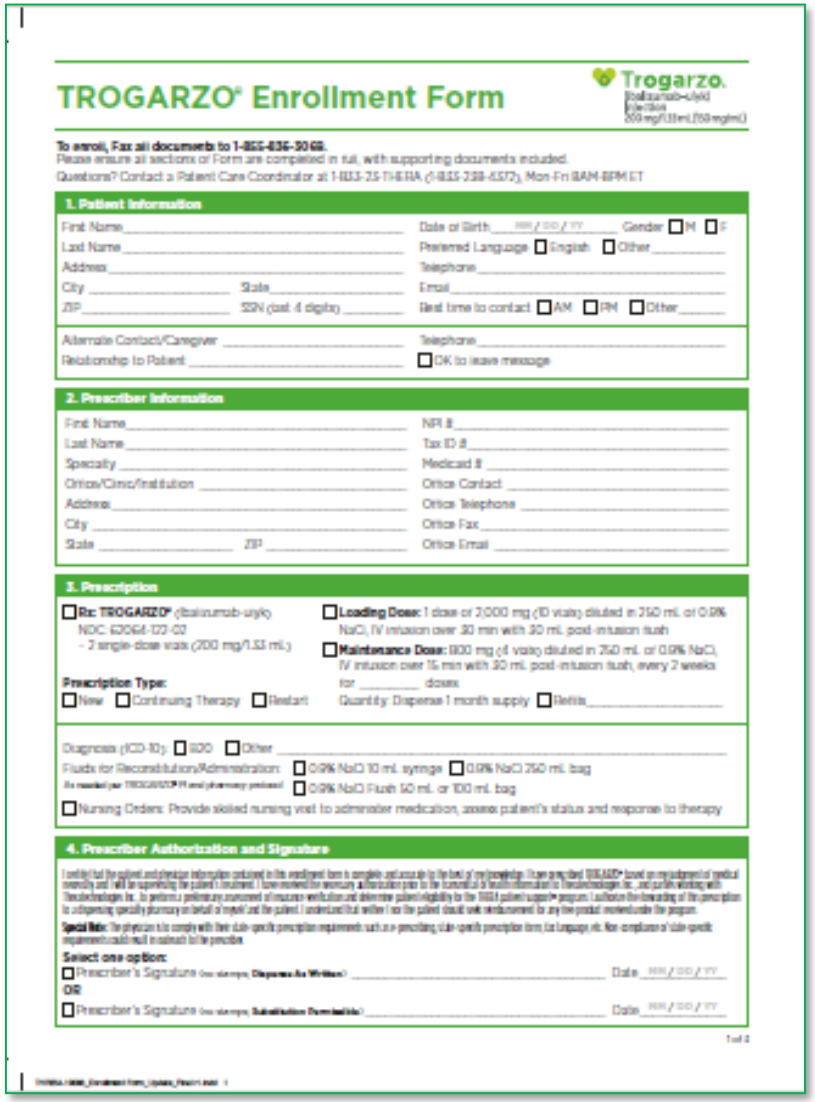
THERA patient support® Service/Support Center (HUB)

THERA patient support®

- Hours: 8:30 am – 8 pm EST Monday – Friday
- Phone: 1-833-23-THERA (1-833-238-4372)
- Fax: 855-836-3069
- Websites:
  - Trogarzo.com
  - Therapatientsupport.com
  - EgriftaSV.com

THERA technologies

FAX Form



TROGARZO® Enrollment Form

Trogarzo

To enroll, Fax all documents to 1-855-836-3069.
Please ensure all sections or Form are completed in full, with supporting documents included.
Questions? Contact a Patient Care Coordinator at 1-833-23-THERA (1-833-238-4372), Mon-Fri 8AM-8PM ET

1. Patient Information

First Name _____ Date of Birth __/__/__ Gender ☐ M ☐ F
Last Name _____ Preferred Language ☐ English ☐ Other _____
Address _____ Telephone _____
City _____ State _____ Email _____
ZIP _____ SSN (last 4 digits) _____ Best time to contact ☐ AM ☐ PM ☐ Other _____

Alternate Contact/Caregiver _____ Telephone _____
Relationship to Patient _____ ☐ OK to leave message

2. Prescriber Information

First Name _____ NPI # _____
Last Name _____ Tax ID # _____
Specialty _____ Medicaid # _____
Office/Clinic/Institution _____ Office Contact _____
Address _____ Office Telephone _____
City _____ Office Fax _____
State _____ ZIP _____ Office Email _____

3. Prescription

☐ **Rx: TROGARZO®** (ibalizumab-uiyk)
NDC: 62064-122-02
– 2 single-dose vials (200 mg/1.33 mL)

Prescription Type:
☐ New ☐ Continuing Therapy ☐ Restart

☐ **Loading Dose:** 1 dose of 2,000 mg (10 vials) diluted in 250 mL of 0.9% NaCl, IV infusion over 30 min with 30 mL post-infusion flush

☐ **Maintenance Dose:** 800 mg (4 vials) diluted in 250 mL of 0.9% NaCl, IV infusion over 15 min with 30 mL post-infusion flush, every 2 weeks for _____ doses
Quantity: Dispense 1 month supply ☐ Refills _____

Diagnosis (ICD-10): ☐ B20 ☐ Other _____
Fluids for Reconstitution/Administration: ☐ 0.9% NaCl 10 mL syringe ☐ 0.9% NaCl 250 mL bag
☐ 0.9% NaCl Flush 50 mL or 100 mL bag

☐ Nursing Orders: Provide skilled nursing visit to administer medication, assess patient's status and response to therapy

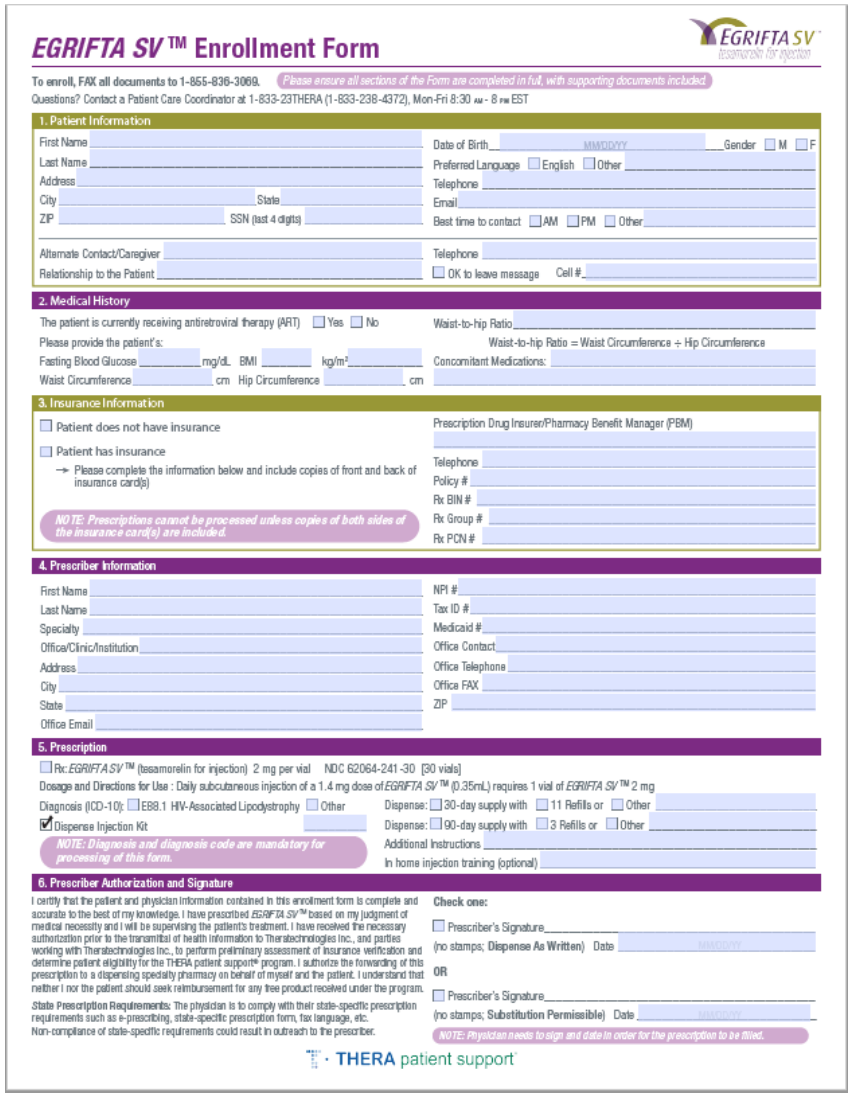
4. Prescriber Authorization and Signature

I certify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed TROGARZO® based on my judgment of medical necessity and I will be supervising the patient's treatment. I have received the necessary authorization prior to the transmittal of health information to Therabiotechnologies Inc., and parties working with Therabiotechnologies Inc., to perform a preliminary assessment of insurance verification and determine patient eligibility for the THERA patient support® program. I authorize the forwarding of this prescription to a dispensing specialty pharmacy on behalf of myself and the patient. I understand that neither I nor the patient should seek reimbursement for any free product received under the program.

Special Rx: The physician is to comply with their state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language etc. Non-compliance of state-specific requirements could result in outreach to the prescriber.

Select one option:
☐ Prescriber's Signature (no stamps; **Dispense As Written**) _____ Date __/__/__
OR
☐ Prescriber's Signature (no stamps; **Substitution Permissible**) _____ Date __/__/__

1 of 2



EGRIFTA SV™ Enrollment Form

EGRIFTA SV
tesamorelin for injection

To enroll, FAX all documents to 1-855-836-3069. *Please ensure all sections of the Form are completed in full, with supporting documents included.*
Questions? Contact a Patient Care Coordinator at 1-833-23THERA (1-833-238-4372), Mon-Fri 8:30 AM - 8 PM EST

1. Patient Information

First Name _____ Date of Birth MM/DD/YY Gender ☐ M ☐ F
Last Name _____ Preferred Language ☐ English ☐ Other _____
Address _____ Telephone _____
City _____ State _____ Email _____
ZIP _____ SSN (last 4 digits) _____ Best time to contact ☐ AM ☐ PM ☐ Other _____

Alternate Contact/Caregiver _____ Telephone _____
Relationship to the Patient _____ ☐ OK to leave message Cell # _____

2. Medical History

The patient is currently receiving antiretroviral therapy (ART) ☐ Yes ☐ No
Please provide the patient's:
Fasting Blood Glucose _____ mg/dL BMI _____ kg/m² _____
Waist Circumference _____ cm Hip Circumference _____ cm
Waist-to-hip Ratio _____
Waist-to-hip Ratio = Waist Circumference ÷ Hip Circumference
Concomitant Medications: _____

3. Insurance Information

☐ Patient does not have insurance
☐ Patient has insurance
→ Please complete the information below and include copies of front and back of insurance card(s)

NOTE: Prescriptions cannot be processed unless copies of both sides of the insurance card(s) are included.

Prescription Drug Insurer/Pharmacy Benefit Manager (PBM) _____
Telephone _____
Policy # _____
Rx BIN # _____
Rx Group # _____
Rx PCN # _____

4. Prescriber Information

First Name _____ NPI # _____
Last Name _____ Tax ID # _____
Specialty _____ Medicaid # _____
Office/Clinic/Institution _____ Office Contact _____
Address _____ Office Telephone _____
City _____ Office FAX _____
State _____ ZIP _____
Office Email _____

5. Prescription

☐ Rx: *EGRIFTA SV*™ (tesamorelin for injection) 2 mg per vial NDC 62064-241-30 (30 vials)
Dosage and Directions for Use : Daily subcutaneous injection of a 1.4 mg dose of *EGRIFTA SV*™ (0.35mL) requires 1 vial of *EGRIFTA SV*™ 2 mg
Diagnosis (ICD-10): ☐ E88.1 HIV-Associated Lipodystrophy ☐ Other _____
☑ Dispense Injection Kit
NOTE: Diagnosis and diagnosis code are mandatory for processing of this form.

Dispense: ☐ 30-day supply with ☐ 11 Refills or ☐ Other _____
Dispense: ☐ 90-day supply with ☐ 3 Refills or ☐ Other _____
Additional Instructions _____
In home injection training (optional) _____

6. Prescriber Authorization and Signature

I certify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed *EGRIFTA SV*™ based on my judgment of medical necessity and I will be supervising the patient's treatment. I have received the necessary authorization prior to the transmittal of health information to Therabiotechnologies Inc., and parties working with Therabiotechnologies Inc., to perform preliminary assessment of insurance verification and determine patient eligibility for the THERA patient support® program. I authorize the forwarding of this prescription to a dispensing specialty pharmacy on behalf of myself and the patient. I understand that neither I nor the patient should seek reimbursement for any free product received under the program.

State Prescription Requirements: The physician is to comply with their state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc.
Non-compliance of state-specific requirements could result in outreach to the prescriber.

Check one:
☐ Prescriber's Signature _____
(no stamps; **Dispense As Written**) Date MM/DD/YY
OR
☐ Prescriber's Signature _____
(no stamps; **Substitution Permissible**) Date MM/DD/YY
NOTE: Physician needs to sign and date in order for the prescription to be filled.

THERA patient support

THERApatientsupport.com

THERA patient support® is here to help

Trogarzo®
(ibalizumab-uiyk)
Injection
200 mg/1.33 mL (150 mg/mL)

PROGRAM SERVICES

1. Enrollment Assistance
   - Choose to ePrescribe through your EMR, submit online through our prescriber portal, or fax the completed enrollement form to start new patients on TROGARZO® and connect them with **THERA patient support®**.
   - **THERA patient support®** prescriber portal allows users to easily submit referrals online, view patient enrollment status, upload relevant documents, and track referral status through to delivery.
   - After receiving all required forms and documentation, a dedicated Patient care coordinator will begin the enrollment process immediately, to provide timely access to therapy.

2. Reimbursement Navigation and Financial Assistance
   - **THERA patient support®** manages the assessment and verification of private and public insurance coverage, (including ADAP) and will also assist in applying any eligible co-pay assistance. For uninsured patients, alternative coverage or assistance options may be available.
   - For uninsured patients, alternative coverage or assistance options may be available.
   - **THERA patient support®** will also assist in the Prior Authorization process.

3. Infusion Coordination and Support
   - Patients can receive TROGARZO® infusions from a healthcare provider at locations convenient to them: Physician offices, infusion centers, or at home.
   - **THERA patient support®** can coordinate infusion locations and provide ongoing appointment reminders.

ENROLLING NEW PATIENTS

Choose one of our simple enrollment options to get new patients started on TROGARZO® and connected with THERA patient support®:
1) ePrescribe TROGARZO® through your EMR.
2) Enroll online in 3 easy steps at tps.aspnprograms.com/.
3) Download and complete the TROGARZO® Enrollment Form and fax to 1-855-836-3069.

Questions? Contact us at 1-833-23-THERA (1-833-238-4372), Mon-Fri 8:30AM-8PM ET.

FORMS AND RESOURCES

- THERA patient support® ePrescription Guide
- TROGARZO® Enrollment Form
- TROGARZO® Billing & Coding Guide
- TROGARZO® Administration Guide
- TROGARZO® Prescribing Information

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