TROGARZO® Enrollment Form

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

To enroll, fax all documents to 1-855-836-3069.
Please ensure all sections of 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 8:30AM-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 # _____

Speciality _____ 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:

☐ **Undiluted IV Push Maintenance:** 800 mg (4 vials) intravenous push over 30 seconds, with 2 to 5 mL post-intravenous push flush every 2 weeks
Quantity: Dispense 1 month supply ☐ Refills _____

☐ **IV Infusion Maintenance:** 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
Quantity: Dispense 1 month supply ☐ Refills _____

Diagnosis (ICD-10): ☑ B20 ☑ Z16.33 ☐ Other _____

Administration Orders (select one) per TROGARZO® PI and Pharmacy Protocol

☐ Patients on IV Infusion Loading and **Undiluted IV Push Maintenance** Doses:
0.9% NaCl 10 mL syringes, 0.9% NaCl 250 mL bags, 0.9% NaCl Flush 50 mL or 100 mL bags; Nursing Orders – Administer medication via skilled nursing, monitor patient status and response to therapy

☐ Patients on IV Infusion Loading and **IV Infusion Maintenance** Doses:
0.9% NaCl 10 mL syringes, 0.9% NaCl 250 mL bags, 0.9% NaCl Flush 50 mL or 100 mL bags; Nursing Orders – Administer medication via skilled nursing, monitor patient status and response to therapy
As needed per TROGARZO® PI and pharmacy protocol

4. Prescription

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 Theratechnologies Inc., and parties working with Theratechnologies 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 Note: 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: _____

5. Insurance Information

Patient does not have insurance
OR
Patient has insurance

Please complete the information below and include copies of front and back of insurance card(s)

☐ Primary Medical Insurance _____ Policy # _____

Cardholder Name _____ Cardholder Date of Birth _____

Relationship to Cardholder _____

☐ Secondary Medical Insurance _____ Policy # _____

Cardholder Name _____ Cardholder Date of Birth _____

Relationship to Cardholder _____

☐ Prescription Drug Insurer/Pharmacy Benefit Manager (PBM)

Telephone _____ Policy # _____

Rx BIN # _____ Rx Group # _____ Rx PCN # _____

6. Site of Care

Initial Dose: (select one option)

☐ Infusion Center _____

☐ Prescribing Physician Office _____

☐ Home Infusion _____

All Subsequent Dosing: (select one option)

☐ Same as Initial Dose _____

☐ Different _____

☐ Authorization for Ancillary Supplies: Needles, syringes, etc., as needed for administration

☐ Drug/Food Allergies _____ ☐ NKDA

☐ Medication History Included

Please attach complete antiretroviral list along with concomitant medication history

Patient Authorization and Signature

Patient Authorization to Use and Disclose Protected Health Information

I authorize health care providers and their staff involved in my care to disclose my Protected Health Information (as defined below), including but not limited to my medical record and other health information on my completed Statement of Medical Necessity form or other forms, records that may contain information created by other persons, entities, physicians, and health care providers information concerning HIV/AIDS diagnosis and treatment, including HIV test results, as well as information regarding substance use disorder treatment services and mental health services (excluding psychotherapy notes) (collectively, "Protected Health Information"), to Theratechnologies Inc. and its agents, representatives, and direct and indirect service providers (collectively, "Theratechnologies"), so that Theratechnologies may:

1. Facilitate the filling of my prescription for and the delivery and administration of Theratechnologies products, including disclosing or redisclosing Protected Health Information to pharmacies;
2. Assist me in obtaining insurance coverage for Theratechnologies products, including disclosing or redisclosing Protected Health Information to health plans;
3. Partner me with a Nurse Navigator for training and adherence assistance. Interaction can be live audio/video training offering education for proper use, if appliable, administration and continuous adherence guidance. I have the right not to be recorded at any time. Theratechnologies will have access to my communications to provide adequate patient care. Any dissemination, storage or retention of an identifiable patient image or other information shall comply with federal and state laws and regulations requiring confidentiality;
4. Create deidentified and aggregate information to be used and shared for reimbursement, publication, or commercial purposes.

I authorize Theratechnologies to contact me by mail, email, video and/or telephone to enroll me in, and administer programs that provide support services.

To accomplish these purposes, I further authorize Theratechnologies to share information, including HIV/AIDS information, between and among the entities defined in this Authorization as Theratechnologies. I understand that once my Protected Health Information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy law and regulations known as "HIPAA" or state privacy laws and may be the subject to further disclosure by Theratechnologies and third parties with whom Theratechnologies may share the information. However, other state and federal laws may prohibit the recipient from disclosing specially protected information such as certain HIV/AIDS-related information, substance use disorder treatment information, and mental health information. I understand that I may refuse to sign this authorization. My refusal will not affect my ability to receive Theratechnologies products, treatment, payment, enrollment in a health plan, or eligibility for benefits but my refusal may limit my ability to receive certain support services that are provided by Theratechnologies.

I understand that health care providers may receive compensation, remuneration, or other value as a result of their use and disclosure of my Protected Health Information as described in this authorization.

I understand that this authorization will remain in effect for 10 years from the date of my signature, unless limited by state laws and regulations and/or I revoke it in writing by contacting Theratechnologies c/o

ASPN Pharmacies, LLC
290 West Mount Pleasant Ave
Building 2, 4th Floor, Suite 4210
Livingston, NJ 07039 United States

If I revoke this authorization, Theratechnologies and any third parties that are notified of my revocation will stop using my Protected Health Information for the purposes outlined in this authorization, but the revocation will not affect prior use or disclosure of my Protected Health Information in reliance on this authorization. I have the right to receive a copy of this authorization after I sign it.

I understand that the support services provided by Theratechnologies that are described in this authorization can be changed at any time, without prior notification.

By checking this box, ☐ I authorize Theratechnologies to:

- Send me text messages about my TROGARZO®. I understand that standard data fees and text messaging fees may apply based on my mobile plan; and
- Provide me with free educational information, information about clinical trials, and marketing materials; and
- Conduct surveys to measure my satisfaction with Theratechnologies products and services.

Patient Name _____ Date of Birth _____

Address _____ Telephone _____

Patient's Signature _____ Date _____

If you are the patient's representative, identify your relationship to the patient and state basis of authority

_____

NOTICE TO RECIPIENT OF INFORMATION:
HIV-related Information: To the extent that HIV-related information has been provided to you, such information has been disclosed to you from records whose confidentiality may be protected by federal and state law. Such laws may prohibit you from making any further disclosure of the HIV-related information without the specific written consent of the person to whom it pertains, or as otherwise permitted by said laws. When obtaining such written consent, you must expressly identify that "HIV-related information is being disclosed" (a general authorization for the release of the entire medical file, for example, is NOT sufficient for this purpose). An oral disclosure shall be accompanied or followed by such notice within 10 days.

US-TRO-2200040-V2