mL Syr)

**Or**

**Port IV access** ☐ Central line/port ☐ PICC line ☐ PowerPort ☐ Other .....

☐ Quantity: QS, NS Sodium Chloride 0.9% (10 mL Syr)

☐ Quantity: QS, Heparin Flush

☐ 10 U 5/10 mL Syr **Or** ☐ 100 U 5/10 mL Syr

☐ Quantity: QS, Huber Needles

☐ 22 G x 1.0" Safe **Or** ☐ 1.5" Safe

**Special Instructions** ..... ☐ Patient has epinephrine prescription

Drug/Non-Drug Allergies ..... ☐ No Known Allergies Concurrent Medications .....

Sign Here

☐ **Dispense as written** **PRESCRIBER** ..... Print ..... Date .....

☐ **Substitution permitted** **PRESCRIBER** ..... Print ..... Date .....

I appoint Pharming Healthcare, Inc., RUCONEST SOLUTIONS, its affiliates, and their representatives on my behalf to convey this prescription described herein to the dispensing pharmacy. I understand that I may not delegate signature authority.

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.

I certify that therapy with RUCONEST is medically necessary for this patient. I have reviewed the current RUCONEST Prescribing Information. Disclaimer: By my signature, I certify that I am a physician or a healthcare provider authorized to sign on behalf of a physician and that I authorize RUCONEST SOLUTIONS and its agents (the "Helpline") to use any information provided on this form for the purposes of verifying coverage and benefits for RUCONEST, or referring the patient to the RUCONEST Patient Assistance Program in the event the patient does not have insurance. I certify that I have a signed copy on file of this patient's authorization (in a form that complies with all applicable state and federal laws) that allows me and the patient's health insurers to use and disclose the patient's health information, including his or her medical and insurance coverage information and records, to the Helpline, the RUCONEST Patient Assistance Program, and their respective agents (collectively, the "Helpline"), and that allows the Helpline to use that information to: (1) verify, investigate, assist with, and coordinate the patient's coverage for RUCONEST with health insurers; (2) enroll the patient in, and contact him/her about the Patient Assistance Program, financial support programs and other patient support programs; (3) facilitate and coordinate prescription fulfillment and nursing services with a contracted specialty pharmacy; and (4) assist with analyses related to the quality, efficacy, and safety of RUCONEST. I understand and agree that I remain responsible for complying with all applicable federal and state laws regarding patient privacy. The Authorization form signed by the patient that I have on file informs the patient that: (a) the information disclosed may include the patient's health status; (b) the patient's information may be subject to redisclosure by the recipients and no longer protected by state or federal privacy laws; (c) the patient's treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on the patient providing the authorization; (d) the patient has the right to revoke the Authorization at any time by calling the Helpline at 1-855-613-4423; (e) such revocation would end the patient's eligibility to participate in the program; and (f) if the patient revokes the Authorization, the revocation will not affect previous disclosures made in reliance on the patient's Authorization. The patient's signature will be maintained and available for audit purposes, as required by all applicable state and federal privacy laws. To the best of my knowledge, all information contained in this form is correct and complete and consistent with applicable privacy laws and regulations, and I understand that the Helpline is relying on this representation.

Sign Here

**PRESCRIBER** ..... Date .....

**Please see accompanying full Prescribing Information, including Patient Product Information here, or visit www.ruconest.com.**

RUCONEST SOLUTIONS: 1-855-613-4423

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# Patient Authorization Form

**Fax completed forms to: 1-855-423-5757**

RUCONEST®
C1 esterase inhibitor (recombinant)

1. I am participating in the RUCONEST SOLUTIONS Program ("Program") operated by Pharming Healthcare Inc. which provides me certain clinical and nursing support services related to my use of the biologic RUCONEST, manufactured by Pharming Healthcare Inc., for treatment of my HAE condition. The Program is administered by the Lash Group. This authorization will allow Pharming Healthcare Inc., the Lash Group, my pharmacy, healthcare providers, and health plan to use and disclose certain health information about me to facilitate my treatment with RUCONEST and to improve the Program for the benefit of future patients with HAE. I hereby authorize the use or disclosure of my protected health information (PHI) defined below for the purposes described in Section 5 below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive and use my PHI is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and there is a potential for my PHI to be subject to redisclosure by the recipients.

2. Persons/organizations who may disclose my PHI:
   - Pharming Healthcare Inc. and its authorized representatives ("Pharming")
   - Lash Group
   - My pharmacy(ies) providing the RUCONEST
   - My healthcare provider(s), including physicians and home care nurse educators
   - My health plan(s) providing medical care and prescription coverage

3. Persons/organizations who may receive and use my PHI:
   - Pharming Healthcare Inc. and its authorized representatives
   - Lash Group
   - My pharmacy(ies) that provide RUCONEST
   - My healthcare provider(s), including physicians and home care nurse educators
   - My health plan(s) providing medical care and prescription coverage

4. My PHI consists of the following information about me that may be used or disclosed:
   - Information I provided on the RUCONEST Enrollment Form
   - My healthcare records related to my treatment and HAE condition
   - My health insurance information regarding my coverage, copay, deductibles, and benefit options
   - My prescription information, such as status, fulfillment, and/or shipment of my medication
   - My hospital records for any hospitalization and information related to my transition of care

5. My PHI may be used and disclosed for the following purposes:
   - Administration of the Program
   - Internal data collection and reporting
   - Tracking items such as health/prescription plan coverage, patient cost, shipments of the RUCONEST, health plan coverage trends, use of the Program offerings
   - Nursing services for the purposes of improving the quality of the Program
   - Assessing ongoing and future needs of patients who are prescribed RUCONEST
   - Analyzing the quality, efficacy, and safety of RUCONEST

6. I understand that the specialty pharmacies that dispense my medication may be paid for sharing my PHI with the Program and Pharming so that the recipients may use it for the purposes specified in this authorization.

7. My authorization will remain in effect for two (2) years from the date of my signature unless I revoke it before then. I understand that I may be requested to provide my written authorization on an annual basis by the Program to support continued access to my PHI. I understand that after I have signed this authorization, I may revoke it at any time by sending a written notice to the RUCONEST SOLUTIONS Program at PO Box 221974, Charlotte, NC 28222-1974. The revocation goes into effect once it has been received by the RUCONEST SOLUTIONS Program, and my healthcare providers and health plan, but the revocation will not affect any of my PHI already disclosed in reliance on this authorization.

8. I understand that I can refuse to sign this authorization and it will not affect the start, continuation, or quality of my treatment from my healthcare provider, payment for my treatment or my eligibility for or enrollment in health coverage.

   However, I understand that if I choose not to sign this authorization or revoke it after signing this form, the Program will not be able to provide me with the support described above, after the date of revocation.

9. I understand that I am entitled to a copy of this Authorization after signing below.

.....

**Signature of patient or patient's representative (if signed by someone other than the patient)** **Date**

.....

**Printed name of patient or patient's representative** **Relationship to patient**

**Please see accompanying full Prescribing Information, including Patient Product Information here, or visit www.ruconest.com.**