

Patient Support Program

ENROLLMENT FORM



Monday - Friday, 8 AM - 8 PM ET / Phone: 1-877-81CONNC (1-877-812-6662)
Fax: 1-833-912-3707 / www.CelltrionConnect.com

INSTRUCTIONS FOR ENROLLMENT

Celltrion CONNECT® offers three options for enrollment:

Option 1: Submit through the Portal

At www.CelltrionConnect.com/STEQEYMA/hcpportal, a healthcare provider can:

- Enroll a patient in Celltrion CONNECT
- Instruct the patient to complete electronic consent as applicable
- Inform the patient a Celltrion CONNECT Case Coordinator will contact them by phone with the next steps and to verify their information

Option 2: Send an ePrescription

• Select **ePrescribe to Phyz** via the pharmacy drop-down menu:
NCPDP: 5928809 | **Phone:** 1-844-590-5792

- Phyz will facilitate the enrollment process in Celltrion CONNECT
- Forward the patient's insurance card(s), demographics, chart notes, and clinical documentation through your EMR or via fax to 1-833-912-3707
- Celltrion CONNECT will forward the STEQEYMA® prescription to the appropriate pharmacy

Option 3: Complete this form

- Attach both sides of the patient's insurance card(s)
- Attach the patient's demographics, chart notes, and clinical documentation
- Have the patient and prescriber sign the form
- Fax the completed form, along with attachments, to 1-833-912-3707

Patients may sign the form electronically by visiting www.CelltrionConnect.com/STEQEYMA

REQUESTED SERVICES

Please check all that apply:

☐ **Select All**

☐ Benefits Verification

☐ Prior Authorization Support

☐ Co-pay Support for Commercially Insured Patients

☐ Appeals Support

☐ Medical Claims Support

☐ Nurse Connector™ Support Only*

*Nurse Connectors assist patients in medication and adherence communications, offer medication dispensing support, and provide supplemental injection training. All patients enrolled in Celltrion CONNECT will be offered Nurse Connector support unless they opt out. Nurse Connectors are provided by Celltrion and do not work under the direction of the patient's healthcare provider. Nurse Connectors will direct patients to their healthcare provider for treatment-related inquiries and medical decision-making.

PATIENT INFORMATION

All fields marked with an * are required.

*First Name MI *Last Name
*Address *City *State *Zip
*Date of Birth Sex ☐ Male ☐ Female ☐ Prefer Not to Answer *Weight lb or kg
*Email Preferred Language ☐ English ☐ Other
*Primary Phone ☐ Cell ☐ Home Secondary Phone ☐ Cell ☐ Home
Preferred Contact ☐ Patient ☐ Alternate Contact *By providing alternate contact information, I hereby authorize the release of my protected health information to the authorized alternate contact.*
Alternate Contact Name Relationship to Patient
Primary Phone ☐ Cell ☐ Home Secondary Phone ☐ Cell ☐ Home

PATIENT INSURANCE INFORMATION

Please attach a copy of the patient's insurance card(s) (both front and back). If not available, please complete the following:

☐ Patient does not have insurance. If the patient is uninsured, please complete the Patient Assistance Program application at www.CelltrionConnect.com/STEQEYMA.

Primary Insurance Policyholder Name
Primary Policy # Primary Group # Policyholder Date of Birth
Secondary Insurance Policyholder Name
Secondary Policy # Secondary Group # Policyholder Date of Birth
Does the patient have a separate pharmacy benefit card? ☐ Yes ☐ No
Cardholder Name Pharmacy Benefit Name Policy/Identification #
Rx BIN Rx PCN Group #

Please see Important Safety Information on page 4 and full Prescribing Information.

Celltrion CONNECT does not guarantee coverage or reimbursement. Coverage and reimbursement decisions are made by insurance companies following the receipt of claims.

PRESCRIBER INFORMATION - All fields required.

Prescriber First Name

MI

Prescriber Last Name

Prescriber NPI

Tax ID #

Medicare PTAN #

Prescriber Address

City

State

Zip

Phone

Fax

Practice Name

Practice Contact Name

Practice Contact Title

Phone

Practice Contact Email Address

CLINICAL INFORMATION - All fields marked with an * are required.

*Primary Diagnosis

☐ Crohn's Disease (K50)

☐ Ulcerative Colitis (K51)

☐ Plaque Psoriasis (L40)

☐ Psoriatic Arthritis (L40.52)

Date of Diagnosis or Years With the Disease

Date of Previous TB Test

For Patients With Psoriasis, % BSA Affected

%

Prior Medications (required to complete prior authorization)

☐ 5-ASA

☐ Azathioprine

☐ Cimzia*

☐ Cyclosporine

☐ Humira® and its Biosimilars

☐ Remicade® and its Biosimilars

☐ Tysabri®

☐ Zeposia®

☐ None

☐ 6-MP

☐ Azulfidine®

☐ Corticosteroids

☐ Entyvio®

☐ Methotrexate

☐ Stelara®

☐ Xeljanz®

☐ Zymfentra®

☐ Other

For Patients With Plaque Psoriasis or Psoriatic Arthritis

☐ Arava®

☐ Cosentyx®

☐ Enbrel®

☐ Methotrexate

☐ Phototherapy

☐ Soriatane®

☐ Taltz®

☐ Xeljanz®

☐ Other

☐ Corticosteroids

☐ Cyclosporine

☐ Humira®

☐ Otezla®

☐ Skyrizi®

☐ Stelara®

☐ Tremfya®

☐ None

☐ Other

PRESCRIPTION INFORMATION - All fields required.

Product STEQEYMA® (ustekinumab-stba)

Preferred Specialty Pharmacy (Optional, for Maintenance Therapy):

Site of Infusion

☐ Prescriber's Office

☐ Hospital Outpatient

☐ Infusion Center

☐ Other

Shipping Information for Induction Therapy (Note: Shipments cannot be sent to PO boxes)

Site Name

Address

City

State

Zip

Phone

For Adult Patients With Crohn's Disease or Ulcerative Colitis

Date of Anticipated Infusion Induction Dose (if known)

Date of Last Dose (if known)

☐ IV Loading Dose

☐ Subcutaneous Maintenance Dose

Initial Therapy

Weight Range

Dose (given as a single intravenous infusion)

≤55 kg

☐ 260 mg (2 x 130 mg/26 mL vials)

>55 kg to 85 kg

☐ 390 mg (3 x 130 mg/26 mL vials)

>85 kg

☐ 520 mg (4 x 130 mg/26 mL vials)

Maintenance Therapy

☐ 90 mg single-dose prefilled syringe administered subcutaneously 8 weeks after the initial intravenous dose, then every 8 weeks thereafter

Qty:

Refills:

For Patients With Plaque Psoriasis or Psoriatic Arthritis

Date of Last Dose (if known)

☐ Subcutaneous Loading Dose

☐ Subcutaneous Maintenance Dose

Indication	Patient Weight	Initial Therapy	Maintenance Therapy
Plaque Psoriasis Adult	≤100 kg	☐ 45 mg single-dose prefilled syringe administered subcutaneously initially and 4 weeks later	☐ 45 mg single-dose prefilled syringe administered subcutaneously every 12 weeks Qty: Refills:
	>100 kg	☐ 90 mg single-dose prefilled syringe administered subcutaneously initially and 4 weeks later	☐ 90 mg single-dose prefilled syringe administered subcutaneously every 12 weeks Qty: Refills:
Plaque Psoriasis Pediatric Patients (6 to 17 years old)	60 kg to 100 kg	☐ 45 mg single-dose prefilled syringe administered subcutaneously initially and 4 weeks later	☐ 45 mg single-dose prefilled syringe administered subcutaneously every 12 weeks Qty: Refills:
	>100 kg	☐ 90 mg single-dose prefilled syringe administered subcutaneously initially and 4 weeks later	☐ 90 mg single-dose prefilled syringe administered subcutaneously every 12 weeks Qty: Refills:
Psoriatic Arthritis Adult	All adult patients	☐ 45 mg single-dose prefilled syringe administered subcutaneously initially and 4 weeks later	☐ 45 mg single-dose prefilled syringe administered subcutaneously every 12 weeks Qty: Refills:
	Patients weighing greater than 100 kg (with co-existent moderate-to-severe plaque psoriasis)	☐ 90 mg single-dose prefilled syringe administered subcutaneously initially and 4 weeks later	☐ 90 mg single-dose prefilled syringe administered subcutaneously every 12 weeks Qty: Refills:
Psoriatic Arthritis Pediatric Patients (6 to 17 years old)	≥ 60 kg	☐ Based on body weight, the recommended dose is 45 mg single-dose prefilled syringe given subcutaneously at weeks 0 and 4, then every 12 weeks thereafter	☐ 45 mg single-dose prefilled syringe administered subcutaneously every 12 weeks Qty: Refills:
	Patients weighing greater than 100 kg (with co-existent moderate-to-severe plaque psoriasis)	☐ Based on body weight, the recommended dose is 90 mg single-dose prefilled syringe given subcutaneously at weeks 0 and 4, then every 12 weeks thereafter	☐ 90 mg single-dose prefilled syringe administered subcutaneously every 12 weeks Qty: Refills:

There is no dosage form for STEQEYMA that allows weight-based dosing for pediatric patients below 60 kg.

PRESCRIBER ATTESTATION/AUTHORIZATION

I certify that the information provided in this STEQEYMA Prescription Form is complete and accurate to the best of my knowledge. I have prescribed STEQEYMA based on my judgment of medical necessity. I certify that I have obtained my patient's written authorization in accordance with applicable state and federal law, including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations to provide the individually identifiable health information on this form to agents and service providers of Celltrion Inc. and to the Celltrion CONNECT program for benefits eligibility, coverage authorization, coordination and dispensing of STEQEYMA, and providing my patient and me with other educational and support services associated with STEQEYMA. I agree that the Celltrion CONNECT program may contact me for additional information relating to STEQEYMA, including but not limited to via email, fax, and telephone. I authorize the Celltrion CONNECT program to transmit the above prescription to the pharmacy.

SIGN & DATE

Prescriber Signature and Date (no stamps)

Dispense as Written/Brand Medically Necessary

Date

May Substitute/Product Selection Permitted

Date

CA, MA, NC, and PR: Interchange is mandated unless the prescriber writes the words "No Substitution" HERE

ATTN: Please submit the electronic prescription as required by your state law

Please see Important Safety Information on page 4 and full Prescribing Information.

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Patient Name Patient Date of Birth **PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION**

By signing this form, the patient gives their permission for their physicians, pharmacies, laboratories, and other healthcare providers ("Healthcare Providers") and their health insurers to share their individually identifiable health information with Celltrion USA, Inc., the Celltrion Patient Assistance Foundation, and Celltrion affiliates and its vendors (collectively, "Celltrion").

The patient understands that their individually identifiable health information may include their full name, address, date of birth, demographic information, financial information, insurance information, and information related to their medical condition, treatment, care management, medication history, and prescriptions (collectively, "Health Information"), whether in written or verbal form, including portions of their medical record.

The patient's Health Information will be shared with Celltrion so that Celltrion may provide them with various support and information to help them access a Celltrion medicine, which may include the following, depending on the program (collectively, "Patient Support Activities"):

- Processing this application
- Verifying the information provided in this application
- Providing benefit investigation/verification and reimbursement support, including:
 - Assisting with identification of prior authorization requirements
 - Assisting with the identification of requirements of their insurer for appeal of a denied claim
- Determining their eligibility for and helping them access co-pay support or free drug programs
- Communicating with their Healthcare Providers about a Celltrion medicine and Patient Support Activities
- Coordinating the dispensing and delivery of medication
- Providing them with financial assistance resources and information if they are eligible
- Providing them with disease management and other educational materials, as well as information about Celltrion's products, services, and programs, may include sending them surveys about their experience with Celltrion products, services, and programs
- Providing them with access to Nurse Connectors™ who can assist in educational support communications

Celltrion also may use their Health Information for auditing for compliance with Program requirements, for quality assurance purposes, and to evaluate and improve our operations and services.

The patient understands that Celltrion may de-identify their Health Information and use it in performing research, education, business analytics, marketing studies, or for other commercial purposes, including linkage with other de-identified data Celltrion receives from other sources.

The patient understands that they do not have to sign this form, and choosing not to sign will not affect their ability to receive treatment from their Healthcare Providers or payment from their health insurer. However, if they do not sign this form, Celltrion may not be able to provide them with assistance.

The patient understands that once their Health Information is shared, it may no longer be protected by federal privacy law. However, Celltrion agrees to protect their Health Information and to use it for the purposes described in this form or as required or permitted by law. Select pharmacies may receive remuneration from Celltrion in exchange for their Health Information and/or for any Patient Support Activities provided to them. The patient understands that this form will remain in effect for three (3) years from the date of their signature or shall otherwise expire at a shorter duration as required under applicable state law unless they provide written notice that they would like to withdraw their approval to share their Health Information sooner. If the patient would like to withdraw their approval, they may contact Celltrion at 1-877-81CONN (1-877-812-6662). This withdrawal will not affect the use or sharing of their Health Information that took place before they withdraw their approval. The patient understands that they may receive a copy of this form.

SIGN & DATE**Patient or Patient Authorized Representative Signature****Date**

Patient Representative First and Last Name (print):

Relationship to Patient

By checking this box, the patient elects to opt out of Nurse Connectors™ educational support communications. ☐

PATIENT AUTHORIZATION TO TELEPHONE CONSUMER PROTECTION ACT (TCPA) INFORMATION

By signing up for text messages from Celltrion, the patient agrees that they are the primary owner of the phone number(s) provided and consent to receiving promotional communications in the form of phone calls or text messages relating to Celltrion products and services and/or their condition or treatment at the phone number(s) provided. These communications may be sent from an automated system for the selection and dialing of telephone numbers, including an automatic telephone dialing system, or may use an artificial or pre-recorded voice, including recording messages or pre-recorded voicemails. Your agreement and consent is not required as a condition for the purchase of any goods or services. Message and data rates may apply. Unsubscribe at any time by replying STOP or clicking the unsubscribe link (where available). Text HELP for help. Message frequency varies. To the maximum extent permitted by law: (i) all information contained in SMS text messages is provided "as is" without warranty of any kind, either express or implied, including but not limited to the implied warranties of merchantability, fitness for a particular purpose, or noninfringement; and (ii) Celltrion expressly excludes any liability for any direct, indirect, or consequential loss or damage incurred by any user in connection with the receipt, use, failure of, or inability to use SMS text messages.

The patient also gives their permission to receive communications from Celltrion and parties acting on its behalf, including calls or messages made with an automated system for the selection and dialing of telephone numbers, including an automatic telephone dialing system, or may use an artificial or pre-recorded voice, including recorded messages or prerecorded voicemails at the phone number(s) provided to determine their eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as co-pay support or free drug programs, Nurse Connectors™ educational support communications, and/or other nonmarketing purposes. The patient understands that they can opt out of these telephonic communications concerning Patient Support Activities at any time by contacting Celltrion at 1-877-81CONN (1-877-812-6662), Monday - Friday, 8 AM - 8 PM ET.

Celltrion CONNECT®: View our privacy policy: <https://www.celltrionconnect.com/patient-privacy-policy> | View our terms of use: <https://www.celltrionconnect.com/terms-of-use/>

By signing below, the patient expressly consents to the terms of this section.

☐ By checking this box, the patient accepts receiving SMS messages with the cell phone number(s) provided in the Patient Information section.

SIGN & DATE**Patient or Patient Authorized Representative Signature****Date**

Patient Representative First and Last Name (print):

Relationship to Patient

Please see Important Safety Information on page 4 and full Prescribing Information.

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Indications and Consumer ISI for STEQEYMA (ustekinumab-stba) injection

INDICATIONS

STEQEYMA is a prescription medicine used to treat:

- **moderate or severe plaque psoriasis** in adults and children 6 years and older who may benefit from taking injections or pills (systemic therapy) or phototherapy (treatment using ultraviolet light alone or with pills).
- **active psoriatic arthritis** in adults and children 6 years and older.
- **moderately to severely active Crohn's disease** in adults 18 years and older.
- **moderately to severely active ulcerative colitis** in adults 18 years and older.

It is not known if STEQEYMA is safe and effective in children less than 6 years of age.

Do not take STEQEYMA if you are allergic to ustekinumab products or any of the ingredients in STEQEYMA.

IMPORTANT SAFETY INFORMATION

Serious infections. STEQEYMA affects your immune system and can increase the risk of serious infections, including tuberculosis (TB), bacterial, fungal, and viral infections. Some infections may require hospitalization.

Before starting STEQEYMA:

- Your doctor will test you for TB.
- If you're at risk for TB, you may need treatment before and during STEQEYMA.
- **Tell your doctor if you:**
 - Have an infection or signs of infection: fever, chills, cough, muscle aches, shortness of breath, weight loss, blood in phlegm, tiredness, diarrhea, stomach pain, skin sores, or burning when urinating.
 - Are being treated for an infection or have any open cuts.
 - Get frequent or recurring infections.
 - Have TB or have been exposed to TB.
 - Ever had an allergic reaction to ustekinumab products.
 - Recently had or plan to get vaccines (*you must avoid live vaccines, including the BCG vaccine during treatment and for a year afterward*).
 - Have new or changing lesions within psoriasis areas or on normal skin.
 - Are receiving or have received allergy shots or phototherapy.
 - Are pregnant, planning to become pregnant, or breastfeeding. STEQEYMA can pass into breast milk.
 - Received STEQEYMA while pregnant, inform your baby's healthcare provider before they get vaccinations.
- **Tell your doctor about all the medicines you take**, including prescription and over-the-counter medicines, vitamins, and herbal supplements. Know all the medicines, vitamins, and supplements you take, and share them with your doctor.

After starting STEQEYMA:

Call your doctor right away if you develop symptoms of an infection, such as chest infections, skin infections, or shingles. STEQEYMA can increase the risk of infections or make existing infections worse.

Cancers

STEQEYMA may increase the risk of certain cancers, including skin cancer. Tell your doctor if you have a history of cancer or notice any new skin growths during treatment.

Posterior Reversible Encephalopathy Syndrome (PRES)

PRES is a rare but serious brain condition that can cause death. Symptoms include headache, confusion, seizures, and vision problems. Contact your doctor immediately if these occur.

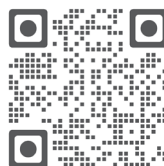
Serious Allergic Reactions. Serious allergic reactions can occur with STEQEYMA. Stop using STEQEYMA and get medical help right away if you have any of the following symptoms of a serious allergic reaction: feeling faint, chest tightness, swelling of your face, eyelids, tongue, or throat, or a skin rash.

Lung Inflammation. Cases of lung inflammation have happened in some people who receive ustekinumab products and may be serious. These lung problems may need to be treated in a hospital. Tell your doctor right away if you develop shortness of breath or a cough that doesn't go away during treatment with STEQEYMA.

Common Side Effects of STEQEYMA. Common side effects of STEQEYMA include nasal congestion, sore throat, and runny nose; upper respiratory infections; fever; headache; tiredness; itching; nausea and vomiting; redness at the injection site; vaginal yeast infections; urinary tract infections; sinus infection; bronchitis; diarrhea; and stomach pain.

These are not all of the possible side effects of STEQEYMA. Call your doctor for medical advice about side effects.

You may report side effects to FDA at 1-800-FDA-1088. You may also report side effects to CELLTRION USA, Inc. at 1-800-560-9414.



Please see full Prescribing Information by scanning the QR code.

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