Uplizna® Patient Referral Form

uplizna® inebilizumab-cdon

Phone **1-833-ViB-VIPs** (1-833-842-8477) • Fax **1-833-FAX-VIPs** (1-833-329-8477)
Print legibly using blue or black ink.

This form serves a dual purpose. It will enroll the patient in Viela VIPs and also serves as a prescription for Uplizna.

☐ I opt not to enroll in Viela VIPs. I understand that this will not affect my ability to receive Uplizna.

Patient completes Step 1 and Step 2 below, then Patient Authorization on page 3.

Step 1: Patient Information

First Name: MI: Last Name:

Address: City: State: Zip:

DOB: / / Gender: ◯ Male ◯ Female

Preferred Phone #: Can we leave a message?

Alternate Authorized Contact: Phone #: Relationship to Patient:

Step 2: Insurance Information

(If available, provide copies of the front and back of insurance cards and submit with this form.)

Primary Insurance:	**Secondary Insurance:**
Policy Holder:	Policy Holder:
Policy ID #: *	Policy ID #: *
Group #:	Group #:
Phone #:	Phone #:

Prescription Card (Name)

Group #: ID #: Rx BIN #: PCN #:

* At least one ID # is needed

Complete the Patient Authorization on Page 3

Please see full Important Safety Information on Page 5.

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Physician office completes Step 3 and Step 4, then Statement of Medical Necessity on page 4.

Step 3: Prescriber Information

First Name: Last Name:

Specialty:

Institution/Office:

Address: City: State: Zip:

Phone: Fax: Email:

NPI #: State License #: Tax ID:

Contact Person: Phone # (direct): Email:

Step 4: Uplizna Prescription

℞

Patient Name: Patient Date of Birth: / /

☐ Provided by Specialty Distributor (Buy & Bill): Cardinal Health (prescription does not need to be completed)

☐ Provided by Specialty Pharmacy: PANTHERx Rare

Prescription Information: Uplizna® (inebilizumab-cdon) ICD 10 # G36.0
NDC # 72677-551-01: Carton containing three 100 mg/10mL vials

Dose: 300 mg per IV infusion

Initial Rx: ☐ 300 mg IV infusion over 90 minutes at week 0 & week 2 Refill: 0 times

Maintenance Rx: ☐ 300 mg IV infusion over 90 minutes every 6 months for chronic usage Refill: ___ times

☐ I certify that the above therapy is medically necessary for the treatment of neuromyelitis optica spectrum disorder (NMOSD). The information provided is accurate to the best of my knowledge. I appoint Viela VIPs, on my behalf, to convey this prescription to the dispensing pharmacy.

The prescriber's signature is required to initiate registration in Viela VIPs and to fill the prescription for Uplizna.

Prescriber Signature (Substitution permitted)

Prescriber Signature (Dispense as written)

Date

Date

Step 5: Site of Care*

Place of Infusion: ☐ Prescriber's office ☐ Other HCP office ☐ Hospital outpatient ☐ Other

Infusion Site Name:

Site Contact Name: Phone: Fax:

Address: City: State: Zip:

Infusion Site NPI #: PTAN #:

Infusion Site Tax ID #:

*Required

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Patient completes Patient Authorization below.

Patient Authorization

By signing this authorization ("Authorization"), I hereby certify and agree to the following:

I am (i) the Patient and legally permitted to make decisions about how my health information is used and disclosed or (ii) the parent, legal guardian, or authorized representative of the Patient and legally permitted to make decisions about how the Patient's health information is used and disclosed.

I authorize my healthcare providers and staff to disclose my Protected Health Information (PHI) to Viela Bio (including Viela VIPs and its affiliates, vendors and business partners who are performing services related to this program) as related to the use of and/or need for Uplizna. Viela Bio may further disclose my information to other healthcare providers, pharmacies, insurance companies, prescription drug plans, and other third-party payers in order to (1) Determine the Patient's insurance eligibility, coverage and payment obligations for Uplizna; (2) Provide Uplizna and related services to the Patient and to coordinate care for the Patient related to the Patient's Uplizna prescription; (3) Provide the Patient with ongoing support services such as patient education, information about treatment adherence programs, educational resources, reminder calls, emails, letters or text messages; (4) Address adverse events and product quality complaints.

I authorize Viela Bio to use and give out my Personal Health Information to send me information or materials related to Uplizna (or any other related products or services in which I might be interested), and to contact me occasionally to get my feedback (for market research purposes) about Uplizna or Uplizna Programs, as required or permitted by law. I understand that my Personal Health Information disclosed under this authorization may be redisclosed by Viela Bio and is no longer protected by federal privacy laws.

I understand that I can refuse to sign this Authorization and that this will not affect my ability to receive Uplizna; payment for treatment; enrollment in a health plan; or eligibility for benefits. However, if I do not sign this Authorization, I will not be able to receive support services from Viela VIPs.

I understand that I may cancel this Authorization at any time by calling 833-842-8477.

This authorization expires one year after the date the form is signed. I acknowledge that this Authorization may authorize uses and disclosures of the Patient's information even after the Patient has stopped using Uplizna. I understand that information disclosed pursuant to this Authorization could be re-disclosed by Recipients. Such re-disclosed information may no longer be protected by federal or state medical privacy laws, including the federal Health Insurance Portability and Accountability Act (HIPAA).

I have received a copy of this Authorization:

Patient Signature*: _____ Date: _____

Guardian Signature: _____ Date: _____

Relationship to Patient: _____

* If patient and/or caregiver are unable to sign the form, verbal attestation can be provided by calling Viela VIPs at 1-833-842-8477.

Please see full Important Safety Information on Page 5.

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Fax Completed Forms to: **1-833-FAX-VIPs** (1-833-329-8477)
For questions, call **1-833-ViB-VIPs** (1-833-842-8477)

Physician office completes Statement of Medical Necessity below.

Patient Name/Information*:

First Name: MI: Last Name: DOB: / /

Drug Allergies:

Diagnosis*: ☐ ICD 10 G 36.0 Neuromyelitis Optica Spectrum Disorder (NMOSD)

Date of Diagnosis: / /

Method of Diagnosis (check all that apply):

☐ Clinical signs and symptoms

AQP4 Test*: ☐ Positive ☐ Negative

Clinical Signs and Symptoms:

Visually Impaired Yes ☐ No ☐

Mobility Impaired Yes ☐ No ☐

EDSS Score:

Loss of bladder/bowel control Yes ☐ No ☐

Number of attacks to date: Date of last attack: / /

Prior Treatments for NMOSD (check all that apply):

Therapy: ☐ inebilizumab ☐ rituximab ☐ eculizumab ☐ azathioprine ☐ mycophenolate mofetil

Date of last dose (for most recent therapy): / /

Anticipated date of Uplizna infusion: / /

I certify that the above therapy is medically necessary for the treatment of NMOSD and that the information provided is accurate to the best of my knowledge. I appoint Viela VIPs on my behalf, to provide this form or any information contained on this form to the insurer of the above-named patient or to the dispensing pharmacy.

Prescriber's Name (please print):

Prescriber's Signature: Date:

State License #

*Required

Please see full Important Safety Information on Page 5.

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 at www.Uplizna.com.

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