RUCONEST SOLUTIONS™
Expertise. Delivered personally.

Patient Enrollment Form

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

RUCONEST®
C1 esterase inhibitor (recombinant)

Please triage to ORSINI

Getting Started

Step 1:

Fill out all 3 pages of the Enrollment Form

Page 1

Patient to read and sign the Consent Form

NOTE: Patient signature on Consent Form is required to access RUCONEST Solutions support, including RPA services, copay assistance, and any free goods program, including StarterRx. If consent is not submitted with the enrollment form, RUCONEST Solutions will work with the patient to obtain consent.

Pages 2 and 3

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

NOTE: The Enrollment Form provides prescription for both Commercial and Free Goods Programs

Step 2:

Submit Pages 1 through 3 of the Enrollment Form to RUCONEST Solutions, along with the following documentation:

- Copy of recent labs related to 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 patient 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 patient's clinical history
- Documentation of other therapies used to treat symptoms of HAE

This requested documentation will help RUCONEST Solutions to support your office with coverage authorizations when 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 you are sending in a referral for them 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.

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

RUCONEST SOLUTIONS™
Expertise. Delivered personally.

Patient Enrollment Form

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

RUCONEST®
C1esterase inhibitor (recombinant)

Please triage to ORSINI

Patient Consent Form

Patient Name: _____ **DOB:** _____

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

Emergency Contact Name: _____ **Relationship to Patient:** _____

Emergency Contact Phone: _____

Consent to Share Health Information: By signing this Consent, I authorize my healthcare provider, including physicians and home care nurse educators, my health plan(s) providing medical care and prescription coverage, and my pharmacy(ies) providing the RUCONEST to disclose to RUCONEST Solutions ("Program") operated by Pharming Healthcare and companies working with Pharming Healthcare, health information relating to my medical condition, treatment, and insurance coverage. I also authorize my healthcare provider, including physicians and home care nurse educators, my health plan(s) providing medical care and prescription coverage, and my pharmacy(ies) providing the RUCONEST to receive health information related to my medical condition, treatment, and insurance coverage from the Program. I authorize Pharming Healthcare to provide me with (i) support services (and related information and materials) related to any of Pharming Healthcare's products, including but not limited to, insurance coverage, prescription fulfillment, online support, financial assistance services, adherence, and other therapy support services; and (ii) information about Pharming Healthcare's products, services, and programs. I understand that Pharming may use my health information to conduct data analytics, market research, and other internal business activities. Once my health information has been disclosed to Pharming Healthcare, I understand that federal privacy laws no longer protect the information. However, Pharming Healthcare agrees to protect my health information by using and disclosing it only for purposes authorized in this Consent or as required by law or regulations. I understand that my pharmacy provider may receive remuneration from Pharming Healthcare in exchange for the health information and/or for any therapy support services provided to me. I understand that I may refuse to sign this Consent. I further understand that my treatment (including with a Pharming Healthcare product), insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this Consent; but if I do not sign it or later cancel it, I will not be able to receive Pharming Healthcare's patient program support. I may cancel this consent at any time by calling (855) 613-4423. Canceling this Consent will end my consent to further disclosure of my health information to Pharming Healthcare by my Healthcare Entities after they are notified of my cancellation but will not affect previous disclosures by them pursuant to this Consent. Canceling this Consent will not affect my ability to receive treatment, or my eligibility for health insurance. This Consent expires five (5) years from the date signed unless a shorter period is required by state law. I understand that I am entitled to a copy of this Authorization after signing below.

Patient Support Services: I authorize the Program and its affiliated team members to contact me to provide me support related to any of Pharming Healthcare's products, including but not limited to insurance coverage, prescription fulfillment, product assistance, financial assistance services, adherence, and other therapy support services, relevant disease-related information, as well as any information or materials related to such services. I understand that any personnel providing support as part of the Program are not employed by my healthcare professional. RUCONEST Solutions or Pharming Healthcare may contact me by mail, email, fax, telephone call, text message (including calls and text messages made with an automatic telephone dialing system or a prerecorded voice),* and other mutually agreed upon means. I also authorize Pharming Healthcare to use my health information in connection with the services and programs, including, without limitation, sharing such information with my Healthcare Entities.

Opt-in for Other Resources: By signing below, I authorize Pharming Healthcare, and companies working with Pharming Healthcare, to contact me by mail, email, fax, text messaging,* and/or telephone regarding other potential topics of interest to me, customer surveys, or occasionally for market research purposes. I understand that I am not required to provide this consent as a condition of receiving any Pharming Healthcare medicine or Patient Support Services. Note that Pharming Healthcare will not sell or trade my personal data to any unrelated third party.

☐ I would like to **opt out** of receiving other resources

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 above on my behalf in the event of an emergency.

By signing below, I confirm that I have read and understand the Consent to Share Health Information and Patient Support Services above and agree to the terms.

Printed Patient/Legal Representative Name: _____

Patient Sign

Patient/Legal Representative Signature: _____ Date: _____

If Legal Representative, Relationship to Patient: _____

*Data rates may apply.

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

RUCONEST SOLUTIONS™
Expertise. Delivered personally.

Patient Enrollment Form

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

RUCONEST®
C1esterase inhibitor (recombinant)

Please triage to ORSINI

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) ☐ **Per Month**
☐ 16 doses (32 vials) ☐ ____doses (____vials) ☐ **Per Shipment**

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
☐ 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

Anaphylaxis Order Specialty pharmacy to provide anaphylactic kit per provider protocol. Substitution permitted unless DAW specified _____

Epinephrine #2 pack ☐ 0.15mg ☐ 0.3mg **Refills:** _____
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. Optional Prescription for StarterRx, Bridge-to-Therapy, and/or PAP Program

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) ☐ **Per Month**
☐ ____ doses (vials) ☐ **Per Shipment**

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
☐ 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

☐ **Substitution permitted** ☐ **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

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 _____
☐ Patient does not require skilled nursing visits

MD Sign

PRESCRIBER _____ Date _____

RUCONEST SOLUTIONS™
Expertise. Delivered personally.

Patient Enrollment Form

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

RUCONEST®
C1esterase inhibitor (recombinant)

Please triage to ORSINI

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