# PATIENT ENROLLMENT AND PRESCRIPTION FORM

gamifant® emapalumab-lzsg

**Phone: 1-833-597-6530**
**Website: www.Gamifant.com**
**Email: gamifantpatientservices@rxallcare.com**

Fax the Start Form to Gamifant Patient Services at **1-866-895-7204**.
Fields marked with * are required.

## PATIENT INFORMATION

*Last Name: _____ *First Name: _____ Middle Initial: ___
*Date of Birth: _____/_____/_____ *Sex: ☐ Male ☐ Female *US Resident: ☐ Yes ☐ No

## PARENT/CAREGIVER INFORMATION

*Last Name: _____ *First Name: _____ Middle Initial: ___
*Street: _____ Unit:_____ *City: _____ *State: _____ *ZIP Code: _____
*Preferred Contact Method: ☐ Mobile Phone ☐ Home Phone ☐ Text ☐ Email Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening
*☐ Mobile Phone #: _____ ☐ Home Phone #: _____ *Email: _____
*Preferred Language: _____

***Patient or Caregiver Signature:** _____ ***Date:** _____/_____/_____
*Patient or Caregiver Name (please print): _____ *Relationship to Patient: _____

## INSURANCE INFORMATION

Please fax a copy of all insurance cards (front and back) to Gamifant Patient Services ☐ **No insurance**

***Primary Medical Insurance:** _____ Insurance Phone #: _____
*Policyholder Full Name: _____ *Policyholder Date of Birth: _____/_____/_____
*Relationship to Patient: _____ *Group #: _____ *Member ID #: _____
**Secondary Medical Insurance:** _____ Insurance Phone #: _____
Policyholder Full Name: _____ Policyholder Date of Birth: _____/_____/_____
Relationship to Patient: _____ Group #: _____ Member ID #: _____
*Prescription Insurance: _____ *RxGroup:_____ *RxBin:_____ *RxPCN: _____

## PRESCRIBER AND INSTITUTION INFORMATION

*Last Name: _____ *First Name: _____ *Institution Name: _____
*Street: _____ Suite:_____ *City: _____ *State: _____ *ZIP Code: _____
*NPI #: _____ *DEA #: _____ *Tax ID #: _____
*Phone #: _____ Ext.: _____ *Fax #: _____ *Email: _____
*Specialty: _____ *Preferred Contact Method: ☐ Phone ☐ Fax ☐ Email
Administrative Contact Name: _____ Administrative Contact Phone #: _____
Administrative Contact Email: _____

## PHARMACY INFORMATION

Pharmacy Contact Name: _____ Institution Name: _____
Street: _____ City: _____ State: ____ ZIP Code: _____
Phone #: _____ Ext.: _____ Fax #: _____ Email: _____
Prior Authorization Contact Name: _____ Prior Authorization Contact Email: _____
Prior Authorization Contact Phone #: _____

## SITE OF CARE

☐ Inpatient ☐ Outpatient ☐ Other: _____
Site of Care Name: _____ Hospital Admission Date: _____/_____/_____
Street: _____ City: _____ State: ____ ZIP Code: _____

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## PRESCRIPTION INFORMATION

**Gamifant® Indication:** Gamifant is indicated for the treatment of adult and pediatric (newborn and older) patients with primary hemophagocytic lymphohistiocytosis with refractory, recurrent or progressive disease or intolerance with conventional HLH therapy.

Diagnosis: ☐ Primary hemophagocytic lymphohistiocytosis (pHLH) ☐ Other: _____

Patient Weight: _____kg Anticipated Start Date: _____/_____/_____ Anticipated Starting Dose: _____mg

## DIRECTIONS

Infuse 1 mg/kg intravenously over 1 hour twice a week (every 3 to 4 days). Titrate dosing as necessary: on Day 3 increase dosage to 3 mg/kg, on Day 6 increase it to 6 mg/kg, and on Day 9 increase it to 10 mg/kg.

Note: Dosing and administration information can be found in the Prescribing Information for Gamifant and at www.Gamifant.com.

| MEDICATION | STRENGTH | QUANTITY | REFILLS |
|---|---|---|---|
| ☐ Gamifant® (emapalumab-lzsg) | 10 mg/2 mL (5 mg/mL) single-dose vial | | |
| ☐ Gamifant® (emapalumab-lzsg) | 50 mg/10 mL (5 mg/mL) single-dose vial | | |

*Prescriber Signature: _____ Date: _____/_____/_____

*Stamp Signature Not Allowed*

## PRESCRIBER AUTHORIZATION:

My signature certifies that the person named on this form is my patient; that the information provided, to the best of my knowledge, is complete and accurate; and that therapy with Gamifant is medically necessary. I certify that I have obtained the written authorization of my patient's parent or caregiver in accordance with all applicable state and federal laws to release the individually identifiable health information included on this form to Sobi and Gamifant Patient Services, and I understand that the information that I provide on this form will be used by the program for purposes of verifying my patient's insurance coverage and eligibility; coordinating the dispensing of my patient's prescription medicine; and introducing Gamifant Patient Services to my patient, including contacting my patient's parent/caregiver by telephone or mail for these purposes. I authorize Gamifant Patient Services to transmit the above prescription to the appropriate specialty pharmacy for my patient. I understand that I am under no obligation to prescribe any Sobi products and that I have not received nor will I receive any benefit from Sobi for doing so. I will not seek reimbursement from any third-party payer or government entity for any product provided free of charge by Gamifant Patient Services.

Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form.

*Prescriber Signature: _____ *Date: _____/_____/_____

*Prescriber Name (please print): _____

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## AUTHORIZATION TO SHARE HEALTH INFORMATION

Gamifant Patient Services is an optional program provided by Sobi for patients and their parents, guardians, and providers that can help you understand your coverage and financial obligation for Gamifant and provide resources to help with treatment and payment for treatment. Gamifant Patient Services representatives can answer questions related to prescription coverage, out-of-pocket costs, and pharmacy options; affordability programs (based on eligibility); and claims and appeal process support. Parent/guardian should complete this form legibly and sign it. All completed forms should be faxed to 1-866-895-7204 or emailed to gamifantpatientservices@rxallcare.com.

By signing this Authorization, I authorize healthcare providers, insurance companies or pharmacies to disclose in electronic or other forms the patient's personal and protected health information, including address, medical records, and prescription and insurance information, to or by the following: Sobi, Inc. and its subsidiaries and affiliates, contractors, employees, agents and successors (collectively, "Sobi"). Sobi, Inc. will provide support services, including insurance and reimbursement assistance. Such authorization allows for support in the receipt of treatment; claims settlement; submission of claims to health insurers for payment; communication of information to the physician, other healthcare providers, and insurance carriers; reimbursement services; eligibility for any financial assistance; and administration of Gamifant® (emapalumab-lzsg). I also authorize and understand that Sobi and healthcare providers involved in the patient's care may use and disclose protected health information for quality assurance purposes, including but not limited to quality assurance reviews.

I understand that I am not required to sign this Authorization as a condition to receiving treatment with Sobi's products or payment for healthcare; enrolling in a health plan; or establishing eligibility for benefits.

I understand that I am entitled to keep a copy of this Authorization after I sign it. I understand that this authorization shall remain in effect until it expires, unless I revoke it sooner. I may revoke this Authorization at any time by contacting Gamifant Patient Services by phone at 1-833-597-6530 or in writing at 50 Bearfoot Rd, Northborough, MA 01532, Attn: Gamifant Patient Services. I understand that the revocation will be effective upon actual receipt of my letter by Gamifant Patient Services at the above address. If I do withdraw the authorization, it can no longer be relied upon to make uses and disclosures of the patient's protected health information, but that will not invalidate uses and disclosures already made in reliance upon this authorization.

I understand that the protected health information released based on this Authorization may be subject to redisclosure by Sobi, and therefore may no longer be protected by certain federal privacy regulations, but Sobi plans to use and disclose the information only as described within this authorization. This Authorization expires ten (10) years (or such lesser time as state law may require) from the date this Authorization is signed.

*__Patient or Caregiver Signature:__ _____ *__Date:__ _____/_____/_____

*Patient or Caregiver Name (please print): _____ *Relationship to Patient: _____

## CONSENT TO ENROLL IN GAMIFANT PATIENT SERVICES

Gamifant Patient Services is authorized to contact me by mail, e-mail, text, telephone, and/or any alternative communication method that I request for the purposes as described herein. Sobi, Inc. may use the information disclosed in the Data provided by HCP or Institution for research, analysis, marketing, sales and other internal business purposes, and Sobi, Inc. may disclose the Data to any Sobi, Inc. affiliate, and any person or entity providing services with respect to Gamifant. I understand that third parties may receive payment from Sobi or those acting on behalf of Sobi in exchange for disclosing protected health information to Sobi and/or for providing me with support services, including sending communications to me, for purposes of the Gamifant Patient Services program as defined herein.

I understand that I am entitled to keep a copy of this Authorization after I sign it. I understand that this authorization shall remain in effect until it expires, unless I revoke it sooner. I may revoke this Authorization at any time by contacting Gamifant Patient Services by phone at 1-833-597-6530 or in writing at 50 Bearfoot Rd, Northborough, MA 01532, Attn: Gamifant Patient Services. I understand that the revocation will be effective upon actual receipt of my letter by Gamifant Patient Services at the above address. If I do withdraw the authorization, it can no longer be relied upon to make uses and disclosures of the patient's protected health information, but that will not invalidate uses and disclosures already made in reliance upon this authorization.

I understand that the protected health information released based on this Authorization may be subject to redisclosure by Sobi, and therefore may no longer be protected by certain federal privacy regulations, but Sobi plans to use and disclose the information only as described within this authorization. This Authorization expires ten (10) years (or such lesser time as state law may require) from the date this Authorization is signed.

*__Patient or Caregiver Signature:__ _____ *__Date:__ _____/_____/_____

*Patient or Caregiver Name (please print): _____ *Relationship to Patient: _____

# INDICATION AND USAGE AND IMPORTANT SAFETY INFORMATION

## Indication and Usage

Gamifant® (emapalumab-lzsg) is an interferon gamma (IFNγ)–blocking antibody indicated for the treatment of adult and pediatric (newborn and older) patients with primary hemophagocytic lymphohistiocytosis (HLH) with refractory, recurrent, or progressive disease or intolerance with conventional HLH therapy.

## Important Safety Information

Before initiating Gamifant, patients should be evaluated for infection, including latent tuberculosis (TB). Prophylaxis for TB should be administered to patients who are at risk for TB or known to have positive purified protein derivative (PPD) test result or positive IFNγ release assay.

During Gamifant treatment, patients should be monitored for TB, adenovirus, Epstein-Barr virus (EBV), and cytomegalovirus (CMV) every 2 weeks and as clinically indicated.

Patients should be administered prophylaxis for herpes zoster, *Pneumocystis jirovecii*, and fungal infections prior to Gamifant administration.

Do not administer live or live attenuated vaccines to patients receiving Gamifant and for at least 4 weeks after the last dose of Gamifant. The safety of immunization with live vaccines during or following Gamifant therapy has not been studied.

### Infusion-Related Reactions

Infusion-related reactions, including drug eruption, pyrexia, rash, erythema, and hyperhidrosis, were reported with Gamifant treatment in 27% of patients. In one-third of these patients, the infusion-related reaction occurred during the first infusion.

### Adverse Reactions

In the pivotal trial, the most commonly reported adverse reactions (≥10%) for Gamifant included infection (56%), hypertension (41%), infusion-related reactions (27%), pyrexia (24%), hypokalemia (15%), constipation (15%), rash (12%), abdominal pain (12%), CMV infection (12%), diarrhea (12%), lymphocytosis (12%), cough (12%), irritability (12%), tachycardia (12%), and tachypnea (12%).

Additional selected adverse reactions (all grades) that were reported in less than 10% of patients treated with Gamifant included vomiting, acute kidney injury, asthenia, bradycardia, dyspnea, gastrointestinal hemorrhage, epistaxis, and peripheral edema.

**Please see the full Prescribing Information for Gamifant at Gamifant.com.**