HORIZON BY your side | UPLIZNA® inebilizumab-cdon

PATIENT ENROLLMENT FORM GUIDE

CLICK OR SCAN TO COMPLETE A DIGITAL VERSION OF THE PATIENT ENROLLMENT FORM

THREE EASY STEPS TO INITIATE THE PATIENT ENROLLMENT PROCESS FOR UPLIZNA*:

1. Fill out all required fields as indicated by asterisk and X
2. Complete the signature and date within the Prescriber Certification section
3. Send both the front and back of the patient's insurance card along with completed form

*A patient signature is required to complete the patient enrollment process.

Please see Important Safety Information on last page and Full Prescribing Information.

PATIENT ENROLLMENT FORM GUIDE

The Patient Enrollment Form must be properly filled out in order to get your patients started on UPLIZNA and initiate their enrollment in Horizon By Your Side, a patient support program. This guide is designed to help you understand the different fields on the form and how to complete the form accurately for submission.

Please note: the fields marked with an X or an asterisk are mandatory to initiate the patient enrollment process in Horizon By Your Side, but all fields should be completed to help with communication and coordination throughout the process.

If you have any questions while completing the form, please contact Horizon By Your Side at 1-833-842-8477.

1 PATIENT INFORMATION

Provide the patient demographic and contact information.

- Required fields are needed to conduct a benefits investigation, contact the patient for any follow-up, and provide support from Horizon By Your Side
- Email is optional but greatly helps streamline the process
- Alternate contact information is optional
  - It may be helpful to include a caregiver's information as an alternative contact

2 DIAGNOSIS

Confirm the diagnosis code by filling in the circle next to "Diagnosis." This is required to conduct a benefits investigation.

- Include date of diagnosis
- Fill in the circle next to "Yes" if the patient has ever tested positive for AQP4 antibodies
- Fill in the circles next to any previous NMOSD therapies that the patient has received

3 INSURANCE INFORMATION

Provide the patient's primary insurance information, which is required to conduct a benefits investigation. Results will be delivered after the patient authorization is received.

- Include secondary insurance plan information, if applicable, to improve the accuracy of the benefits investigation
- If the patient does not have any insurance, fill in the circle next to "UNINSURED"

Please include the front and back of your patient's insurance card(s), if available, along with the completed Patient Enrollment Form.

4 PATIENT AUTHORIZATION

A patient signature is required to complete enrollment in Horizon By Your Side, which provides the patient with logistical and non-medical treatment support and education about the insurance process.

- Ensure that the patient has signed and dated the form along with providing their full name
- If the patient can't sign the form at your office, Horizon By Your Side can follow up to obtain patient authorization. Your patient must sign the authorization to complete enrollment and benefit from patient-focused services and resources

Please see Important Safety Information on last page and Full Prescribing Information.

PATIENT ENROLLMENT FORM

Once complete, submit by fax **1-833-329-8477**
or email **UPLIZNAHBYS@horizontherapeutics.com**

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

1 PATIENT INFORMATION (* or X Indicates a required field)

X Jane — First name* | X Brown — Last name*

X Sex*: ○ Male ◉ Female | Date of birth*: X 01/01/1978 (MM/DD/YYYY)

English — Primary language | janebrown@email.com — Email address

X 555-123-1234 — Primary telephone* | Consent to leave voice message at patient and/or alternative contact telephone? ◉ Yes ○ No

○ Home ◉ Cell | Consent to send text message? ◉ Yes ○ No

X 123 Main Street — Address*

X Lake Forest — City* | X IL — State* | X 60045 — ZIP Code*

John Brown — Alternative contact | 555-123-2345 — Alternative contact telephone

2 DIAGNOSIS (* or X Indicates a required field) (Required for benefits investigation)

X Diagnosis*: ◉ G36.0 - Neuromyelitis optica [Devic] Date of diagnosis: 01/01/2021 (MM/DD/YYYY)

X Has the patient ever tested positive for AQP4 antibodies?*: ◉ Yes ○ No

Check all previous NMOSD therapies:

○ None/new diagnosis	○ Satralizumab-mwge	○ Riabni
○ Tocilizumab	○ Eculizumab	○ Ruxience
○ Steroid	○ Rituxan	○ Truxima

○ Other: _____

3 INSURANCE INFORMATION (* or X Indicates a required field) (Please include front and back copies of insurance card(s) with this form)

X Insurance Provider One — Primary insurance* | Insurance Provider Two — Secondary insurance

X 000-000000-01 — Policy #* | 000-000000-02 — Policy #

X Jane Brown — Policyholder's first and last name* | Jane Brown — Policyholder's first and last name

X 555-123-5555 — Insurance company telephone* | 555-123-1111 — Insurance company telephone

X 000001 — Group #* | 000002 — Group #

Policyholder's DOB*: X 01/01/1978 (MM/DD/YYYY) | Policyholder's DOB: 01/01/1978 (MM/DD/YYYY)

○ UNINSURED: Patient is uninsured to my knowledge.

4 PATIENT AUTHORIZATION (Please see authorization language on page 2)

X *Jane Brown* — Patient signature* Please read page 2 | Date*: X 09/05/2023 (MM/DD/YYYY)

X Jane Brown — Printed full name*

Please include page 2 with the Patient Enrollment Form submission.

Please see Important Safety Information on page 2 and see accompanying Full Prescribing Information or visit UPLIZNAhcp.com.

P-UPZ-00050-6

5 PRESCRIBER INFORMATION (* or X Indicates a required field)

X Sarah — First name* | X Williams — Last name*

X 123 Medical Way — Address*

X Lake Forest — City* | X IL — State* | X 60045 — ZIP Code*

X 0000000000 — NPI #* | X 00-0000000 — Tax ID #* | X 000000 — State license #*

Memorial Hospital — Clinic/hospital affiliation

Sam Davis — Office contact name

X 555-123-2222 — Office contact telephone* | X 555-123-9999 — Fax*

drsarahwilliams@memorialhospital.com — Email address

Preferred communication: ○ Telephone ◉ Email

Prescriber specialty: Neurologist

6 INFUSION FACILITY

Do you have a preferred infusion facility? ○ Yes ◉ No If yes, please provide the preferred infusion facility information below. If no, Horizon By Your Side will provide options for your patient.

Facility name

Facility address

City | State | ZIP Code

Telephone | Fax

Facility NPI # | Facility tax ID #

7 PRESCRIPTION INFORMATION (Required for specialty pharmacy)

Prescription Information: UPLIZNA® (inebilizumab-cdon) **ICD-10 code:** G36.0

NDC: 75987-150-03: One carton containing three 100 mg/10 mL vials

Dose: 300 mg per IV infusion **Target infusion date:** 01/01/2024 (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: 2 times

○ **Patient is Medically Urgent:** Medically Urgent means a patient who (1) is at risk of permanent disability from either an NMOSD medical crisis or potential attack; (2) is either: (i) not on an NMOSD maintenance therapy OR (ii) on an alternate maintenance therapy; and (3) requires accelerated treatment with UPLIZNA because a viable insurance access pathway is not available prior to the proposed first infusion date, resulting in a delay in receiving treatment. I certify that the treatment of the Patient is Medically Urgent per the definition above, requiring accelerated access to UPLIZNA.

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.

PRESCRIBER CERTIFICATION (Please see certification language on page 2)

X *Sarah Williams* — Prescriber signature/Dispense as written* | Substitutions allowed. Written or e-signature only; stamps not acceptable.

Date*: X 09/05/2023 (MM/DD/YYYY)

The above signature grants permission to share records with the co-management team and infusion facility.

X ◉ **I certify that the above therapy is medically necessary for the treatment of neuromyelitis optica spectrum disorder (NMOSD).***

I authorize Horizon Therapeutics USA, Inc. and its affiliates and their respective employees or agents (collectively, "Horizon") to transmit the above prescription by any means allowed under applicable law to the appropriate specialty pharmacy for my patient.

CHOOSE 1 OF THE 3 METHODS BELOW TO SUBMIT THE PATIENT ENROLLMENT FORM:

Fax: 1-833-329-8477
Email: UPLIZNAHBYS@horizontherapeutics.com
Via DocuSign at UPLIZNArx.com

CLICK OR SCAN TO COMPLETE A DIGITAL VERSION OF THE PATIENT ENROLLMENT FORM.

5 PRESCRIBER INFORMATION

Provide the prescriber name, contact information, NPI, Tax ID, and state license numbers, which are required for processing.

- Include the office contact name to ensure proper follow-up
- Including email address helps to streamline communication throughout the access journey

6 INFUSION FACILITY

Indicate whether you have a preference for the infusion facility where your patient will receive UPLIZNA.

- If you do not have a specific preference, Horizon By Your Side will provide options based on the patient's insurance and proximity to the patient
- Providing NPI or Provider Transaction Access Number (PTAN) helps verify network status

7 PRESCRIPTION INFORMATION

This section should be completed, as it can be used as a prescription by the specialty pharmacy or the infusion center.

- If known, provide the target infusion date
- Fill in the circle next to "Initial Rx" and/or "Maintenance Rx." Please also include the number of refills
- Fill in the circle next to "Patient is Medically Urgent" if the patient meets the criteria as described on the Patient Enrollment Form

8 PRESCRIBER CERTIFICATION

The Prescriber Certification is required for processing the Patient Enrollment Form.

- Ensure that the prescriber has signed and dated the form and checked the appropriate attestation box
  - The attestation confirms that the therapy is medically necessary for documented neuromyelitis optica spectrum disorder (NMOSD)

UPLIZNA® inebilizumab-cdon

INDICATION AND IMPORTANT SAFETY INFORMATION

INDICATION

UPLIZNA (inebilizumab-cdon) is indicated for the treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive.

IMPORTANT SAFETY INFORMATION

UPLIZNA is contraindicated in patients with:

- A history of life-threatening infusion reaction to UPLIZNA
- Active hepatitis B infection
- Active or untreated latent tuberculosis

WARNINGS AND PRECAUTIONS

Infusion Reactions: UPLIZNA can cause infusion reactions, which can include headache, nausea, somnolence, dyspnea, fever, myalgia, rash, or other symptoms. Infusion reactions were most common with the first infusion but were also observed during subsequent infusions. Administer pre-medication with a corticosteroid, an antihistamine, and an anti-pyretic.

Infections: The most common infections reported by UPLIZNA-treated patients in the randomized and open-label periods included urinary tract infection (20%), nasopharyngitis (13%), upper respiratory tract infection (8%), and influenza (7%). Delay UPLIZNA administration in patients with an active infection until the infection is resolved.

Increased immunosuppressive effects are possible if combining UPLIZNA with another immunosuppressive therapy.

The risk of Hepatitis B Virus (HBV) reactivation has been observed with other B-cell-depleting antibodies. Perform HBV screening in all patients before initiation of treatment with UPLIZNA. Do not administer to patients with active hepatitis.

Although no confirmed cases of Progressive Multifocal Leukoencephalopathy (PML) were identified in UPLIZNA clinical trials, JC virus infection resulting in PML has been observed in patients treated with other B-cell-depleting antibodies and other therapies that affect immune competence. At the first sign or symptom suggestive of PML, withhold UPLIZNA and perform an appropriate diagnostic evaluation.

Patients should be evaluated for tuberculosis risk factors and tested for latent infection prior to initiating UPLIZNA.

Vaccination with live-attenuated or live vaccines is not recommended during treatment and after discontinuation, until B-cell repletion.

Reduction in Immunoglobulins: There may be a progressive and prolonged hypogammaglobulinemia or decline in the levels of total and individual immunoglobulins such as immunoglobulins G and M (IgG and IgM) with continued UPLIZNA treatment. Monitor the level of immunoglobulins at the beginning, during, and after discontinuation of treatment with UPLIZNA until B-cell repletion especially in patients with opportunistic or recurrent infections.

Fetal Risk: May cause fetal harm based on animal data. Advise females of reproductive potential of the potential risk to a fetus and to use an effective method of contraception during treatment and for 6 months after stopping UPLIZNA.

Adverse Reactions: The most common adverse reactions (at least 10% of patients treated with UPLIZNA and greater than placebo) were urinary tract infection and arthralgia.

Please see Full Prescribing Information.

UPLIZNA™
inebilizumab-cdon