EGRIFTA SV™ Enrollment Form

EGRIFTA SV™ tesamorelin for injection

To enroll, FAX all documents to 1-855-836-3069. *Please ensure all sections of the Form are completed in full, with supporting documents included.*

Questions? Contact a Patient Care Coordinator at 1-833-23THERA (1-833-238-4372), Mon-Fri 8:30 AM - 8 PM EST

1. Patient Information

First Name _____ Date of Birth _____ MM/DD/YY _____ Gender ☐ M ☐ F

Last Name _____ Preferred Language ☐ English ☐ Other _____

Address _____ Telephone _____

City _____ State _____ Email _____

ZIP _____ SSN (last 4 digits) _____ Best time to contact ☐ AM ☐ PM ☐ Other _____

Alternate Contact/Caregiver _____ Telephone _____

Relationship to the Patient _____ ☐ OK to leave message Cell # _____

2. Medical History

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

Please provide the patient's:

Fasting Blood Glucose _____ mg/dL BMI _____ kg/m^2 _____

Waist Circumference _____ cm Hip Circumference _____ cm

Waist-to-hip Ratio _____

Waist-to-hip Ratio = Waist Circumference ÷ Hip Circumference

Concomitant Medications: _____

3. Insurance Information

☐ Patient does not have insurance

☐ Patient has insurance

→ Please complete the information below and include copies of front and back of insurance card(s)

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

Prescription Drug Insurer/Pharmacy Benefit Manager (PBM) _____

Telephone _____

Policy # _____

Rx BIN # _____

Rx Group # _____

Rx PCN # _____

4. Prescriber Information

First Name _____ NPI # _____

Last Name _____ Tax ID # _____

Specialty _____ Medicaid # _____

Office/Clinic/Institution _____ Office Contact _____

Address _____ Office Telephone _____

City _____ Office FAX _____

State _____ ZIP _____

Office Email _____

5. Prescription

☐ Rx: *EGRIFTA SV* ™ (tesamorelin for injection) 2 mg per vial NDC 62064-241-30 [30 vials]

Dosage and Directions for Use : Daily subcutaneous injection of a 1.4 mg dose of *EGRIFTA SV* ™ (0.35mL) requires 1 vial of *EGRIFTA SV* ™ 2 mg

Diagnosis (ICD-10): ☐ E88.1 HIV-Associated Lipodystrophy ☐ Other _____

☑ Dispense Injection Kit _____

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

Dispense: ☐ 30-day supply with ☐ 11 Refills or ☐ Other _____

Dispense: ☐ 90-day supply with ☐ 3 Refills or ☐ Other _____

Additional Instructions _____

In home injection training (optional) _____

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 SV*™ 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 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 _____ MM/DD/YY

OR

☐ Prescriber's Signature _____

(no stamps; **Substitution Permissible**) Date _____ MM/DD/YY

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

Patient Authorization to Use and Disclose Protected Health Information

I authorize health care 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 health care 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; and
3. Contact me by mail, email, and/or telephone to enroll me in, and administer, programs that provide support services. **In addition, by checking this box ☐, I authorize Theratechnologies to:**
   - Send me text messages about my *EGRIFTA SV* ™ order. 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.

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 the 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 health care 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 or I revoke it in writing earlier by contacting Theratechnologies c/o Asembia, 200 Park Ave., suite 300, Florham Park, NJ 07932.

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.

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

Address _____ Telephone _____

Sign this authorization _____ Date _____ MM/DD/YY

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

_____

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 the 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" (a 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.