# Patient Enrollment Form Guide

## Initiate process to enroll patients prescribed ACTIMMUNE® (Interferon gamma-1b) in Horizon By Your Side

Fill out all required fields to ensure a thorough benefits investigation

Complete the prescriber signature and date on the Patient Enrollment Form. Make sure your patient or their legally authorized representative has completed, signed, and dated the Patient Authorization Form for Horizon By Your Side, a patient support program

Send copies of both sides of the patient's insurance card(s) and both completed forms to Horizon By Your Side

**Please see Important Safety Information on page 3 and see Full Prescribing Information available at ACTIMMUNEhcp.com.**

ACTIMMUNE®
(Interferon gamma-1b)

## 1 PATIENT INFORMATION

- **Fill out all patient information**, including height, weight, and whether the patient is currently being prescribed ACTIMMUNE® (Interferon gamma-1b)
  - — Required fields are needed to **conduct a benefits investigation, to contact the patient for any follow-up, and to provide support from Horizon By Your Side**
- Please include caregiver's contact information

## 2 PRESCRIBER INFORMATION

- **Fill out all prescriber information**, including prescriber name, contact information, and NPI number
  - — Include the office contact name, phone number, and email address

## 3 INSURANCE INFORMATION

- **Provide the patient's primary insurance information**
  - — Select the "No Insurance" box if the patient does not have any insurance
  - — Include secondary insurance plan information, if applicable
- **Please include copies of both sides of your patient's insurance card(s), if available, along with the completed Patient Enrollment Form**
  - — If not available, or if the patient is uninsured, you may attach the electronic medical record demographics page as an alternative to the image of the cards

Ensure that you submit **pages 1 and 2 of the Patient Enrollment Form**, along with copies of **both sides of the patient's insurance card(s)**. Retain a copy of this form in the patient's records.

NPI, National Provider Identifier.

HORIZON Patient Services®

**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 Jane MI A Last Name Smith
Address 123 Main Street City White Plains State NY ZIP 10605
Home Phone 100-000-0001 Mobile Phone 100-000-0002
Date of Birth 01/01/2012 Gender ☐ M ☒ F Height 4'2" Weight 55 lbs
Email jane.smith@email.com Preferred Method of Contact ☐ Home ☒ Mobile ☐ Email ☐ Mail

ALTERNATIVE CONTACT AND/OR CAREGIVER Best Time to Contact Weekdays after 4pm
First Name John MI J Last Name Smith
Home Phone 100-000-0001 Mobile Phone 100-000-0003
Email john.smith@email.com Preferred Method of Contact ☐ Home ☒ Mobile ☐ Email ☐ Mail
Is your patient currently on ACTIMMUNE®? ☒ Yes ☐ No If Yes, provide last date of use: 02/19/2021

**2. PRESCRIBER INFORMATION**

Prescriber First Name Maria MI A Last Name Davis Prescriber NPI# 0000000000
Address 123 Medical Way City White Plains State NY ZIP 10605
Phone 100-000-0004 Fax 100-000-0005 Physician Specialty Immunologist
Office Contact Name Sam Wilson Email sam.wilson@email.com Phone 100-000-0006

**3. INSURANCE INFORMATION** — Please attach a copy of both sides of the patient's insurance card(s). ☐ No Insurance

| PRIMARY INSURANCE | SECONDARY INSURANCE (if any) |
| --- | --- |
| Insurance Carrier Insurance Provider One | Insurance Carrier Insurance Provider Two |
| Customer Service Phone 000-100-0007 | Customer Service Phone 000-100-0008 |
| Subscriber Name John Smith | Subscriber Name John Smith |
| Patient's Relationship to Subscriber Child | Patient's Relationship to Subscriber Child |
| Subscriber Date of Birth 02/02/1974 | Subscriber Date of Birth 02/02/1974 |
| Subscriber ID Number 000-000001-01 | Subscriber ID Number 000-000001-023 |
| Policy/Employer/Group Number 000001 | Policy/Employer/Group Number 000001 |
| Prescription Card? ☒ Yes If Yes, Carrier: Prescription Rx | Phone 100-222-0000 |

**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: XX mcg SubQ: 3x/weekly (frequency of dosing)
Vial Qty: ☒ 12 ☐ Other: Refills: 12

Anticipated Start Date: ASAP
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 and that the information provided is accurate to the best of my knowledge. 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 Patient Services™ program (the "Program"), which provides assistance to patients in verifying insurance coverage for ACTIMMUNE® and assistance in initiating or continuing ACTIMMUNE® as prescribed. By my signature, I also certify that 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. I appoint the Program, on my behalf, to proceed with services offered and to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. 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.

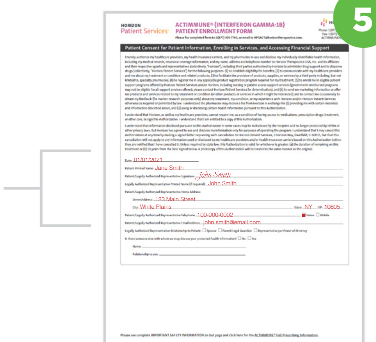
State requirements: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

**By filling out and signing this form, the enrollment process in Horizon Patient Services has initiated; however, your patient must sign a Patient Authorization to complete enrollment in Horizon Patient Services. Please note that your patient will not benefit from the services and support offered by Horizon Patient Services 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 *Maria Davis* (Dispense as Written) Date 02/23/2021 ________ (Substitution Permitted)
Written signature only; stamps not acceptable.

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

Date: 02/23/2021
Patient Printed Name: Jane Smith
Patient/Legally Authorized Representative Signature: *John Smith*
Legally Authorized Representative Printed Name (if required): John Smith
Patient/Legally Authorized Representative Home Address:
Street Address: 123 Main Street
City: White Plains State: NY ZIP: 10605
Patient/Legally Authorized Representative Telephone: 100-000-0001 ☒ Home ☐ Mobile
Patient/Legally Authorized Representative Email Address: john.smith@email.com



## 4 PRESCRIPTION AND CLINICAL INFORMATION

- **Provide diagnosis code**
  - — If there is no box for the primary diagnosis, select "Other" and note the primary diagnosis code
- **Fill out all prescription information**
  - — Reference the select ACTIMMUNE® dosing instructions included in the Patient Enrollment Form or the Full Prescribing Information for complete dosing information
- **Review, sign, and date the prescriber certification**. In signing, you are indicating that ACTIMMUNE® should be dispensed as written. If a substitution is allowed, it should be noted
  - — Please complete the ancillary supply section based on the appropriate prescription
  - — Must be a written signature; stamps and digital signatures are not accepted

**All prescription fields must be fully completed based on HCP's description. Incomplete prescriptions may result in delays at specialty pharmacies and require additional outreach for prescription clarification.**

## 5 PATIENT CONSENT

- **The Patient Authorization is located on the second page of the Patient Enrollment Form**
  - — A patient or patient's legally authorized representative signature **is required** for the team at Horizon By Your Side to provide nonmedical logistical support to the patient
- If the patient/legally authorized representative is not available to sign the form at your office, the Horizon By Your Side team can follow up to obtain HIPAA consent

**Submit the Patient Enrollment Form using one of the methods below:**

**FAX** to Horizon By Your Side
**1-877-305-7706**

**EMAIL**
**HPSACT@horizontherapeutics.com**

HCP, healthcare provider; HIPAA, Health Insurance Portability and Accountability Act.

Please see Important Safety Information on page 3 and see Full Prescribing Information available at ACTIMMUNEhcp.com.

# 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 see Full Prescribing Information available at ACTIMMUNEhcp.com.**

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