UPLIZNA® (inebilizumab-cdon) PATIENT ENROLLMENT FORM

Once complete, submit pages 1-4 by fax 1-833-329-8477 or email UPLIZNAABYS@amgen.com

Complete all required fields, including prescriber's signature and date, to initiate patient enrollment process. For support and/or assistance obtaining patient signature, call Amgen By Your Side at 1-833-842-8477. (X Indicates a required field)

USA-335-81798

PATIENT INFORMATION

X **First name** | X **Last name**

X **Gender:** ○ Male ○ Female | X **Date of birth:** ___ /___ /_____ (MM/DD/YYYY)

X **Email address** | Primary language

X _____ ○ Primary **Mobile phone** | X _____ ○ Primary **Home phone**

X **Address**

X **City** | X **State** | X **ZIP code**

Alternate contact name | Alternate contact phone

DIAGNOSIS

X **Diagnosis:*** **Required for processing**
- ○ G70.00 Myasthenia gravis without (acute) exacerbation
- ○ G70.01 Myasthenia gravis with (acute) exacerbation
- ○ G36.0 - Neuromyelitis optica [Devic]

Date of diagnosis: ___ /___ /_____ (MM/DD/YYYY)

X **gMG ONLY Has the patient ever tested positive for AChR antibodies?** ○ Yes ○ No

X **gMG ONLY Has the patient ever tested positive for MuSK antibodies?** ○ Yes ○ No

X **NMOSD ONLY Has the patient ever tested positive for AQP4 antibodies?** ○ Yes ○ No

gMG ONLY MG-ADL score _____ MGFA clinical classification (I, II, III, IV, V) _____

Check all previous NMOSD/gMG therapies:

- ○ Azathioprine
- ○ Eculizumab
- ○ Efgartigimod
- ○ Efgartigimod plus hyaluronidase
- ○ Methotrexate
- ○ Mycophenolate mofetil
- ○ Nipocalimab
- ○ Pyridostigmine
- ○ Ravulizumab
- ○ Riabni
- ○ Rituxan
- ○ Rozanolixizumab
- ○ Ruxience
- ○ Satralizumab
- ○ Steroid
- ○ Tocilizumab
- ○ Truxima
- ○ Zilucoplan
- ○ None/new diagnosis
- ○ Other: _____

INSURANCE INFORMATION

(Please include front and back copies of insurance card(s) with this form)

X **Primary insurance** | Secondary insurance

X **Policy #** | Policy #

X **Policyholder's first and last name** | Policyholder's first and last name

X **Insurance company phone** | Insurance company phone

X **Group #** | Group #

Policyholder's Date of birth: X ___ /___ /_____ (MM/DD/YYYY) | Policyholder's Date of birth: ___ /___ /_____ (MM/DD/YYYY)

○ Patient is uninsured to my knowledge.

PRESCRIBER INFORMATION

X **First name** | X **Last name**

X **Address**

X **City** | X **State** | X **ZIP code**

X **NPI #** | X **State license #** | X **Tax ID #**

Clinic/hospital affiliation

X **Office contact name**

X **Office contact phone** | X **Fax number**

X **Office contact email address**

Preferred communication: ○ Phone ○ Email

Prescriber specialty

PREFERRED INFUSION FACILITY

If none, Amgen By Your Side can provide options.

○ The infusion facility is the same as the prescribing office

Facility name

Address

City | State | ZIP code

Phone | Fax number

Facility NPI # | Tax ID #

Complete signatures and prescription information on next page

*These codes are not all-inclusive. Appropriate codes vary by patient, payers, and setting for care. Correct coding is the responsibility of the provider submitting the claim. Amgen does not make any representation or guarantee for reimbursement or coverage.

USA-335-81798

PATIENT CONSENT AND AUTHORIZATION (Required—please see language on pages 3-4.)

USA-335-81798

You must read the Consent to Health Data Processing on page 4 and then select one of the below responses.
Select "I consent" to proceed with enrollment. If you select "I do not consent," you will not be able to enroll in Amgen By Your Side

X ○ **I consent to the collection, processing, and disclosure of my Health Data for the purposes set forth on page 4.**
○ **I do not consent to the collection, processing, or disclosure of my Health Data for the purposes set forth on page 4.**

By signing below, I am indicating that I have read and understood the Authorization for Use and Disclosure of Protected Health Information (pages 3-4), that I am legally authorized to consent, and that I am providing my consent as the patient or the patient's legal representative for Amgen and its contractors and business partners to use and share the personal information I provide for the purposes described within the Authorization for Use and Disclosure of Protected Health Information.

X _____ **Patient name**

_____ Name of Legal Representative (if needed)

X X _____ **Signature of Patient (or Legal Representative)**

X _____ / _____ / _____ **Date of signature** (MM/DD/YYYY)

PRESCRIPTION (Required)

X _____ **Patient first name**

X _____ **Patient last name**

X _____ / _____ / _____ **Date of Birth** (MM/DD/YYYY)

Prescription Information: UPLIZNA® (inebilizumab-cdon)

X **ICD-10 code:**
○ G70.00 Myasthenia gravis without (acute) exacerbation
○ G70.01 Myasthenia gravis with (acute) exacerbation
○ G36.0 - Neuromyelitis optica [Devic]

Allergies: _____ ○ No known drug allergies (NKDA)

NDC: 75987-150-03: One carton containing three 100 mg/10 mL vials **Dose:** 300 mg per IV infusion **Target infusion date:** ___ /___ /_____ (MM/DD/YYYY)

Initial Rx: ○ 300 mg IV infusion over 90 minutes at Day 1 and 2 weeks later

Maintenance Rx: ○ 300 mg IV infusion over 90 minutes every 6 months Refill: _____ times

○ **NMOSD-ONLY Patient is Medically Urgent:** A Medically Urgent patient is a patient who (1) is at immediate risk of permanent disability from either an NMOSD medical crisis or potential attack; (2) is not on an NMOSD maintenance therapy OR has experienced new NMOSD-related disease activity while on current maintenance therapy OR is unable to tolerate current maintenance therapy and (3) requires treatment with UPLIZNA while insurance coverage for UPLIZNA is actively being pursued. I certify that the patient meets the definition of Medically Urgent above.

Administration instructions: Dilute 300 mg (30 mL) in 250 mL 0.9% Sodium Chloride Injection and administer diluted infusion over approximately 90 minutes at an increasing rate: 42 mL/hour for first 30 minutes, followed by 125 mL/hour for the next 30 minutes, then 333 mL/hour until completion.

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.

Signature below indicates prescription authorization and prescriber certification.

X X _____ **Prescriber signature/Dispense as written**
Written or e-signature only; stamps not acceptable.

_____ Prescriber signature (substitutions allowed)

X ___ /___ /_____ **Date** (MM/DD/YYYY)

Prescriber Certification: I certify that the above therapy is medically necessary, that the information provided is accurate to the best of my knowledge and that my patient is being administered UPLIZNA® (inebilizumab-cdon) injection, 300 mg, for intravenous infusion in accordance with the labeled use of the product. I represent that my patient has requested and authorized the disclosure of their personal information to Amgen Inc. and its affiliates and their respective employees or agents (collectively, "Amgen") for Amgen to administer the Amgen By Your Side program (the "Program"), which provides patient-focused support, including providing logistical and non-medical treatment support for UPLIZNA, as prescribed, and educating about the insurance process. I further represent that I have explained to the patient, and the patient indicated they understand and have consented to, the following: 1) Amgen will use the patient's name, date of birth, contact information, prescriptions, and other necessary health information to administer the Program; 2) Amgen will then disclose the patient's personal information to the patient's insurer(s) for the same purposes; 3) the patient can withdraw their consent by contacting Amgen at 1-844-469-4297 or visiting www.amgen.com/DataSubjectRights, but if the patient does not agree to, or withdraws consent for, these uses and disclosures, the patient cannot receive these patient support services for this medication which necessarily requires Amgen to process the patient's personal information; and 4) the patient can view more details about Amgen's privacy practice at www.amgen.com/privacy. I authorize Amgen to transmit this prescription on my behalf to the appropriate pharmacy designated by the patient utilizing their benefit plan by any means allowed under appliable 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 UPLIZNA or any other Amgen product or service, for any other person; (b) my decision to prescribe UPLIZNA 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 Amgen 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. Amgen makes no representation or guarantee concerning coverage or reimbursement for any item or service. On behalf of the patient, Amgen expects the prescriber to coordinate with Amgen By Your Side to provide, to the best of the prescriber's ability, in-network infusion services and work with Amgen By Your Side to effectively communicate both in-network and out-of-network choices and the corresponding financial obligations of the patient connected to each choice. Should the prescriber knowingly perform out-of-network services without the knowledge and consent of the patient, the prescriber cannot balance bill the patient for the out-of-network services. State requirements: I certify that the prescription I am submitting as part of this Patient Enrollment Form complies with my state's prescription requirements (e.g., e-prescribing, state-specific prescription form, fax language). I understand that noncompliance with my state's specific prescription requirements will result in outreach to me to obtain a compliant prescription.
By filling out and signing this form, the enrollment process in Amgen By Your Side has initiated; however, your patient must sign a Patient Authorization to complete enrollment in Amgen By Your Side. Please note that your patient will not benefit from the services and support offered by the Program 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, Amgen will contact the patient to determine whether the patient is interested in signing a separate Patient Authorization.

Medically Urgent Attestation
If I have checked the "Patient is Medically Urgent" box, I understand and agree that (a) my determination that the patient is Medically Urgent is based solely on my professional medical judgment; (b) Amgen will provide UPLIZNA at no cost to the patient, up to limits as set by Amgen; (c) I am actively pursuing insurance coverage for UPLIZNA for the patient, which is a requirement for the patient to be eligible to receive UPLIZNA at no cost; (d) I will not seek reimbursement, including from any government program, insurer, or the patient, for UPLIZNA provided by Amgen at no cost to the patient; and (e) Amgen may modify or terminate Medically Urgent supply at any time without notice.

Uses and Disclosure of Protected Health Information

I authorize Amgen and its data processors (collectively, "Amgen") to collect, use, and disclose my protected health information for the following purposes:

- To operate, administer, enroll me in, and/or continue my participation in the Amgen By Your Side program or any other Amgen-affiliated patient support services and activities related to my condition or treatment (for example, co-pay card programs, reimbursement assistance programs, drug coverage verification, patient access liaison services, adherence program and disease management support);
- To contact, with my permission, my doctor and the rest of my health care team and share with them my health information that may be useful for my care;
- To improve, develop, and evaluate Amgen's products, services, materials and programs related to my condition or treatment.

In order for Amgen to provide me with the services and/or programs described above, Amgen needs to collect and use my personal information, including my protected health information. I understand that my protected health information may include any information, in electronic or physical form, in the possession of or derived from a health care provider, health care plan, pharmacy, pharmaceutical company, laboratory and/or their contractor (each, a "Health Care Provider"). This may include select information from or about my medical history and general health, my health care plan benefits, payment limits or restrictions covered by my health care plan policy, and/or my adherence to my treatment.

I authorize my Health Care Providers to disclose my protected health information to Amgen, and between themselves, as necessary, but only for the purposes stated above in this Authorization. I understand that certain of my Health Care Providers (such as pharmacies and specialty pharmacies) may receive remuneration from Amgen in exchange for disclosing my protected health information and/or for using my information to contact me with communications about Amgen products which have been prescribed to me (for example, medication reminder programs and other patient support services).

Expiration, Right to Obtain a Copy, and Right to Cancel

I understand that by signing this form, I authorize my Health Care Providers or others who might hold my health information to disclose it to Amgen. I also understand I am authorizing my personal information, including my protected health information, to be used for the purposes described above. I understand and agree that by signing below, I am authorizing those who rely on this Authorization to disclose my protected health information for the earlier of five (5) years or until my participation in the Amgen By Your Side program ends through my cancellation, unless a shorter time period is required by state law.

I understand that I can obtain a copy of this Authorization or cancel this Authorization at any time by calling Amgen at 1-844-469-4297 or by writing to Amgen By Your Side, 1 Horizon Way, Deerfield, IL 60015. If I cancel this Authorization, I will no longer qualify for the services described. I also understand that if a Health Care Provider is disclosing my protected health information to Amgen in reliance on this Authorization on an on-going basis, my cancellation with Amgen will be effective with respect to any such Health Care Providers as soon as they receive notice of my cancellation.

No Effect on Treatment

I understand I do not have to sign this Authorization and that my enrollment in any of the services

and/or programs described above is entirely voluntary. I understand that Amgen, as well as Health Care Providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment or other care, to sign this Authorization. Federal Law (including HIPAA) requires a signed authorization in order for Amgen to collect my protected health information from my Health Care Providers. I understand I cannot participate in the listed services and/or programs without signing this Authorization or an equivalent authorization with my Health Care Providers.

Information Received from Health Care Providers

I understand that once my protected health information has been disclosed to Amgen, federal privacy laws may no longer apply and may no longer protect it from further disclosure, and that Amgen may disclose my protected health information to its data processors, contractors, and business partners for its business purposes. Amgen agrees, however, to protect my protected health information by only using and disclosing it as stated in the Authorization or as otherwise allowed or required by law.

U.S. STATE LAW CONSENT TO PROCESS HEALTH DATA FOR AMGEN BY YOUR SIDE

Please read and provide response in Patient Consent and Authorization section on page 2

I consent to Amgen processing my Health Data for the following purposes:

- To enroll me and manage my participation in the Amgen By Your Side program, which includes activities related to my condition or treatment (for example, co-pay card programs, payer medication coverage verification, patient access liaison support, disease management support), and to manage Amgen's products, services, and programs related to my condition or treatment.

Amgen uses the following when it administers the Amgen By Your Side program:

- Health Data – my name (and the name of my caregiver if applicable), gender, date of birth, contact information and information relating to my health condition or treatment.

I understand that my consent to processing is required for me to participate in the Amgen By Your Side program. I also understand that Amgen will not sell my Health Data to third parties, but Amgen may disclose my Health Data to Amgen's data processors, contractors, and business partners for Amgen's business purposes related to the Amgen By Your Side program. I understand that Amgen may use my Health Data to contact me by mail, email, telephone, or text for the above purposes. Mobile Terms & Conditions can be found at AmgenByYourSide.com/mobile-terms-and-conditions. I also understand that if I do not consent to the use of my Health Data for the above purposes, I will not be able to participate in the Amgen By Your Side program. Finally, I understand that I may withdraw my consent to processing my Health Data for the above purposes at any time using one of the methods listed in the Additional Disclosures section below and that if I withdraw my consent, I will no longer be able to participate in the Amgen By Your Side program.

Additional Disclosures

I understand that participation in the Amgen By Your Side program is an optional service at no cost to me. The consent above in no way affects my right to obtain any medications and I do not have to provide consent to be able to receive any medications. To obtain a copy of the consent above or to withdraw my consent to collection, processing, and/or disclosure of my Health Data for any of the above purposes to which I have consented, I can contact Amgen by visiting www.amgen.com/DataSubjectRights or calling 1-844-469-4297. For more information about Amgen's privacy practices, Amgen's Privacy Statement can be found at http://www.amgen.com/privacy

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PURE INFUSION℠

UPLIZNA (inebilizumab-cdon)

AIC Order Form

To ensure swift processing of your order, please complete all fields.

PATIENT INFORMATION

Patient Name:_____ Sex:_____ DOB:_____

Address:_____ City:_____ State: _____ Zip:_____

Phone:_____ Alt. Phone:_____ Height:_____ Weight: _____kg

Allergies:_____ ☐ No Known Drug Allergies

Emergency Contact:_____ Emergency Contact Phone:_____

Alternate Contact:_____ Alternate Contact Phone:_____

Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Therapy change Last Infusion Date (if applicable):_____

Is the patient pregnant, nursing or planning a pregnancy? ☐ Yes ☐ No Does the patient need interpreter services? ☐ Yes ☐ No

PRESCRIBER INFORMATION

Referral Co. Name:_____ Referral Co. Phone:_____

Referral Co. Email:_____ Practice Name:_____

Prescriber's Name:_____ Address:_____

NPI:_____ Tax ID: _____ Phone:_____ Fax:_____

PREFERRED PURE INFUSION LOCATION

City, State:_____

REQUIRED DOCUMENTATION (submit copies of the following with this order form)

☐ Insurance card (front & back)
☐ Current Medications
☐ History/Progress Notes to Support Diagnosis
☐ Hepatitis B surface antigen
☐ Hepatitis B core antibody total
☐ Negative TB
☐ Serum immunoglobulin panel

LAB ORDERS

☐ Required pre-treatment labs to be completed prior to infusion/injection. If lab results are unavailable or outside required timeframes, Pure may obtain required labs.

☐ Other:_____

If patient has port, please complete port order form.

DIAGNOSIS (ICD-10 Codes)

☐ D89.84 IgG4-related disease
☐ G70.00 Myasthenia gravis without (acute) exacerbation
☐ G36.0 Neuromyelitis Optica Spectrum Disorder
☐ G70.01 Myasthenia gravis with (acute) exacerbation
☐ Other: _____

MEDICATION ORDER — DOSE/DIRECTIONS FOR USE

☐ Uplizna® (inebilizumab-cdon)
☐ 300mg IV day 1 and day 15 then every 6 months
☐ 300mg IV every 6 months

Duration: 1 year of treatment unless indicated otherwise here _____

PRE-MEDICATIONS

☐ acetaminophen (Tylenol) ☐ 500 mg PO ☐ 650 mg PO ☐ 1000 mg PO
☐ diphenhydramine (Benadryl) ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ cetirizine (Zyrtec) ☐ 10 mg PO OR ☐ loratadine (Claritin) ☐ 10 mg PO
☐ methylprednisolone (Solu-Medrol) ☐ 40 mg IV ☐ 125 mg IV OR ☐ hydrocortisone (Solu-Cortef) ☐ 100 mg IV
☐ Other:_____ ☐ No pre-medications

UPLIZNA (inebilizumab-cdon)

AIC Order Form

To ensure swift processing of your order, please complete all fields.

PATIENT INFORMATION

Patient Name:_____ DOB:_____

INFUSION REACTION PROTOCOL

☐ Pure Infusion Reaction Protocol

☐ Other Reaction Protocol (please send with order)

_____ _____ _____

Prescriber's Signature | Date | Time