AFSTYLA® Antihemophilic Factor (Recombinant), Single Chain
Enrollment Form

PRINT AND FAX COMPLETED FORM TO: 1-844-727-2757
FOR ANY QUESTIONS ABOUT THIS FORM, PLEASE CALL 1-800-676-4266

SECTIONS 1 AND 2 MUST BE COMPLETED FOR ALL SERVICE REQUESTS

PATIENT

1 Patient Information (Required)

Patient name _____ DOB ___/___/___ SSN (last 4 digits only) _____ Sex ☐ M ☐ F
Street address _____ City _____ State _____ ZIP _____
Home phone _____ ☐ OK to leave message Mobile phone _____ ☐ OK to leave message Email _____
Current therapy status: ☐ Existing AFSTYLA patient ☐ Switch from HELIXATE® FS (Antihemophilic Factor [Recombinant])
☐ Switch from another Factor VIII therapy _____ ☐ Other _____

2 Patient Insurance Information (Required) Please attach copies of both sides of patient's insurance card(s), if available.

☐ **Check if patient does not have insurance**

Primary insurance _____
Insurance phone _____ Policy # _____
Policyholder name _____ Policyholder DOB ___/___/___

Secondary insurance _____
Insurance phone _____ Policy # _____
Policyholder name _____ Policyholder DOB ___/___/___

Pharmacy plan _____ Group # _____ Policy # _____ Rx BIN # _____ Rx PCN # _____

3 Authorization for Release of Patient Health Information (Required to initiate benefits investigation)

I have read and understand the "Authorization for Release of Patient Health Information" section of the instructions on Page 2. My signature also signifies that the information on this form is accurate and complete.

PATIENT SIGNATURE _____ Date _____

In addition, I authorize the disclosure of my health information to the following designated individual (optional):
Designated Individual (print name) _____ Relationship _____

PARENT OR GUARDIAN SIGNATURE (for patients under 18 years old) _____ Date _____

4 Opt in to receive relevant CSL Behring communications and/or patient resources (Optional)

I have read and understand the "Marketing Opt-In" section of the instructions on Page 2.

PATIENT SIGNATURE _____ Date _____

PATIENT

COMPLETE ONLY IF INTERESTED IN: (Please check appropriate box) ☐ **TRIAL PROGRAM** ☐ **PRESCRIPTION REFERRAL**

PRESCRIBER

A Prescriber Information

Prescriber name _____ State license # _____ NPI # _____
Tax ID # _____ DEA _____ PTAN _____
Facility name _____ Facility address _____ City _____ State _____ ZIP _____
Office contact _____ Phone _____ Fax _____ Email _____
Ship to: ☐ Patient home ☐ Facility

B Dosing Information

Rx: AFSTYLA Dosing

Patients ≥ 12 years of age: 20-50 IU/kg body weight twice or three times per week.
Patient < 12 years of age: 30-50 IU/kg body weight twice or three times per week. More frequent or higher doses may be required in children.
Patient weight _____ kg Dosage _____ IU/kg Frequency of dosing ☐ 2x/week ☐ 3x/week ☐ Other
Number of refills (If using pharmacy referral) _____ ☐ D66 congenital Factor VIII disorder

C Prescriber Authorization

Prescriber Authorization (Required)

I certify that **AFSTYLA** is medically necessary for this patient. I will be supervising the patient's treatment accordingly. Non-approval of **AFSTYLA** may result in further deterioration of patient's health and/or hospitalization.
By signing below, I certify that I have received the necessary authorization from the patient to release the medical and/or patient information referenced on this form relating to the above-referenced patient to CSL Behring and its contracted agent or contractors working solely on behalf of patient for the purpose of seeking reimbursement through the CSL Behring My Source℠ for **AFSTYLA** Program, verifying insurance coverage and/or the evaluation of the patient's eligibility for alternate sources of funding, patient support services, including materials fulfilment, and product fulfilment via specialty pharmacies.

PRESCRIBER SIGNATURE (required to process prescription) _____ **DATE** _____

PRESCRIBER

The confidentiality of patient information is of utmost importance. Therefore, CSL Behring and its agents comply with all federal, state, and local guidelines regarding patient confidentiality rights.

CSL Behring
Biotherapies for Life®

Enrollment Form Instructions

Thank you for your interest in AFSTYLA® Patient Support Services.
Please call **1-800-676-4266** with any questions.

My Source℠ for AFSTYLA support programs

At CSL Behring, we believe everyone should have access to therapy. My Source for AFSTYLA provides programs to help ensure that you get the treatment you need.

Benefit Investigation: My Source will contact your insurance carrier to obtain coverage and patient costs for AFSTYLA.

Co-pay Assistance: Patients meeting eligibility requirements* will be enrolled in the My Access® program.

**Patient must have coverage for AFSTYLA under a private, commercial plan. Patients covered by state or federally funded programs are excluded (Medicare, Medicaid, PCIP, Tricare, SCHIPs, etc); patients must be a resident of the United States, product only is supplied per the package insert, product must be purchased from a Specialty Pharmacy, Hemophilia Treatment Center, or Outpatient Hospital to be eligible. CSL Behring reserves the right to modify, limit, or discontinue all or any portion of the program without notice. Annual benefit is up to $12,000 per enrollment year. Patients must re-enroll annually.*

Trial Program: Eligible patients can receive a 30-day free trial of AFSTYLA.

If necessary, patients can obtain an additional 30-day bridge† while My Source assists with any unforeseen delays in obtaining coverage for AFSTYLA.

†Patient must have a valid prescription for an on-label use of AFSTYLA, patient must have a private, commercial insurance plan (state and federally funded programs are excluded). Product cannot be billed to a third-party payer.

Pharmacy Referral: My Source will assist in coordinating prescription fulfilment with you or your carrier's preferred Specialty Pharmacy.

PATIENT INSTRUCTIONS

PATIENT

1 Complete Sections 1 and 2 on the Enrollment Form.

2 Read Authorization for Release of Personal Health Information—Sign Section 3 on the Enrollment Form.

By signing this Authorization, I authorize my healthcare providers, including pharmacies and insurance providers, to disclose to CSL Behring and any entities in connection with the administration of My Source℠ and contractors appropriate protected health information (PHI) relevant to my treatment and payment with **AFSTYLA** from CSL Behring. I understand that if I do not sign this authorization, I may be ineligible for participation in My Source℠ and for the reimbursement assistance and treatment support it provides.

The entities in connection with the administration of My Source℠ may use and disclose my PHI to communicate with me (1) to establish my eligibility for benefits; (2) to communicate with my healthcare providers and me about my medical care; (3) to facilitate the provision of products, supplies, or services by a third party (4) to register me in any applicable product registration program required for my treatment. This authorization will expire 2 years after patient provides signature.

I understand that once my PHI is disclosed under this authorization, it may no longer be protected by federal law and could be disclosed to other parties. However, CSL Behring and its agents comply with all federal, state, and local guidelines regarding patient confidentiality rights and will use and disclose your PHI only as described above.

I understand that my decision on whether to sign this authorization will not affect my ability to receive healthcare treatment or insurance benefits outside of My Source℠. I may cancel this authorization at any time by sending a written cancellation notice to My Source℠ by mail to; **PO Box 368 Lewisville, TX 75067**. I understand that I may ask for a copy of my signed authorization.

3 Read Marketing Opt In – Check Box and Sign Section 4 on the Enrollment Form:

Opt-in: By providing consent, I am choosing to receive marketing materials, requests to participate in company sponsored programs, and/or new patient resources from CSL Behring and its affiliates.

PRESCRIBER INSTRUCTIONS—SECTIONS 1 AND 2 MUST ALSO BE COMPLETED

PRESCRIBER

1 Complete Prescriber Information in Section A of the Enrollment Form.

2 Complete the Patient's Dosing Information in Section B of the Enrollment Form, including confirmation of diagnosis code.

3 Read and Sign Prescriber Authorization in Section C of the Enrollment Form.

Prescriber attests that he/she has obtained consent to release the patient's health information. Prescriber attests that samples will not be used in exchange for money, services, or other property. No portion of the products given in the free trial or bridging program will be utilized to seek reimbursement from Medicare, Medicaid, or any other third-party payer that provides charge-based or cost-based reimbursement to the provider or participating institution—either directly or indirectly.