EGRIFTA WR™ Enrollment Form

THERA patient support®

EGRIFTA (tesamorelin) for injection™

Please ensure all sections of the form are completed in full, with supporting documents included.

To enroll, fax all documents to 1-855-836-3069.

Questions? Contact a Thera patient support® Patient Care Coordinator at 1-833-23THERA (1-833-238-4372), Mon–Fri 8:30 a.m. – 8 p.m. EST.

1. Patient Information

First Name _____
Last Name _____
Address _____
City _____ State _____
ZIP _____ SSN (last 4 digits) _____

Date of Birth (MM/DD/YY) _____ Sex ☐ M ☐ F
Preferred Language ☐ English ☐ Other _____
Phone Number _____
Best Time to Contact ☐ AM ☐ PM ☐ Other _____
☐ OK to Leave Message
Email _____

Alternate Contact/Caregiver _____
Relationship to the Patient _____

Phone Number _____

2. Medical History

The patient is currently receiving antiretroviral therapy (ART) ☐ Yes ☐ No

Concomitant Medications: _____

Please provide the patient's:
Fasting Blood Glucose _____ mg/dL BMI _____ kg/m²
Waist Circumference _____ cm Hip Circumference _____ cm
Waist-to-Hip Ratio _____
Waist-to-Hip Ratio = Waist Circumference ÷ Hip Circumference

3. Insurance Information

☐ Patient does not have insurance ☐ Patient has insurance

Please complete the information on the right and include copies of the front and back of the insurance card(s).

Note: Prescriptions cannot be processed unless copies of both sides of insurance card(s) are included.

Prescription Drug Insurer/Pharmacy Benefit Manager (PBM) _____
Phone Number _____
Policy # _____
Rx BIN # _____
Rx Group # _____
Rx PCN # _____

4. Prescriber Information

First Name _____
Last Name _____
Specialty _____
Office/Clinic/Institution _____
Address _____
City _____ State _____
ZIP _____

NPI # _____
Tax ID # _____
State License # _____
Office Contact _____
Office Phone Number _____
Office Fax _____
Office Email _____

5. Prescription

☑ Rx: *EGRIFTA WR*™ (tesamorelin) for injection 11.6 mg per vial/week NDC 62064-381-04 [4 vials for 28 days]

Dosage and Directions for Use: Inject 1.28 mg of *EGRIFTA WR*™ (0.16 ml) subcutaneously once daily. Each 11.6 mg *EGRIFTA WR*™ vial provides the daily doses for 7 consecutive days. Four vials are needed for 28 days.

Diagnosis (ICD-10): ☑ E88.1 HIV-Associated Lipodystrophy ☑ B20 Human Immunodeficiency Virus (HIV) Disease ☐ Other _____

☑ Dispense Injection Kit Dispense: ☐ 28-day supply with 12 Refills ☐ Other _____
Dispense: ☐ 84-day supply with 4 Refills ☐ Other _____

Note: Diagnosis and diagnosis code are mandatory for processing of this form.

Additional Instructions _____

Preferred Pharmacy Name _____
Phone Number _____

Address _____
City _____ State _____ ZIP _____

6. Prescriber Authorization and Signature

I certify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed *EGRIFTA WR*™ based on my judgment of medical necessity, and I will be supervising the patient's treatment. I have received the necessary authorization prior to the transmittal of health information to Theratechnologies Inc., and parties working with Theratechnologies Inc., to perform a preliminary assessment of insurance verification and determine patient eligibility for the THERA patient support® program. I authorize the forwarding of this prescription to a dispensing specialty pharmacy on behalf of myself and the patient. I understand that neither I nor the patient should seek reimbursement for any free product received under the program.

State Prescription Requirements: The physician is to comply with their state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance of state-specific requirements could result in outreach to the prescriber.

Check one:

☐ Prescriber's Signature _____
(no stamps; **dispense as written**)
Date _____

☐ Prescriber's Signature _____
(no stamps; **substitution permissible**)
Date _____

Note: Physician needs to sign and date in order for the prescription to be filled.

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Patient Authorization and Signature

Patient Authorization to Use and Disclose Protected Health Information

I authorize healthcare providers and their staff involved in my care to disclose my Protected Health Information (as defined below), including but not limited to my medical record and other health information on my completed Statement of Medical Necessity form or other forms, records that may contain information created by other persons, entities, physicians, and healthcare providers; information concerning HIV/AIDS diagnosis and treatment, including HIV test results, as well as information regarding substance use disorder treatment services and mental health services (excluding psychotherapy notes) (collectively, "Protected Health Information"), to Theratechnologies Inc. and its agents, representatives, and direct and indirect service providers (collectively, "Theratechnologies"), so that Theratechnologies may:

1. Facilitate the filling of my prescription for and the delivery and administration of Theratechnologies products, including disclosing or redisclosing Protected Health Information to pharmacies;
2. Assist me in obtaining insurance coverage for Theratechnologies products, including disclosing or redisclosing Protected Health Information to health plans;
3. Partner a Nurse Navigator to contact me for training and adherence assistance. Interaction can be live audio/video training offering education for proper use, if appliable, administration, and continuous adherence guidance. I have the right not to be recorded at any time. Theratechnologies will have access to my communications to provide adequate patient care. Any dissemination, storage or retention of an identifiable patient image or other information shall comply with federal and state laws and regulations requiring confidentiality;
4. Create deidentified and aggregate information to be used and shared for reimbursement, publication, or commercial purposes.

I authorize Theratechnologies to contact me by mail, email, video and/or telephone to enroll me in, and administer programs that provide support services.

To accomplish these purposes, I further authorize Theratechnologies to share information, including HIV/AIDS information, between and among the entities defined in this Authorization as Theratechnologies.

I understand that once my Protected Health Information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy law and regulations known as "HIPAA" or state privacy laws and may be the subject to further disclosure by Theratechnologies and third parties with whom Theratechnologies may share the information. However, other state and federal laws may prohibit the recipient from disclosing specially protected information such as certain HIV/AIDS- related information, substance use disorder treatment information, and mental health information. I understand that I may refuse to sign this authorization. My refusal will not affect my ability to receive Theratechnologies products, treatment, payment, enrollment in a health plan, or eligibility for benefits but my refusal may limit my ability to receive certain support services that are provided by Theratechnologies.

I understand that healthcare providers may receive compensation, remuneration, or other value as a result of their use and disclosure of my Protected Health Information as described in this authorization.

I understand that this authorization will remain in effect for 10 years from the date of my signature, unless limited by state laws and regulations and/or I revoke it in writing by contacting Theratechnologies c/o:

ASPN Pharmacies, LLC
290 West Mount Pleasant Ave
Building 2, 4th Floor, Suite 4210
Livingston, NJ 07039 United States

If I revoke this authorization, Theratechnologies and any third parties that are notified of my revocation will stop using my Protected Health Information for the purposes outlined in this authorization, but the revocation will not affect prior use or disclosure of my Protected Health Information in reliance on this authorization. I have the right to receive a copy of this authorization after I sign it.

I understand that the support services provided by Theratechnologies that are described in this authorization can be changed at any time, without prior notification.

By checking this box, ☐ I authorize Theratechnologies to:

- Send me text messages about my *EGRIFTA WR*™ order to the phone number. I understand that standard data fees and text messaging fees may apply based on my mobile plan; and
- Provide me with free educational information and marketing materials; and
- Conduct surveys to measure my satisfaction with Theratechnologies products and services.

Patient Name _____ Date of Birth _____ MM/DD/YY

Address _____ Phone Number _____

Patient's Signature _____ Date _____ MM/DD/YY

Authorized Representative Name _____

If you are the patient's representative, identify your relationship to the patient and state the basis of authority

_____

Patients can also provide their consent digitally by scanning the QR code.

NOTICE TO RECIPIENT OF INFORMATION:

HIV-related Information: To the extent that HIV-related information has been provided to you, such information has been disclosed to you from records whose confidentiality may be protected by federal and state law. Such laws may prohibit you from making any further disclosure of HIV-related information without the specific written consent of the person to whom it pertains, or as otherwise permitted by said laws. When obtaining such written consent, you must expressly identify that "HIV-related information is being disclosed" (general authorization for the release of the entire medical file, for example, is NOT sufficient for this purpose).

An oral disclosure shall be accompanied or followed by such notice within 10 days.