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ACTIMMUNE® (Interferon gamma-1b) PATIENT ENROLLMENT FORM INSTRUCTIONS

The ACTIMMUNE® (Interferon gamma-1b) Patient Enrollment Form is required to initiate treatment with ACTIMMUNE®.

Instructions:

1. Complete all required patient information.
2. Complete all required insurance information for the patient and, if possible, attach a copy of the patient's insurance card.
3. Complete the diagnosis and prescription information in its entirety; all fields are required. The patient's healthcare provider should fill out this section.
4. Complete all required prescriber information, including the contact information for the practice or facility.
5. A signature is required from the patient's healthcare provider.
6. Fax the completed form to TranscendRare at **1 (877) 305-7706**.
7. Check in with your patient to ensure he or she has completed the Patient Authorization Form. It must be completed and sent in to initiate services.
8. If you have any questions or comments, please contact TranscendRare at **1 (877) 305-7704**.

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Please fax the completed form to 1 (877) 305-7706
Phone: 1 (877) 305-7704
Please visit www.ACTIMMUNE.com/support

ACTIMMUNE® (Interferon gamma-1b) PATIENT ENROLLMENT FORM

All new referral patients must complete the ACTIMMUNE® (Interferon gamma-1b) Patient Enrollment Form.

Patient Information (* indicates required field)

Patient Name*: ______ DOB*: ___/___/___ Gender*: ☐ Male ☐ Female Height: ___ Weight: ___

Address*: ______ City*: ______ State*: ______ Zip Code*: ______

Preferred Phone*: (___) ______ Alternate Phone: (___) ______ Email: ______

Caregiver/Alternate Contact Name: ______ Relationship: ______ Phone*: (___) ______

Preferred Contact: ☐ Patient ☐ Caregiver Preferred Type: ☐ Phone (Day) ☐ Phone (Evening) ☐ Email Preferred Language: ______

Is your patient currently on ACTIMMUNE®?: ☐ Yes ☐ No If Yes, provide last date of use: ______

Dihydrorhodamine (DHR) Test

Is the DHR test covered by your patient's insurance? ☐ Yes ☐ No

Insurance Information (* indicates required field) **Please attach copies of insurance card(s), if available.**

Primary Insurance Company*: ______ Phone*: (___) ______

Policy Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Other Policy #: ______ Group #: ______

Policyholder Name*: ______ Relationship: ______ DOB: ___/___/___

Secondary Insurance Company: ______ Phone: (___) ______

Policy Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Other Policy #: ______ Group #: ______

Policyholder Name: ______ Relationship: ______ DOB: ___/___/___

Prescription Card?: ☐ Yes If Yes, Carrier*: ______ Phone*: (___) ______

Identification #: ______ Bin #: ______ Policy/Group #: ______

Policyholder Name*: ______ Relationship: ______ DOB: ___/___/___

Diagnosis Information and Prescription Information (ALL fields required)

☐ Chronic Granulomatous Disease (CGD) ICD-10: D71
☐ Severe, Malignant Osteopetrosis ICD-10: Q78.1
☐ Other: ______ (ICD-10: ______)

Rx: ACTIMMUNE® (Interferon gamma -1b)
100 mcg (2 million IU)/0.5 mL, single-use vials

Sig: ______ mcg SubQ: ______ (frequency of dosing)

Vial Qty: ☐ 12 ☐ Other: ______ Refills: ______

Anticipated Start Dart: ______

Injection Setting: ☐ Physician's Office ☐ Home ☐ Other: ______

Ancillary Supplies:
☐ 0.3 mL 31 G 5/16″ Qty: ☐ 12 ☐ Other: ______
☐ 0.5 mL 30 G 5/16″ or 1/2″ Qty: ☐ 12 ☐ Other: ______
☐ 1 mL 30 G 1/2″ Qty: ☐ 12 ☐ Other: ______
☐ Alcohol Swabs: Qty: ☐ 12 ☐ Other: ______
☐ No Substitute

I certify that therapy is medically necessary and that this information is accurate to the best of my knowledge. Please comply with state-specific prescription requirements. Noncompliance with state-specific requirements could result in outreach to the prescriber.

______ Dispense as Written (No Stamps Allowed) Date

______ Product Substitution Permitted (No Stamps Allowed) Date

Prescriber Information (* indicates required field)

First and Last Name*: ______ Credentials: ______

NPI #*: ______ State License #: ______ State Issued: ______ Tax ID*: ______ Specialty*: ______

Practice/Facility Name*: ______ Primary Contact Name*: ______

Address*: ______ City*: ______ State*: ______ Zip Code*: ______

Phone*: (___) ______ Fax: (___) ______ Prescriber Email: ______

Referring Physician: ______

Prescriber Acknowledgement: 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 Pharma and its employees or agents (collectively, "Horizon") will use this information to administer the TranscendRare program (the "Program"), which provides assistance to patients in obtaining coverage for ACTIMMUNE® (Interferon gamma-1b) and assistance in initiating or continuing ACTIMMUNE® (Interferon gamma-1b). By my signature, I also acknowledge that my patient or his or 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 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 ACTIMMUNE® (Interferon gamma-1b), or any other Horizon product or service, for any other person, (b) my decision to prescribe ACTIMMUNE® (Interferon gamma-1b) 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.

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 chronic granulomatous disease or severe, malignant osteopetrosis patient is automatically enrolled into the Nurse Educator Program.

☐ Check here if you choose not to enroll this patient into the Nurse Educator Program.

Prescriber Name*: ______ Date: ______

Prescriber Signature*: ______ Dispense as Written (No Stamps Allowed) ______ Substitution Allowed

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Please see the Important Safety Information for ACTIMMUNE® on the following page. For more information on ACTIMMUNE®, please see the Full Prescribing Information and Information for Patient/Caregiver available at ACTIMMUNE.com.

Please fax the completed form to 1 (877) 305-7706
Phone: 1 (877) 305-7704
Please visit www.ACTIMMUNE.com/support

IMPORTANT SAFETY INFORMATION

What is ACTIMMUNE® (Interferon gamma-1b) used for?

ACTIMMUNE® is part of a drug regimen used to treat Chronic Granulomatous Disease, or CGD. CGD is a genetic disorder, usually diagnosed in childhood, that affects some cells of the immune system and the body's ability to fight infections effectively. CGD is often treated (though not cured) with antibiotics, antifungals, and ACTIMMUNE.

ACTIMMUNE is also used to slow the worsening of severe, malignant osteopetrosis (SMO). SMO is a genetic disorder that affects normal bone formation and is usually diagnosed in the first few months after birth.

When should I not take ACTIMMUNE?

Don't use ACTIMMUNE if you are allergic to interferon-gamma, *E coli*-derived products, or any ingredients contained in the product.

What warnings should I know about ACTIMMUNE?

At high doses, ACTIMMUNE can cause (flu-like) symptoms, which may worsen some pre-existing heart conditions.

ACTIMMUNE may cause decreased mental status, walking disturbances, and dizziness, particularly at very high doses. These symptoms are usually reversible within a few days upon dose reduction or discontinuation of therapy.

Bone marrow function may be suppressed with ACTIMMUNE, and decreased production of cells important to the body may occur. This effect, which can be severe, is usually reversible when the drug is discontinued or the dose is reduced.

Taking ACTIMMUNE may cause reversible changes to your liver function, particularly in patients less than 1 year old. Your doctor should monitor your liver function every 3 months, and monthly in children under 1 year.

In rare cases, ACTIMMUNE can cause severe allergic reactions and/or rash. If you experience a serious reaction to ACTIMMUNE, discontinue it immediately and contact your doctor or seek medical help.

What should I tell my healthcare provider?

Be sure to tell your doctor about all the medications you are taking.

Tell your doctor if you:

- are pregnant or plan to become pregnant or plan to nurse
- have a cardiac condition such as irregular heartbeat, heart failure, or decreased blood flow to your heart
- have a history of seizures or other neurologic disorders
- have, or have had, reduced bone marrow function. Your doctor will monitor these cells with blood tests at the beginning of therapy and at 3-month intervals on ACTIMMUNE therapy

What are the side effects of ACTIMMUNE?

The most common side effects with ACTIMMUNE are "flu-like" symptoms such as fever, headache, chills, muscle pain, or fatigue, which may decrease in severity as treatment continues. Bedtime administration of ACTIMMUNE may help reduce some of these symptoms. Acetaminophen may be helpful in preventing fever and headache.

What other medications might interact with ACTIMMUNE?

Some drugs may interact with ACTIMMUNE to potentially increase the risk of damage to your heart or nervous system, such as certain chemotherapy drugs. Tell your doctor about all other medications you are taking.

Avoid taking ACTIMMUNE at the same time as a vaccination.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088. You may also contact the Horizon Pharma Medical Information Department toll-free at 1-866-479-6742 or medicalinformation@horizonpharma.com.

The risk information provided here is not comprehensive. To learn more, talk about ACTIMMUNE with your healthcare provider or pharmacist. The FDA-approved product labeling can be found at http://www.ACTIMMUNE.com or 1-866-479-6742.

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P-ACT-00221 October 2017

TranscendRare

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ACTIMMUNE® (Interferon gamma-1b) PATIENT AUTHORIZATION FORM INSTRUCTIONS

The ACTIMMUNE® (Interferon gamma-1b) Patient Authorization Form gives Horizon Pharma and the Horizon TranscendRare team the ability to provide support for patients on ACTIMMUNE®. The services include prescription management, support in securing reimbursement, information regarding independent patient financial support programs, drug shipment, and refills outreach to qualified patients prescribed ACTIMMUNE®.

Instructions:

1. Read the HIPAA Authorization, and complete the fields below it.
2. Fax the completed form to TranscendRare at **1 (877) 305-7706**. The form may also be mailed to TranscendRare at The Lash Group, 9715 Key West Avenue, Rockville, MD 20850.
3. For any questions about completing this form, please contact TranscendRare at **1 (877) 305-7704**.

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ACTIMMUNE® (Interferon gamma-1b) PATIENT AUTHORIZATION FORM

Please fax the completed form to 1 (877) 305-7706.

HIPAA Authorization

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 Pharma 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, "TranscendRare™") for the following purposes: (1) to establish eligibility for benefits; (2) to communicate with healthcare providers and me about my medical care; (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 TranscendRare™ and/or Horizon, including nursing or patient access support services (government-reimbursed programs may not be eligible for all support services offered; please contact TranscendRare™ for determination); and (6) to send me marketing information related to my treatment or condition (or related 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 TranscendRare™ 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 TranscendRare™, Lash Group, Inc., 9717 Key West Avenue, Rockville, MD 20850, 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.

Date: ____________________

Patient's Printed Name: ____________________

Patient's/Legally Authorized Representative's Signature: ____________________

Legally Authorized Representative's Printed Name (if required): ____________________

Patient's/Legally Authorized Representative's Home Address:

Street Address: ____________________

City: ____________________ State: ________ Zip Code: ________

Patient's/Legally Authorized Representative's Telephone: ____________________ ☐ Home ☐ Mobile

Patient's/Legally Authorized Representative's Email Address: ____________________

Legally Authorized Representative's Relationship to Patient: ☐ Spouse ☐ Parent/Legal Guardian ☐ Representative per Power of Attorney

For more information on ACTIMMUNE®, please see the Full Prescribing Information and Information for Patient/Caregiver available at ACTIMMUNE.com.

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P-ACT-00321 November 2017