

## **ACTIMMUNE® (Interferon gamma-1b) PATIENT ENROLLMENT FORM INSTRUCTIONS**

The ACTIMMUNE® (Interferon gamma-1b) Patient Enrollment Form is required to initiate treatment with ACTIMMUNE®.

**Instructions:**

1. Complete the following enrollment form in its entirety, including
  - a. Patient information
  - b. Insurance information with picture 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 Patient Services at **1 (877) 305-7706**.
4. Check with your patient to ensure he or she has printed, signed, and dated the required Patient Authorization Form providing HIPAA authorization for Horizon Patient Services and initiation of patient support.
5. If you have any questions or comments, please contact Horizon Patient Services at **1 (877) 305-7704**.

## ACTIMMUNE® (Interferon gamma-1b) PATIENT ENROLLMENT FORM

All new referral patients must complete the ACTIMMUNE® (Interferon gamma-1b) Patient Enrollment Form.

\* Indicates required field.

### Patient Information

Patient Name\*: \_\_\_\_\_ DOB\*: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender\*:  Male  Female Height\*: \_\_\_\_ Weight\*: \_\_\_\_  
 Address\*: \_\_\_\_\_ City\*: \_\_\_\_\_ State\*: \_\_\_\_\_ ZIP Code\*: \_\_\_\_\_  
 Preferred Phone\*: (\_\_\_\_) \_\_\_\_\_ Alternate Phone: (\_\_\_\_) \_\_\_\_\_ Email\*: \_\_\_\_\_  
 Caregiver/Alternate Contact Name\*: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone\*: (\_\_\_\_) \_\_\_\_\_  
 Preferred Contact:  Patient  Caregiver Preferred Type:  Phone (Day)  Phone (Evening)  Email Preferred Language: \_\_\_\_\_  
 Is your patient currently on ACTIMMUNE®?:  Yes  No If Yes, provide last date of use: \_\_\_\_\_

### Insurance Information | Please attach both sides of the patient's insurance card(s)

No insurance

Primary Insurance Company*: _____	Secondary Insurance Company (if applicable)*: _____
Phone*: (____) _____	Phone*: (____) _____
Policy Type: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Commercial <input type="checkbox"/> Other	Policy Type: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Commercial <input type="checkbox"/> Other
Policy #*: _____ Group #*: _____	Policy #*: _____ Group #*: _____
Policyholder Name*: _____	Policyholder Name*: _____
Relationship: _____	Relationship: _____
DOB: ____/____/____	DOB: ____/____/____

### Diagnosis Information and Prescription Information (ALL fields required)

Chronic Granulomatous Disease (CGD) ICD-10: D71  
 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 Information

First and Last Name\*: \_\_\_\_\_ Credentials: \_\_\_\_\_  
 NPI #\*: \_\_\_\_\_ State License #\*: \_\_\_\_\_ State Issued\*: \_\_\_\_\_ Tax ID\*: \_\_\_\_\_ Specialty\*: \_\_\_\_\_  
 Practice/Facility Name\*: \_\_\_\_\_ Primary Contact Name\*: \_\_\_\_\_  
 Address\*: \_\_\_\_\_ City\*: \_\_\_\_\_ State\*: \_\_\_\_\_ ZIP Code\*: \_\_\_\_\_  
 Phone\*: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ Prescriber Email: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_

**Prescriber Acknowledgement:** 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 Pharma and its employees or agents (collectively, "Horizon") will use this information to administer the Horizon Patient Services program (the "Program"), which provides assistance to patients in obtaining coverage for ACTIMMUNE® (Interferon gamma-1b) and assistance in initiating or continuing ACTIMMUNE® (Interferon gamma-1b). By my signature, I also acknowledge that my patient or his or 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 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® (Interferon gamma-1b), or any other Horizon product or service, for any other person, (b) my decision to prescribe ACTIMMUNE® (Interferon gamma-1b) 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.

**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 this form, your chronic granulomatous disease or severe, malignant osteopetrosis patient is automatically enrolled into the Nurse Educator Program.

Check here if you choose not to enroll this patient into the Nurse Educator Program.

Prescriber Name\*: \_\_\_\_\_ Date\*: \_\_\_\_\_

Prescriber Signature\*: \_\_\_\_\_

Dispense as Written (No Stamps Allowed)

## HIPAA 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 Pharma 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 Patient Services") for the following purposes: (1) to establish eligibility for benefits; (2) to communicate with healthcare providers and me about my medical care; (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 Patient Services 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 Patient Services for determination); and (6) to send me marketing information related to my treatment or condition (or related 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 Patient Services otherwise as required or permitted by 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 Patient Services, 150 South Saunders Rd, Lake Forest, IL 60045, 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's Printed Name: \_\_\_\_\_

Patient's/Legally Authorized Representative's Signature: \_\_\_\_\_

Legally Authorized Representative's Printed Name (if required): \_\_\_\_\_

Patient's/Legally Authorized Representative's Home Address:

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Patient's/Legally Authorized Representative's Telephone: \_\_\_\_\_  Home  Mobile

Patient's/Legally Authorized Representative's Email Address: \_\_\_\_\_

Legally Authorized Representative's 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: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

## IMPORTANT SAFETY INFORMATION

### What is ACTIMMUNE® (Interferon gamma-1b) used for?

ACTIMMUNE® is part of a drug regimen used to treat Chronic Granulomatous Disease, or CGD. CGD is a genetic disorder, usually diagnosed in childhood, that affects some cells of the immune system and the body's ability to fight infections effectively. CGD is often treated (though not cured) with antibiotics, antifungals, and ACTIMMUNE.

ACTIMMUNE is also used to slow the worsening of severe, malignant osteopetrosis (SMO). SMO is a genetic disorder that affects normal bone formation and is usually diagnosed in the first few months after birth.

### When should I not take ACTIMMUNE?

Don't use ACTIMMUNE if you are allergic to interferon-gamma, *E coli*-derived products, or any ingredients contained in the product.

### What warnings should I know about ACTIMMUNE?

At high doses, ACTIMMUNE can cause (flu-like) symptoms, which may worsen some pre-existing heart conditions.

ACTIMMUNE may cause decreased mental status, walking disturbances, and dizziness, particularly at very high doses. These symptoms are usually reversible within a few days upon dose reduction or discontinuation of therapy.

Bone marrow function may be suppressed with ACTIMMUNE, and decreased production of cells important to the body may occur. This effect, which can be severe, is usually reversible when the drug is discontinued or the dose is reduced.

Taking ACTIMMUNE may cause reversible changes to your liver function, particularly in patients less than 1 year old. Your doctor should monitor your liver function every 3 months, and monthly in children under 1 year.

In rare cases, ACTIMMUNE can cause severe allergic reactions and/or rash. If you experience a serious reaction to ACTIMMUNE, discontinue it immediately and contact your doctor or seek medical help.

### What should I tell my healthcare provider?

Be sure to tell your doctor about all the medications you are taking.

Tell your doctor if you:

- are pregnant or plan to become pregnant or plan to nurse
- have a cardiac condition such as irregular heartbeat, heart failure, or decreased blood flow to your heart
- have a history of seizures or other neurologic disorders
- have, or have had, reduced bone marrow function. Your doctor will monitor these cells with blood tests at the beginning of therapy and at 3-month intervals on ACTIMMUNE therapy

### What are the side effects of ACTIMMUNE?

The most common side effects with ACTIMMUNE are "flu-like" symptoms such as fever, headache, chills, muscle pain, or fatigue, which may decrease in severity as treatment continues. Bedtime administration of ACTIMMUNE may help reduce some of these symptoms. Acetaminophen may be helpful in preventing fever and headache.

### What other medications might interact with ACTIMMUNE?

Some drugs may interact with ACTIMMUNE to potentially increase the risk of damage to your heart or nervous system, such as certain chemotherapy drugs. Tell your doctor about all other medications you are taking.

Avoid taking ACTIMMUNE at the same time as a vaccination.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit [www.fda.gov/medwatch](http://www.fda.gov/medwatch), or call 1-800-FDA-1088.

*The risk information provided here is not comprehensive. To learn more, talk about ACTIMMUNE with your healthcare provider or pharmacist. The FDA-approved product labeling can be found at <http://www.ACTIMMUNE.com> or 1-866-479-6742.*