Uplizna™ Patient Referral Form—Tip Sheet

uplizna™ inebilizumab-cdon

Use this Tip Sheet to help complete and submit the Uplizna Patient Referral Form

All pages of the form and photocopies of insurance cards should be sent to Viela VIPs via fax at 1-833-329-8477.

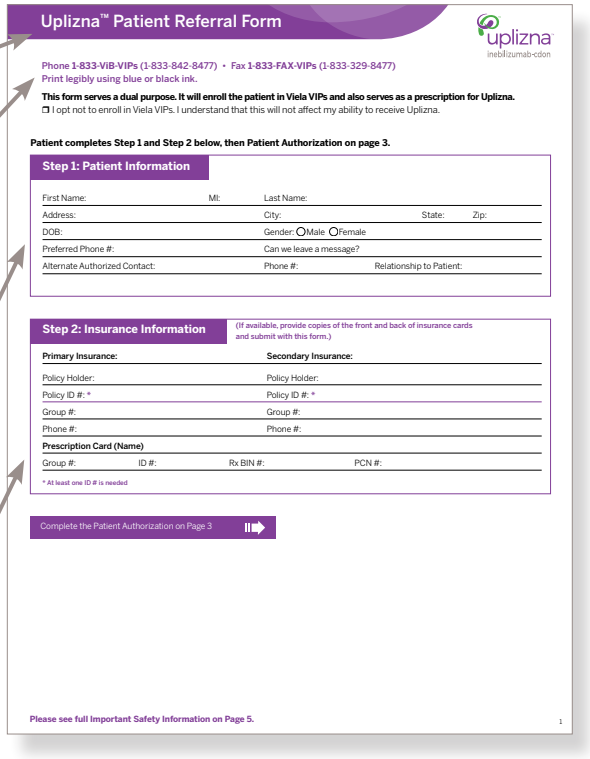
Page 1

This form serves a dual purpose. It is used to register patients in Viela VIPs, and it also serves as a prescription for Uplizna.

All pages of the form and photocopies of insurance cards should be sent to Viela VIPs via fax at **1-833-329-8477**.

The correct patient information is necessary for timely processing. Type information directly into the fields on the form. If writing information on the form, print legibly using blue or black ink.

Photocopies (front and back) of the patient's medical and prescription insurance cards should be included when submitting this form.



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 #:	

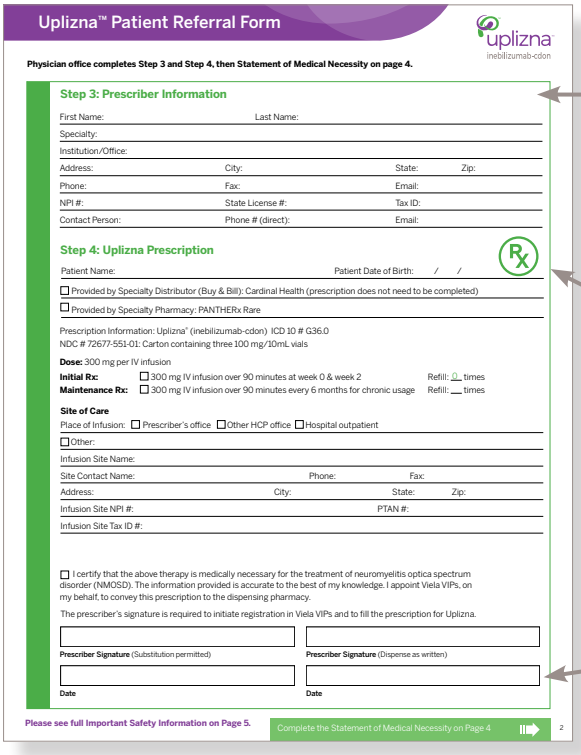
* At least one ID # is needed

Complete the Patient Authorization on Page 3

Please see full Important Safety Information on Page 5.

1

Page 2



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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

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 #:

❒ 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**

Please see full Important Safety Information on Page 5. Complete the Statement of Medical Necessity on Page 4

2

The information in this section is essential. Without it, the Uplizna prescription cannot be filled.

This is the prescription for Uplizna. Any changes will require the submission of a new form. Fill in all required fields to prevent disruption in product access.

The prescriber's signature is required to initiate registration in Viela VIPs and fill the prescription. Stamped signatures will be accepted.

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US-INEB-2000083 09/20

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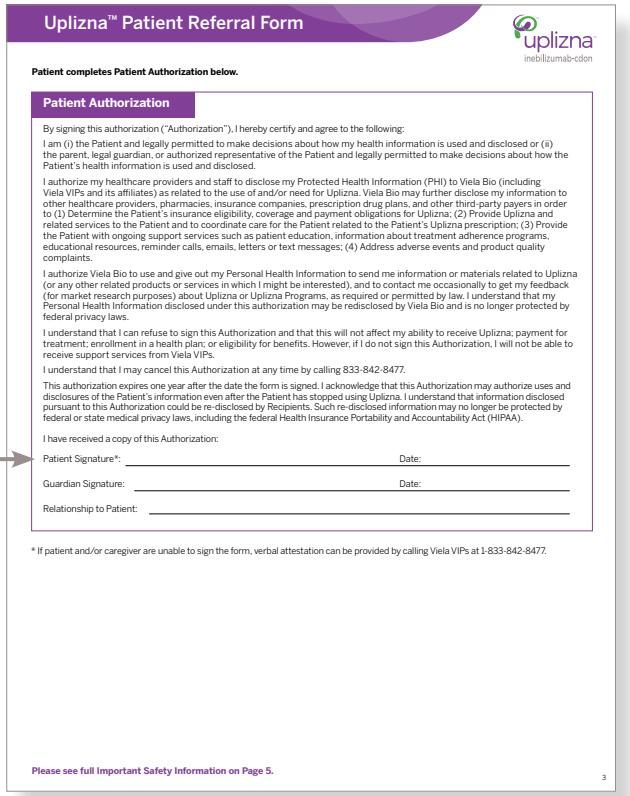
Page 3



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uplizna inebilizumab-cdon

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) 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.

3

The patient's signature is required to release his/her health information to Viela VIPs and open a dialogue about insurance. 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. Incomplete forms will not be processed.

Page 4

Uplizna™ Patient Referral Form

uplizna inebilizumab-cdon

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):

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.

4

Complete all fields and provide as much detail as possible to enable the prescription to be filled in a timely manner.

The prescriber's signature is required to certify that Uplizna is medically necessary for the treatment of NMOSD for this patient.

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