RUCONEST SOLUTIONS™
Expertise. Delivered personally.

Patient Enrollment Form

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

RUCONEST®
C1 esterase inhibitor (recombinant)

Getting Started

Step 1:

Fill out all 3 pages of the Patient Enrollment Form

Page 1

Patient to read and sign the Consent Form

NOTE: Patient signature on the Consent Form is required to access RUCONEST Solutions support, including clinical educator services, copay assistance, and product assistance, including StarterRx. If consent is not submitted with the enrollment form, RUCONEST Solutions will work with the patient to obtain consent. Benefit verification will occur without receipt of consent.

Pages 2 and 3

Provider to fill out and sign the Patient Enrollment Form, including a copy of the patient's insurance card

NOTE: The Patient Enrollment Form can serve as a Commercial prescription and a request for product assistance

Step 2:

For prior authorization support, submit Pages 1 through 3 of the Patient Enrollment Form to RUCONEST Solutions, along with the following documentation:

- Copy of recent labs related to hereditary angioedema (HAE)
- Patient's current weight and full medication list, including previous and current HAE therapies and any known drug or other allergies
- Clinical notes documenting the patient's signs, symptoms, and manifestations of HAE
- Any swell log or diary details of recent frequency, severity, and duration of acute HAE attacks
- Any additional clinical information pertaining to the patient's clinical history
- Documentation of other therapies used to treat symptoms of HAE

This requested documentation will help RUCONEST Solutions to support the patient with coverage authorizations when they are allowed by an insurance company. There may be occasions where the insurer will request additional documentation and/or mandate that your office submit the coverage requests. If this is the case, your office will be informed on a subsequent fax or phone call from the RUCONEST Solutions support team.

Step 3:

Let your patient know that you have prescribed RUCONEST and that RUCONEST Solutions will be calling them

Fax:
1-855-423-5757

Questions? Call 855-613-4423 between 8 am-8 pm ET M-F for additional assistance.

Submission of this form does not guarantee that any services will be provided. Additional information may be needed to assess eligibility for and provide the services.

INDICATIONS AND USAGE

RUCONEST® (C1 esterase inhibitor [recombinant]) is indicated for the treatment of acute attacks in adult and adolescent patients with hereditary angioedema (HAE). Effectiveness in clinical studies was not established in HAE patients with laryngeal attacks.

IMPORTANT SAFETY INFORMATION

RUCONEST is contraindicated in patients with a history of allergy to rabbits or rabbit-derived products and for patients with a history of life-threatening immediate hypersensitivity reactions, including anaphylaxis, to C1 esterase inhibitor (C1-INH) preparations.

Monitor patients for early signs of allergic or hypersensitivity reactions (including hives, generalized urticaria, tightness of the chest, wheezing, hypotension, and/or anaphylaxis). If symptoms occur, discontinue RUCONEST and administer appropriate treatment.

Serious arterial and venous thromboembolic (TE) events have been reported with plasma-derived C1-INH products. Risk factors may include the presence of an indwelling venous catheter/access device, prior history of thrombosis, underlying atherosclerosis, use of oral contraceptives or certain androgens, morbid obesity, and immobility. Monitor patients with known risk factors for TE events during and after RUCONEST administration.

Appropriately trained patients may self-administer RUCONEST upon recognition of an HAE attack. Advise patients to seek medical attention if progress of any attack makes them unable to properly prepare or administer a dose of RUCONEST. No more than 2 doses should be administered within a 24-hour period.

The serious adverse reaction reported in clinical trials was anaphylaxis. The most common adverse reactions (incidence ≥2%) were headache, nausea, and diarrhea.

Before prescribing RUCONEST, please read the accompanying full Prescribing Information or go to www.ruconest.com

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Patient Consent Form

Patient Name: _____ **DOB:** _____

Patient Email: _____ **Patient Phone (Cell):** _____

Authorization to Share Health Information: By signing this Authorization, I authorize my healthcare providers (e.g., physicians, pharmacies, other healthcare professionals, facilities and staff) and insurers (e.g., health insurance plans) to share my protected health information with Pharming Healthcare, Inc., and its agents and representatives ("Pharming") for the purposes of enrolling me in and providing me services through Pharming's RUCONEST Solutions ("Program"). I authorize Pharming to receive and use my health information (including information about my medical condition, treatment, and insurance coverage), my contact information and any other information I or my healthcare providers or insurers provide to Pharming ("My Information"). I also authorize my healthcare providers and insurers to receive My Information from the Program. I consent to Pharming enrolling me in the Program and providing me with support related to any of Pharming's products, such as insurance coverage, prescription fulfillment, online support, financial assistance services, adherence, and other therapy support services. I understand that personnel providing support as part of the Program are not employed by my healthcare provider(s). I understand that Pharming may use My Information for: determining my eligibility (or ineligibility) to participate in the Program and providing Program services (such as prescription fulfillment, free product assistance programs, financial assistance services, adherence, insurance coverage assessment, and other therapy support services as further described at www.ruconest.com/patient-support); evaluating, improving or developing the Program; conducting data analytics and market research; communicating with me; and for Pharming's internal business purposes. Once My Information has been disclosed to Pharming , I understand that federal privacy laws no longer protect the information. Pharming agrees to protect My Information as required by law. I understand that Pharming may remunerate service providers, including pharmacies, in exchange for My Information and/or for therapy support services provided to me. I further understand that my treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my signing this Authorization and I may refuse to sign it; but if I do not sign it or later cancel it, I will not be able to participate in the Program. This Authorization expires five (5) years from the date signed unless a shorter period is required by law, or until I am no longer participating in the Program. My Information that is collected before cancelation may continue to be used for the purposes set forth in this Authorization. I may cancel this Authorization at any time by calling (855) 613-4423 or sending an email to info@pharming.com. Canceling this Authorization will not affect how Pharming uses and shares My Information prior to my cancelation. I understand that I am entitled to a copy of this Authorization after signing below. By providing my contact information to Pharming, I authorize the Program to contact me via any of the contact methods provided by me on this Authorization form to provide me support related to any Program services listed above and/or to provide me with information about insurance coverage, prescription fulfillment, product assistance, financial assistance services, adherence, other therapy support services, relevant disease-related information, potential topics of interest to me, customer surveys, or occasionally for market research purposes. I understand that I may opt out of these communications at any time by contacting Pharming at 855-613-4423 or replying "STOP" to any text message I receive. For text messages, reply "HELP" for help or "STOP" to opt-out of receiving marketing texts. Message frequency varies.*

Consent for Collection and Use of Health Information: By signing below, I consent to the collection and use of my health information, contact information and other identifying information by Pharming, which I, my healthcare providers or others share with Pharming for the purposes described in this form and as further described in the Pharming Privacy Policy at www.pharming.com/privacy-statement

☐ **Opt-In for Marketing Communications (Optional):** By checking this box, I consent to receive automated and recurring phone calls and text messages from Pharming for the purpose of sending me marketing messages about Pharming products or services. I understand that I am not required to provide this consent as a condition of participating in the Program. For text messages, reply "HELP" for help or "STOP" to opt-out of receiving marketing texts. Message frequency varies.*

Emergency Contact: I authorize RUCONEST Solutions, my doctor, my pharmacist, or any representative attempting to provide me with access to RUCONEST to contact the emergency contact listed below on my behalf in the event of an emergency.

Emergency Contact Name: _____

Email: _____ **Phone:** _____

By signing below, I confirm that I have read this Authorization form and agree to its terms.

Printed Patient/Legal Representative Name: _____

Patient Sign

Patient/Legal Representative Signature: _____ Date: _____

*Data rates may apply.

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Select which specialty pharmacy the patient currently uses (if known):
☐ Accredo Health Group ☐ CVS Caremark ☐ Orsini

1. Prescription

Patient Name _____
DOB _____ Patient Weight _____kg/_____lbs
Diagnosis: ☐ ICD-10-CM D84.1 (Defects in the complement system [HAE])
☐ Other: _____

Prescription: RUCONEST 2100 international units (IU)/vial injection (50 IU/kg), Max 4200 IU

DIRECTIONS: Administer _____IU as a slow IV injection over 5 min PRN for attacks. No more than 2 doses within a 24-hour period

☐ 4 doses (8 vials) ☐ 8 doses (16 vials)
☐ 16 doses (32 vials) ☐ ____doses (____vials) **/Per Month**

Refill 1 x year, unless noted otherwise
☐ 3 Refills ☐ 6 Refills ☐ 12 Refills ☐ _____ Refills

ANCILLARY ORDERS: Dispense infusion supplies with each prescription. Dispense: One (1) vial of Sterile Water for Injection 14 mL per 2100 IU vial of RUCONEST

Flushing Orders (Selection Required)
☐ Normal saline 3 mL or 5 mL intravenous (peripheral line) or 10 mL intravenous (central line) before and after infusion, or as needed for line patency
☐ Heparin 10 units/mL (#3mL or #5mL) use as a final flush for central line (QS)
☐ Heparin 100 units/mL (#3mL or #5mL) use as a final flush for central line (QS)
☐ **Flushing orders not needed**

Epinephrine #2 pack ☐ 0.15mg ☐ 0.3mg **Refills:**_____
☐ **Epinephrine order not needed**
Inject IM as needed for anaphylaxis reaction. May repeat x 1 in 5 to 15 minutes if symptoms persist. SP to provide at first dispense.

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

☐ **Substitution permitted** ☐ **Dispense as written**

MD Sign
PRESCRIBER_____ Print_____ Date _____
I attest that I have a HIPAA form on file and RUCONEST Solutions is authorized to perform a benefits verification. 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 by any means allowed under applicable law. I understand that I may not delegate signature authority.

2. Prescription for Product Assistance

By signing below, I attest that I am requesting product assistance for an adolescent or adult patient with a documented diagnosis of HAE.
Eligibility is subject to additional program terms and conditions. Pharming reserves the right to rescind, revoke, or amend the program at any time without notice.

Patient Name _____
DOB _____ Patient Weight _____kg/ _____lbs
Diagnosis: ☐ ICD-10-CM D84.1 (Defects in the complement system [HAE])
☐ Other: _____

Prescription: RUCONEST 2100 IU/vial injection (50 IU/kg), Max 4200 IU

DIRECTIONS: Administer _____IU as a slow IV injection over 5 min PRN for attacks. No more than 2 doses within a 24-hour period

☐ 2 doses (4 vials) ☐ ____ doses (vials) **/Per Month**

Refill 1 x year, unless noted otherwise ☐ _____Refills

ANCILLARY ORDERS: Dispense infusion supplies with each prescription. Dispense: One (1) vial of Sterile Water for Injection 14 mL per 2100 IU vial of RUCONEST

Flushing Orders (Selection Required)
☐ Normal saline 3 mL or 5 mL intravenous (peripheral line) or 10 mL intravenous (central line) before and after infusion, or as needed for line patency
☐ Heparin 10 units/mL (#3mL or #5mL) use as a final flush for central line (QS)
☐ Heparin 100 units/mL (#3mL or #5mL) use as a final flush for central line (QS)
☐ **Flushing orders not needed**

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

☐ Dispense as written

MD Sign
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 by any means allowed under applicable law. I understand that I may not delegate signature authority.

3. Optional Nursing Orders for Specialty Pharmacy and/or Home Health Agency Infusions

☐ **Check here if patient does not require skilled nursing visits. Clinical educator training ONLY.**

Skilled nursing visit as needed to provide patient education related to therapy, disease state, self and/or nurse administer of medication as prescribed. Select training or infusion options for your patient, if needed (some patients may need both)

☐ Provide ongoing **self-administration** training until patient/caregiver is independent with self infusion
☐ Provide **ongoing nursing visits** for on demand infusions (PRN)
☐ Patient is available M-F 8am-5pm ☐ Patient requires visits outside of normal work hours ☐ Other _____

MD Sign
PRESCRIBER_____ Date_____

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4. Patient Information

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

Name _____ ☐ Male ☐ Female Last 4 digits of SSN _____ DOB _____

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

Preferred Language _____

Email _____

Address _____

_____

City/State/ZIP _____

Caregiver Information

Caregiver Name (first, last) _____

Relationship to Patient _____

Caregiver Phone # _____ ☐ Okay to leave vm

Caregiver Email _____

5. Patient Insurance Information

☐ **Attach copies of front and back of all medical and prescription insurance 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 # _____

6. Prescriber Information

Provider Specialty: ☐ **Allergy** ☐ **Dermatology** ☐ **GI** ☐ **Immunology** ☐ **Primary Care** ☐ **Other** _____

Provider Name _____ NPI # _____ TIN # _____

Medicaid Provider ID # _____ State License # _____ PTAN # _____

Site Name _____

Address _____

_____

City/State/ZIP _____

Phone _____ Fax # _____

Office Contact Information

Contact Name _____

Role _____

Contact Phone _____

Contact Email _____

7. Prior Authorization (PA) Opt-in

Please indicate whether RUCONEST Solutions should pursue any required Prior Authorization on behalf of the patient. If support is being requested, submit all supporting clinical documentation with the prescription to RUCONEST Solutions.

☐ **Yes** ☐ **No**

The ability to initiate Prior Authorizations may vary by plan. RUCONEST Solutions will follow up with your office regarding outcomes and next steps.

Before prescribing RUCONEST, please read the accompanying full Prescribing Information or go to www.ruconest.com