H.P. **Acthar**® GEL
(repository corticotropin injection) 80 U/mL

Acthar Ophthalmology Start Form

Please complete Start Form and fax toll-free
FAX: 1-877-221-9505 TEL: 1-877-463-8803

Faxed prescriptions will be accepted only from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

DATE MEDICATION NEEDED: _____ **SHIP TO:** ❑ Patient's Home ❑ Prescriber's Office **INJECTION TRAINING?** ❑

1. PROVIDER INFORMATION

PROVIDER NAME | NPI # | GROUP NPI # (IF APPLICABLE) | STATE LICENSE # | DEA # | TAX #

SPECIALTY: ❑ NEPHROLOGY ❑ NEUROLOGY ❑ PULMONOLOGY ❑ RHEUMATOLOGY ❑ OPHTHALMOLOGY ❑ OTHER _____ IF OTHER PLEASE INDICATE

FACILITY NAME | TELEPHONE | FAX

ADDRESS | CITY | STATE | ZIP

OFFICE CONTACT NAME | CONTACT TELEPHONE | EMAIL ADDRESS | PREFERRED METHOD OF COMMUNICATION

2. PATIENT INFORMATION

PATIENT FIRST NAME | PATIENT MIDDLE INITIAL | PATIENT LAST NAME | DATE OF BIRTH | GENDER

HOME ADDRESS | CITY | STATE | ZIP

SHIPPING ADDRESS (IF NOT HOME ADDRESS) | CITY | STATE | ZIP

TELEPHONE | ALTERNATE TELEPHONE | BEST TIME TO CALL | PREFERRED LANGUAGE IF NOT ENGLISH

EMAIL ADDRESS | PATIENT REPRESENTATIVE | RELATIONSHIP | TELEPHONE

KNOWN ALLERGIES: _____ DIAGNOSIS CODE: _____

3. INSURANCE INFORMATION (PLEASE FAX FRONT AND BACK COPY OF ALL INSURANCE CARDS (PRESCRIPTION AND MEDICAL)

PHARMACY BENEFITS | SUBSCRIBER ID # | GROUP # | TEL #

PRIMARY MEDICAL INSURANCE | POLICY HOLDER /RELATIONSHIP | SUBSCRIBER ID # | GROUP # | TEL #

4. PRESCRIPTION: H.P. ACTHAR® GEL

NDC# 63004-8710-1 5 mL multidose vial containing 80 USP units per mL

DIAGNOSIS: _____

INITIATE PATIENT WITH:

DOSE: _____ ❑ UNITS ❑ ML **SCHEDULE/FREQUENCY:** _____

QUANTITY OF 5 ML MULTIDOSE VIALS: _____ **REFILLS:** _____

ROUTE OF ADMINISTRATION: ❑ INTRAMUSCULAR ❑ SUBCUTANEOUS

ADDITIONAL SPECIAL INSTRUCTIONS, OR TAPER DOSE, IF APPLICABLE:

SUPPLIES:

SYRINGE SIZE: ❑ 1 cc ❑ 3 cc (other) ____ **QUANTITY:** ____ **NEEDLE SIZE:** ❑ 20 g needle, 1 inch ❑ 23 g needle, 1 inch ❑ 25 g needle, 1 inch ❑ 25 g needle, 5/8 inch ❑ (other): ____ **QUANTITY:** ____

OTHER SUPPLIES: _____ **REFILLS:** _____

HOME INJECTION TRAINING SERVICES FOR ADULT PATIENTS

By initialing here (original required) I request that company-funded home injection training services be arranged for my patient. I understand that home injection training services is for one instruction visit only and NOT a home health nursing service. I also understand that all reasonable efforts will be made to schedule the home injection training services visit within 24 hours of the patient's receipt of drug shipment.

INITIALS | DATE

5. PATIENT AUTHORIZATION(S)

Patient Authorization and Registration for optional supplemental education and support programs available for patients prescribed Acthar

Mallinckrodt provides ongoing education and support for patients whose healthcare providers have determined that Acthar is the appropriate clinical therapy for their patients. Check the appropriate box(es) and sign below to participate and receive ongoing education and support at no cost to you. (Please see reverse side for full Authorization.)

❑ **By checking this box and signing below, I provide my authorization to the Patient Authorization for the use and disclosure of personal health information**

❑ **By checking this box and signing below, I confirm understanding of the Patient Authorization and Registration for optional supplemental education and support programs available for patients prescribed Acthar.**

Patient Signature - **Patient, please sign and date below - Please sign ONE LINE below**

PATIENT NAME OR LEGAL REPRESENTATIVE | PATIENT SIGNATURE | IF LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT | DATE

6. HCP SIGNATURE

HCP Prescriber Signature - **Please sign ONE LINE below**

DISPENSE AS WRITTEN | DATE | SUBSTITUTIONS ALLOWED | DATE

Prescriber signature required to consent and validate prescriptions. Prescriber attests that this is her/his signature. NO STAMPS. By signing, I certify that the above is medically necessary.

5. PATIENT AUTHORIZATION(S) (CONTINUED FROM REVERSE)

Patient Authorization for use and disclosure of personal health information

By signing this authorization, I authorize my physician(s), my health insurance company, my pharmacy providers and Mallinckrodt ARD Inc., the distributor of Acthar ("Mallinckrodt"), its agents, authorized designees and contractors, including Avella Specialty Pharmacy ("Avella") (Avella, together with Mallinckrodt and its agents, "Designated Parties"), to use and disclose to Designated Parties health information relating to my medical condition, treatment, and insurance coverage (my "Health Information") in order for them to (1) provide certain services to me, including reimbursement and coverage support, patient assistance and access programs, medication shipment tracking, and home injection training, (2) provide me with other educational and support services associated with Acthar therapy, (3) contact me about participation in Acthar patient programs, (4) for the Acthar Support and Access Program's proper management and administration and for Mallinckrodt to carry out its legal responsibilities, (5) for internal business purposes, such as for marketing research, internal financial reporting and operational purposes.

Once my Health Information has been disclosed to the Designated Parties, I understand that it may be redisclosed by them as permitted by this authorization or as otherwise permitted or required by law and will no longer be protected by federal and state privacy laws. However, the Designated Parties agree to protect my Health Information by using and disclosing it only for the purposes authorized in this authorization or as permitted or required by law.

I understand that I may refuse to sign this authorization and that my physician and pharmacy will not condition my treatment on my agreement to sign this authorization form, and my health plan or health insurance company will not condition payment for my treatment, insurance enrollment or eligibility for insurance benefits on my agreement to sign this authorization form. I understand that my pharmacies and Designated Parties may receive payment in connection with the disclosure of my Health Information as provided in this authorization. I understand that I am entitled to receive a copy of this authorization after I sign it.

I may revoke (withdraw) this authorization at any time by mailing a letter to 23620 N. 20th Drive, Suite 12, Phoenix, AZ 85085. Revoking this authorization will end further disclosure of my Health Information to Designated Parties by my pharmacy, physicians and health insurance company when they receive a copy of the revocation, but it will not apply to information they have already disclosed to the Designated Parties based on this authorization.

This authorization is in effect for 1 year once I have signed it unless I cancel it before then. I understand I do not have to sign this form. It plays no role in getting my medicine.

Patient Authorization and Registration for optional supplemental education and support programs available for patients prescribed Acthar
(Continued from reverse)

Specifically, I authorize Mallinckrodt and its agents to (1) contact me about participation in Acthar patient programs, (2) provide me with educational or information materials, (3) administer its education and support programs appropriately, (4) conduct surveys that request my feedback, and (5) for Mallinckrodt to carry out its legal responsibilities. I agree to let Mallinckrodt or its agents contact me in the future about these offerings. However, Mallinckrodt and its agents agree to protect my Health Information by using and disclosing it only for the purposes described in this authorization or as permitted or required by law.

I also know I may cancel my enrollment in a patient support program at any time by contacting Mallinckrodt at 25125 Santa Clara St. #E287, Hayward, CA 94544-2109. If I withdraw my permission, I know that this means I may no longer receive information on supplemental education programs. Once I withdraw my permission, no new information will be disclosed to Mallinckrodt or its agents, but Mallinckrodt and its agents may continue to use the information that was collected before I withdrew my permission as permitted by this authorization or as otherwise permitted or required by law.

For Patient:_____ DOB:_____

7. DIAGNOSIS AND MEDICAL INFORMATION

Diagnosis

Please select diagnosis and responses to associated questions

- ❑ Keratitis
- ❑ Iritis
- ❑ Iridocyclitis
- ❑ Uveitis
- ❑ Choroiditis
- ❑ Optic Neuritis
- ❑ Anterior Segment Inflammation
- ❑ Chorioretinitis
- ❑ Other diagnosis _____

8. RELEVANT TREATMENT HISTORY

Therapy Name	Dose	Start Date	Stop Date (if applicable)	Clinical Comments (eg, type of outcome)

9. HISTORY OF CORTICOSTEROID USE (IF APPLICABLE)

Please check all that apply

A corticosteroid was tried with the following response(s):

- ❑ Patient hypersensitive or allergic
- ❑ Patient intolerant to corticosteroids
- ❑ Corticosteroid use failed, but same response not expected with Acthar
- ❑ Other: _____

OR

A corticosteroid was not tried due to the following response(s):

- ❑ Corticosteroid use is contraindicated for this patient
- ❑ Patient has known intolerance to corticosteroids
- ❑ Intravenous access is not possible for this patient
- ❑ Other:_____

HCP SIGNATURE: REQUIRED FOR DOCUMENTATION

NAME SIGNATURE DATE

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

Acthar Support and Access
FAX: 1-877-221-9505 TEL: 1-877-463-8803

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