Patient Enrollment Form

Once complete, submit by fax 1-833-469-8333 or email TEPEZZAHPS@horizontherapeutics.com

HORIZON Patient Services™ | TEPEZZA™ teprotumumab-trbw

Information above the blue line should be completed to initiate treatment
Questions? Contact Horizon at 1-833-583-7399

Patient Information (* indicates a required field)

First name* _____ **Middle initial*** _____ **Last name*** _____

Sex*: ☐ Male ☐ Female **Date of birth*:** ____/____/____ (MM/DD/YYYY) Weight (kg) _____

Primary language: _____

Email address _____

Mobile telephone* _____ Home telephone _____

Address* _____

City* _____ **State*** _____ **ZIP Code*** _____

Alternate contact name _____ Alternate contact telephone _____

☐ Yes ☐ No Consent to leave voice message at patient and/or alternate contact telephone?

Diagnosis (* indicates a required field)

Primary diagnosis*: ☐ E05.00 — Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism)

☐ Other: _____

Additional disease manifestation codes: _____

☐ Yes ☐ No Does the patient have documented Thyroid Eye Disease (TED)?

→ If no, the patient is not a candidate for TEPEZZA.

Patient Consent for Services and Financial Support (Optional)

> _____ **Date:** ____/____/____ (MM/DD/YYYY)

Patient signature

Please read consent on page 2.

Physician Information (* indicates a required field)

First name* _____ **Last name*** _____

Address _____

City _____ State _____ ZIP Code _____

NPI #* _____ State license # _____

Clinic/hospital affiliation _____

Office contact _____

Office contact telephone* _____ Fax _____

Email address _____

Preferred communication: ☐ Telephone ☐ Email

Physician specialty*: ☐ Oculoplastic Surgeon ☐ Endocrinologist ☐ Rheumatologist ☐ Neuro-ophthalmologist ☐ Comprehensive Ophthalmologist

☐ Other specialty (please specify): _____

Referring physician _____ Referring physician specialty _____

Information below must be completed by an HCP to receive a summary of the patient's insurance benefits

Insurance Information

☐ Request prior authorization support (please send clinical documentation)

Primary insurance _____ Insurance company telephone _____

Policy # _____ Group # _____

Policyholder's first and last name _____ Policyholder's DOB: ____/____/____ (MM/DD/YYYY)

Secondary insurance _____ Policy #/group # _____

Medicaid/governmental payer _____

Please include front and back copy of insurance card(s) along with this form.

☐ UNINSURED: Patient is ineligible for any health insurance, including Medicare and Medicaid, or has been denied by third-party payer. Please evaluate them for Patient Assistance Program. (Proof of income is required.)

Physician 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 Horizon TED Medications and assistance in initiating or continuing Horizon TED Medications, 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 and 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 Horizon TED Medications, or any other Horizon product or service, for any other person, (b) my decision to prescribe Horizon TED Medications 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 this form, your patient is automatically enrolled into Horizon Patient Services.

Please see Important Safety Information on next page and Full Prescribing Information at TEPEZZAhcp.com.

Infusion Facility (Optional)

☐ Send additional copy of summary of benefits to infusion facility

☐ Yes ☐ No Would you like assistance identifying an infusion facility?

→ If no, please fill out the following for your preferred infusion facility.

Facility name _____

Facility address _____

City _____ State _____ ZIP Code _____

Telephone _____ Fax _____

Facility NPI # _____ Facility tax ID # _____

Prescription Information (Required for specialty pharmacy benefit or home infusion)

Medication: TEPEZZA (teprotumumab-trbw) for injection, for intravenous use // 500mg vial

Duration: 1 infusion every 3 weeks for a total of 8 infusions. Administer the first two infusions over 90 minutes. Subsequent infusions may be reduced to 60 minutes if well tolerated.

Dose: Week 0: _____ mg (10mg/kg) 21 day supply; 1 prescription; no refill

Week 3: _____ mg (20mg/kg) 21 day supply; 1 prescription; 6 refills; q3wk

Include patient weight in Patient Information section above.

Allergies: _____ ☐ No known drug allergies (NKDA)

Route of administration: Peripheral IV ☐ Authorize administration supplies as needed

Please attach a list of concurrent medications.

Fluids for reconstitution/administration: Reconstitute each vial with 10mL of Sterile Water for Injection, USP. Administer via an infusion bag containing 0.9% Sodium Chloride Solution, USP. For doses <1800mg, use a 100mL bag. For doses ≥1800mg, use a 250mL bag.

☐ Nursing orders: Provide skilled nursing visit to administer medication, provide education, and assess patient (required for home infusion).

Physician Certification (Required)

> _____ Dispense as written _____ Substitutions allowed

Date: ____/____/____ (MM/DD/YYYY)

Written or e-signature only; stamps not acceptable.

Patient Consent for Services and Financial Support

(Please read and provide signature in Patient Information section on page 1)

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 Therapeutics 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 my healthcare providers and me about my treatment or condition and related products; (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 or offer me products and services related to my treatment or condition (or other 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 S. Saunders Road, 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.

INDICATION

TEPEZZA is indicated for the treatment of Thyroid Eye Disease.

IMPORTANT SAFETY INFORMATION

Warnings and Precautions

Infusion Reactions: TEPEZZA may cause infusion reactions. Infusion reactions have been reported in approximately 4% of patients treated with TEPEZZA. Reported infusion reactions have usually been mild or moderate in severity. Signs and symptoms may include transient increases in blood pressure, feeling hot, tachycardia, dyspnea, headache, and muscular pain. Infusion reactions may occur during an infusion or within 1.5 hours after an infusion. In patients who experience an infusion reaction, consideration should be given to premedicating with an antihistamine, antipyretic, or corticosteroid and/or administering all subsequent infusions at a slower infusion rate.

Preexisting Inflammatory Bowel Disease: TEPEZZA may cause an exacerbation of preexisting inflammatory bowel disease (IBD). Monitor patients with IBD for flare of disease. If IBD exacerbation is suspected, consider discontinuation of TEPEZZA.

Hyperglycemia: Increased blood glucose or hyperglycemia may occur in patients treated with TEPEZZA. In clinical trials, 10% of patients (two-thirds of whom had preexisting diabetes or impaired glucose tolerance) experienced hyperglycemia. Hyperglycemic events should be managed with medications for glycemic control, if necessary. Monitor patients for elevated blood glucose and symptoms of hyperglycemia while on treatment with TEPEZZA. Patients with preexisting diabetes should be under appropriate glycemic control before receiving TEPEZZA.

Adverse Reactions

The most common adverse reactions (incidence ≥5% and greater than placebo) are muscle spasm, nausea, alopecia, diarrhea, fatigue, hyperglycemia, hearing impairment, dysgeusia, headache, and dry skin.

For additional information on TEPEZZA, please see accompanying Full Prescribing Information.

HORIZON

TEPEZZA™
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