ACTIMMUNE® (INTERFERON GAMMA-1B) PATIENT ENROLLMENT FORM INSTRUCTIONS

The Patient Enrollment Form is required to initiate treatment with ACTIMMUNE, a prescription medicine from Horizon Therapeutics.

Instructions:

1. Complete the following enrollment form in its entirety, including:
   a. Patient information
   b. Insurance information with copy of front and back of insurance card
   c. Diagnosis and prescription information
   d. Prescriber information
2. A signature is required from the patient's healthcare provider.
3. Fax the completed form to Horizon By Your Side, a patient support program, at 1 (877) 305-7706.
4. Ensure that your patient has printed, signed, and dated the required Patient Authorization section of this form providing HIPAA authorization for Horizon By Your Side and initiation of patient support.
5. If you have any questions or comments, please contact Horizon By Your Side at 1 (877) 305-7704.

Please see the IMPORTANT SAFETY INFORMATION on last page and click here for the ACTIMMUNE Full Prescribing Information.

HORIZON BY your side

ACTIMMUNE® (INTERFERON GAMMA-1B) PATIENT ENROLLMENT FORM

Please fax completed form to 1 (877) 305-7706, or email to HPSACT@horizontherapeutics.com.

HORIZON
Phone: 1 (877) 305-7704
Fax: 1 (877) 305-7706
ACTIMMUNEhcp.com

1. PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

Address _____ City _____ State _____ ZIP _____

Home Phone _____ Mobile Phone _____

Date of Birth _____ Gender ☐ M ☐ F Height _____ Weight _____

Email _____ Preferred Method of Contact ☐ Home ☐ Mobile ☐ Email ☐ Mail

ALTERNATIVE CONTACT AND/OR CAREGIVER Best Time to Contact _____

First Name _____ MI _____ Last Name _____

Home Phone _____ Mobile Phone _____

Email _____ Preferred Method of Contact ☐ Home ☐ Mobile ☐ Email ☐ Mail

Is your patient currently on ACTIMMUNE? ☐ Yes ☐ No If Yes, provide last date of use: _____

2. PRESCRIBER INFORMATION

Preferred Method of Contact ☐ Email ☐ Phone

Prescriber First Name _____ MI _____ Last Name _____ Prescriber NPI# _____

Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ Physician Specialty _____

Office Contact Name _____ Email _____ Phone _____

3. INSURANCE INFORMATION — Please attach a copy of both sides of the patient's insurance card(s).

☐ No Insurance

PRIMARY INSURANCE

Insurance Carrier _____

Customer Service Phone _____

Subscriber Name _____

Patient's Relationship to Subscriber _____

Subscriber Date of Birth _____

Subscriber ID Number _____

Policy/Employer/Group Number _____

SECONDARY INSURANCE (if any)

Insurance Carrier _____

Customer Service Phone _____

Subscriber Name _____

Patient's Relationship to Subscriber _____

Subscriber Date of Birth _____

Subscriber ID Number _____

Policy/Employer/Group Number _____

Prescription Card? ☐ Yes If Yes, Carrier: _____ Phone _____

4. PRESCRIPTION AND CLINICAL INFORMATION

☐ **Chronic Granulomatous Disease (CGD) ICD-10: D71**

Patient Genotype: ☐ **X-linked** ☐ **Autosomal Recessive**

☐ **Severe Malignant Osteopetrosis (SMO) ICD-10: Q78.2**

☐ **Other:** _____ **ICD-10:** _____

Rx: ACTIMMUNE® (Interferon gamma-1b)
100 mcg (2 million IU)/0.5 mL, single-use vials

Sig: _____ **mcg SubQ:** _____ **(frequency of dosing)**

Vial Qty: ☐ **12** ☐ **Other:** _____ **Refills:** _____

Anticipated Start Date: _____

Injection Setting: ☐ **Physician's Office** ☐ **Home** ☐ **Other:** _____

Ancillary Supplies:

☐ **0.3 mL 31 G 5/16″** **Qty:** ☐ **12** ☐ **Other:** _____
☐ **0.5 mL 30 G 5/16″ or 1/2″** **Qty:** ☐ **12** ☐ **Other:** _____
☐ **1 mL 30 G 1/2″** **Qty:** ☐ **12** ☐ **Other:** _____
☐ **Alcohol Swabs** **Qty:** ☐ **12** ☐ **Other:** _____
☐ **No Substitute**

Prescriber Certification

I certify that the above therapy is medically necessary, that the information provided is accurate to the best of my knowledge and that my patient is being administered ACTIMMUNE® (Interferon gamma-1b) Injection, 100 mcg (2 million IU)/0.5 mL, for subcutaneous injection in accordance with the labeled use of the product. I understand that Horizon Therapeutics USA, Inc. and its affiliates and their respective employees or agents (collectively, "Horizon") will use this information to administer the Horizon By Your Side program (the "Program"), which provides a wide array of patient-focused services, including providing logistical and non-medical treatment support for ACTIMMUNE, as prescribed, and educating about the insurance process. By my signature, I also certify that (1) my patient or his/her personal representative has provided a signed HIPAA authorization that allows me to share protected health information with Horizon for purposes of the Program and (2) I have obtained the patient's authorization to release such information as may be required for AllCare Plus Pharmacy and other entities (or another party acting on behalf of Horizon) to assess insurance coverage for ACTIMMUNE and assistance in initiating or continuing ACTIMMUNE as prescribed. I further understand and agree that (a) any medication or service provided through the Program as a result of this form is for the named patient only and is not being made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use ACTIMMUNE or any other Horizon product or service, for any other person; (b) my decision to prescribe ACTIMMUNE was based solely on my professional determination of medical necessity; and (c) I will not seek reimbursement for any medication or service provided by or through the Program from any government program or third-party insurer. I understand that Horizon may modify or terminate the Program at any time without notice. The completion and submission of coverage- or reimbursement-related documentation are the responsibility of the patient and healthcare provider. Horizon makes no representation or guarantee concerning coverage or reimbursement for any item or service.

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

By filling out and signing this form, the enrollment process in Horizon By Your Side has initiated; however, your patient must sign a Patient Authorization to complete enrollment in Horizon By Your Side. Please note that your patient will not benefit from the services and support offered by the Program unless your patient signs a Patient Authorization, consenting to receiving such services. If your patient does not sign the Patient Authorization contained within this form, Horizon will contact the patient to determine whether the patient is interested in signing a separate Patient Authorization.

X Prescriber Signature _____ Date _____

Written or e-signature only; stamps not acceptable.

(Dispense as Written) _____ (Substitution Permitted)

Please see the IMPORTANT SAFETY INFORMATION on last page and click here for the ACTIMMUNE Full Prescribing Information.

HORIZON BY your side

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Patient Consent for Patient Information, Enrolling in Services, and Accessing Financial Support (Referred to as "Patient Authorization")

I hereby authorize my healthcare providers, my health insurance carriers, and my pharmacies to use and disclose my individually identifiable health information, including my medical records, insurance coverage information, and my name, address, and telephone number to Horizon Therapeutics USA, Inc. and its affiliates and their respective agents and representatives (collectively, "Horizon"), including third parties authorized by Horizon to administer drug support and to dispense drugs (collectively, "Horizon By Your Side") for the following purposes: (1) to establish eligibility for benefits; (2) to communicate with my healthcare providers and me about my treatment or condition and related products; (3) to facilitate the provision of products, supplies, or services by a third party including, but not limited to, specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; (5) to enroll me in eligible patient support programs offered by Horizon By Your Side and/or Horizon, including nursing or patient access support services (government-reimbursed programs may not be eligible for all support services offered; please contact Horizon By Your Side for determination); and (6) to send me marketing information or offer me products and services related to my treatment or condition (or other products or services in which I might be interested) and to contact me occasionally to obtain my feedback (for market research purposes only) about my treatment, my condition, or my experience with Horizon and/or Horizon By Your Side otherwise as required or permitted by law. Further, I appoint the Program, on my behalf, to proceed with Program services and to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. I understand the pharmacies may receive a fee from Horizon in exchange for (1) providing me with certain materials and information described above, and (2) using or disclosing certain health information pursuant to this Authorization.

I understand that Horizon, as well as my healthcare providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment, or other care, to sign this Authorization. I understand that I am entitled to a copy of this Authorization.

I understand that information disclosed pursuant to this Authorization in some cases may be redisclosed by the recipient and no longer protected by HIPAA or other privacy laws. But Horizon has agreed to use and disclose my information only for purposes of operating the Program. I understand that I may cancel this Authorization at any time by mailing a signed letter requesting such cancellation to Horizon By Your Side, 1 Horizon Way, Deerfield, IL 60015, but that this cancellation will not apply to any information used or disclosed by my healthcare providers and/or health insurance carriers based on this Authorization before they are notified that I have cancelled it. Unless required by state law, this Authorization is valid for whichever is greater: (a) the duration of remaining on this treatment or (b) 10 years from the date signed below. A photocopy of this Authorization will be treated in the same manner as the original.

Date: _____

Patient Printed Name: _____

Patient/Legally Authorized Representative Signature: _____

Legally Authorized Representative Printed Name (if required): _____

Patient/Legally Authorized Representative Home Address:

Street Address: _____

City: _____ State: _____ ZIP: _____

Patient/Legally Authorized Representative Telephone: _____ ☐ Home ☐ Mobile

Patient/Legally Authorized Representative Email Address: _____

Legally Authorized Representative Relationship to Patient: ☐ Spouse ☐ Parent/Legal Guardian ☐ Representative per Power of Attorney

Is there someone else with whom we may discuss your protected health information? ☐ No ☐ Yes

Name: _____

Relationship to you: _____

HORIZON

ACTIMMUNE®
(Interferon gamma-1b)

INDICATIONS AND IMPORTANT SAFETY INFORMATION

INDICATIONS AND USAGE

ACTIMMUNE® (Interferon gamma-1b) is indicated:

- For reducing the frequency and severity of serious infections associated with Chronic Granulomatous Disease
- For delaying time to disease progression in patients with severe, malignant osteopetrosis

IMPORTANT SAFETY INFORMATION
CONTRAINDICATIONS

- In patients who develop or have known hypersensitivity to interferon-gamma, *E. coli* derived products, or any component of the product

WARNINGS AND PRECAUTIONS

- ACTIMMUNE should be used with caution in patients with:
  - Pre-existing cardiac conditions, including ischemia, congestive heart failure, or arrhythmia
  - Seizure disorders or compromised central nervous system function; reduce dose or discontinue
  - Myelosuppression, or receiving other potentially myelosuppressive agents; consider dose reduction or discontinuation of therapy
  - Severe renal insufficiency
  - Age <1 year
- Monitoring:
  - Patients begun on ACTIMMUNE before age 1 year should receive monthly assessments of liver function. If severe hepatic enzyme elevations develop, ACTIMMUNE dosage should be modified
  - Monitor renal function regularly when administering ACTIMMUNE in patients with severe renal insufficiency; accumulation of interferon gamma-1b may occur with repeated administration. Renal toxicity has been reported in patients receiving ACTIMMUNE
- Pregnancy, Lactation, and Fertility:
  - ACTIMMUNE should be used during pregnancy only if the potential benefit outweighs the potential risk to the fetus
  - Use of ACTIMMUNE by lactating mothers is not recommended. ACTIMMUNE or nursing should be discontinued dependent on the importance of the drug to the mother
  - Long-term effects of ACTIMMUNE on fertility are not known

DRUG INTERACTIONS

- Concomitant use of drugs with neurotoxic, hematotoxic, or cardiotoxic effects may increase the toxicity of interferons
- Avoid simultaneous administration of ACTIMMUNE with other heterologous serum protein or immunological preparations (eg, vaccines)

ADVERSE REACTIONS

- The most common adverse experiences occurring with ACTIMMUNE therapy are “flu-like” symptoms such as fever, headache, chills, myalgia, or fatigue, which may decrease in severity as treatment continues, and may be minimized by bedtime administration of ACTIMMUNE. Acetaminophen may be used to prevent or partially alleviate the fever and headache
- Isolated cases of acute serious hypersensitivity reactions have been observed in patients receiving ACTIMMUNE
- Reversible neutropenia, thrombocytopenia, and elevations of AST and/or ALT have been observed during ACTIMMUNE therapy
- At doses 10 times greater than the weekly recommended dose, ACTIMMUNE may exacerbate pre-existing cardiac conditions, or may cause reversible neurological effects such as decreased mental status, gait disturbance, and dizziness

Please click here for the Full Prescribing Information.