COMPASS℠
Comprehensive Personalized Patient Prescription Advocacy & Support Services

Phone: 877-305-7704
Fax: 877-305-7706
www.compassforpatients.com
COMPASS℠ Program Hours: 8 AM EST - 6 PM EST

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

Patient Information (*indicates required field)

Patient Name*: _____ DOB*: ___/___/_____ Gender*: ☐ Male ☐ Female
Address*: _____ Height: _____ Weight: _____ Email: _____
City*: _____ State*: _____ Zip Code*: _____ Primary Language; if not English: _____
Phone: (___) _____ Alternate (Cell) Phone: (___) _____
Caregiver/Alternate Contact Name: _____ Preferred Contact Time: ☐Morning ☐Afternoon ☐Evening
Caregiver Relationship: _____ Phone: (___) _____ Is your patient currently on ACTIMMUNE®? Yes ☐ No ☐
Preferred Contact: ☐ Patient ☐ Caregiver If Yes, provide last date of use: _____

Dihydrorhodamine (DHR) Test

☐ Please check the box, to confirm insurance benefit coverage for the DHR test.

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 #*: _____
Policy Holder Name*: _____ Relationship: _____ DOB: ___/___/_____

Secondary Insurance Company: _____ Phone*: (___) _____
Policy Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Other Policy #: _____ Group: _____
Policy Holder Name: _____ Relationship: _____ DOB: ___/___/_____

Prescription Card Carrier Name*: _____ Phone: (___) _____
Identification #: _____ Bin #: _____ Policy/Group#: _____
Policy Holder Name*: _____ Relationship: _____ DOB: ___/___/_____

Diagnosis 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)
100mcg (2 million IU)/0.5ml, single-use vials
Sig: _____mcg SubQ: _____(frequency of dosing)

Vial Qty: ☐ 12 ☐ Other: _____ Refills: _____

Anticipated Start Date: _____
Injection Setting: ☐ Physician's Office ☐ Home ☐ Other: _____
Ancillary Supplies:
☐ 0.3mL 31G 5/16" Qty: ☐ 12 ☐ Other: _____
☐ 0.5mL 30G 5/16" or 1/2" Qty: ☐ 12 ☐ Other: _____
☐ 1mL 30G 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. Non-compliance 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 Acknowledgment: I authorize COMPASS℠ administered by Lash Group, Inc. ("Lash") to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use and disclose any information about any of my patients enrolled with COMPASS℠ to the insurer of such patients and to obtain any information about such patients, including any protected health information (as defined in 45 CFR 160.103), from the insurer, including eligibility and other benefit coverage information, for my payment and/or healthcare operation purposes. I authorize Lash to contact the patient to report coverage information and to inform them about the financial assistance programs offered by COMPASS℠. Lash may de-identify any and all protected health information of my patients, provided that the de-identification complies with the requirements set forth in 45 CFR 164.514(b). I authorize Lash to provide the prescription to the dispensing pharmacy provider, as permitted under state law. As my business associate, Lash is required to comply with, and by my signature hereto and that of Lash, each agrees to comply with the terms of the Business Associate Agreement ("BAA") at www.lashgroup.com/BAA and Lash will safeguard any protected health information that it obtains from me or on my behalf, and will use and disclose this information only for the purposes specified in BAA or as otherwise permitted by law. I permit COMPASS℠ to correspond with and submit applicable paperwork to health insurance providers on behalf of my office with respect to their prior authorization processes. I understand that Horizon Pharma, manufacturer of ACTIMMUNE®, provides funding for COMPASS℠ and the services performed by the program.

By filling out this form, your Chronic Granulomatous Disease or Severe, Malignant Osteopetrosis patient is automatically enrolled into the Clinical Nurse Educator Program

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

Prescriber Name: _____ Prescriber Signature*: _____ Date*: _____
(No Stamps Allowed)

Please see Important Information about ACTIMMUNE® on page 2. For more information on ACTIMMUNE®, please see Full Prescribing Information (PI) and Information for Patient/Caregiver (IPC) included with this piece.

HORIZON PHARMA

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Please fax the completed form to 877-305-7706. **Patients must also complete Page 2**.

Patient Name:_____ **DOB:**____/____/____

Please sign HIPAA Authorization Section before returning.

HIPAA Authorization

By signing this Authorization, I authorize my health plans, physicians and pharmacy providers ("Health Plans and Providers") to disclose my personal health information or the personal health information of the patient/minor child for whom I am the parent or legal guardian relating to my (or my child's) medical conditions, treatment, care management, and health insurance and my need for and use of ACTIMMUNE® (Interferon gamma-1b) ("Personal Health Information"), to The Lash Group, Inc. as administrator of the Comprehensive Personalized Patient Prescription Advocacy & Support Services Program ("COMPASS℠ Program") of Horizon Pharma and its representatives, agents, and contractors (collectively "The Lash Group") for the following purposes:

(1) to establish eligibility for benefits; (2) to facilitate communication among health care providers and me about my (or my child's) medical care; (3) to facilitate the provision of products, supplies or services by third parties; (4) to register me in any applicable product registration program required for my/my child's treatment;(5) enroll me/my child/custodian in eligible patient support programs offered by the COMPASSQK Program, including certain nursing support services (Government reimbursed programs may not be eligible for all support services offered, please contact the COMPASS℠ Program for determination); (6) for me/my child to receive communications from The Lash Group regarding my participation in or experience with the COMPASSQK Program.

I understand and agree that my/my child's specialty pharmacy (Accredo, Curascript, CVS Health, Walgreens or other specialty pharmacies) may receive remuneration from Horizon Pharma in exchange for disclosing my/my child's Personal Health Information to The Lash Group. I understand Horizon Pharma, Inc. may use and give out my information to send me information or materials related to ACTIMMUNE® (or any other related products or services in which I might be interested), to contact me occasionally to get my feedback (for market research purposes) about ACTIMMUNE® or COMPASSQK otherwise as required or permitted by law. I understand that my/my child's Personal Health Information disclosed under this authorization may be redisclosed by The Lash Group and is no longer protected by federal privacy laws. I understand that I may refuse to sign this Authorization and that my/my child's treatment, payment, enrollment or eligibility for benefits, is not conditioned on my signing this Authorization. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to The 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 Health Plans and Providers based on this Authorization before they learn that I have cancelled it. This authorization expires upon the earlier of ten (10) years from the date signed or as required by state law. A photocopy of this authorization will be treated in the same manner as the original.

Patient/Personal Representative Signature*: _____ Date*: _____
Patient/Personal Representative Printed Signature: _____

Important Information About ACTIMMUNE

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

ACTIMMUNE® (Interferon gamma 1-b) 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 www.ACTIMMUNE.com or 1-866-479-6742.

For more information about ACTIMMUNE®, please see Full Prescribing Information (PI) and Information for Patient/Caregiver (IPC) included with this piece.

P-ACT-00023

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