

Patient Support Program

ENROLLMENT FORM



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

Instructions for Enrollment - Celltrion CONNECT® offers 3 options for enrollment:

Option 1: Submit through the Portal

At www.CelltrionConnect.com/ZYMFENTRA/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

OR

Option 2: Send an ePrescription

- Select ePrescribe to Phyz via the pharmacy drop-down menu: **NCPDP: 5928809 | Phone: 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 **833-912-3707**
- Celltrion CONNECT will forward the ZYMFENTRA® prescription to the appropriate pharmacy

OR

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 **833-912-3707**

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

Requested Services - Please check all that apply:

☐ **Select All**

☐ Benefit Verification

☐ Prior Authorization Support

☐ Co-pay Support for Commercially Insured Patients

☐ Appeals Support

☐ Medical Claims Support

☐ Nurse Connector™ Support Only*

For co-pay assistance only, visit www.CelltrionCARES.com to enroll

*Nurse Connectors can assist patients in medication and adherence communications, offer medication dispensing support, and disease state education. 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 <i>By providing alternate contact information, I hereby authorize the release of my protected health information to the authorized alternate contact.</i>				
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/ZYMFENTRA

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? (Optional)	☐ Yes ☐ No		
Cardholder Name		Pharmacy Benefit Name	
		Policy/Identification #	
Rx BIN		Rx PCN	
		Group #	

Please see Important Safety Information, including BOXED WARNING, 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.

Patient Name Patient Date of Birth

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

Is the patient currently receiving intravenous (IV) infliximab?

☐ **Yes**

Which IV infliximab product is the patient receiving?

Date of first dose

Date of last dose

Anticipated patient start date of ZYMFENTRA:

☐ **No**

Would you like to verify coverage for IV infliximab? Yes ☐ No ☐ *If yes, please complete the following:*

Infusion site name, if different from prescriber:

Address:

City:

State:

Zip:

Contact Name:

Phone:

Fax:

Site NPI:

Tax ID:

Medicare #:

Please send statement of coverage to: ☐ Infusion Site ☐ Prescriber ☐ Both

ZYMFENTRA® (infliximab-dyyb) Prescribing Information - All fields required.

Preferred Specialty Pharmacy, if known:

ZYMFENTRA® (infliximab-dyyb)	Select Indication	☐ ICD-10: K50 (Moderately to severely active Crohn's disease following treatment with an infliximab product administered intravenously)	
		☐ ICD-10: K51 (Moderately to severely active Ulcerative colitis following treatment with an infliximab product administered intravenously)	
	Select Quantity and Refill	Quantity	Refills
		120 mg/mL solution in a single-dose prefilled pen , inject subcutaneously every 2 weeks	☐ #2 (1 month) ☐ #6 (3 months)
	120 mg/mL solution in a prefilled syringe with needle shield, inject subcutaneously every 2 weeks	☐ #2 (1 month) ☐ #6 (3 months)	

For commercially insured patients experiencing a delay or gap in prescription coverage

Celltrion may provide ZYMFENTRA to eligible patients, including those with commercial insurance experiencing delays or a gap in coverage of ZYMFENTRA. Eligible patients must have been prescribed ZYMFENTRA for an on-label indication, and their participation is in no way contingent on any requirement or obligation to purchase ZYMFENTRA or any other Celltrion product or service at any time. Patients who are covered, in whole or part, through a state or federal healthcare program, including but not limited to Medicare, Medicaid, Medigap, CHAMPUS, TRICARE, Veterans Affairs, or Department of Defense, are not eligible. Eligibility for continued participation will be verified periodically, and patients will not be eligible to continue participating if they no longer satisfy the eligibility criteria, including when initiation of coverage for ZYMFENTRA is approved by the patient's commercial insurance plan. Void where prohibited or restricted by law, and Celltrion reserves the right to rescind, revoke, or amend the terms and conditions at any time without notice.

☐ I authorize Celltrion to determine a patient's eligibility to receive ZYMFENTRA at no cost. I authorize Celltrion to forward this prescription to the designated pharmacy to dispense ZYMFENTRA directly to the above-named patient. I understand that eligibility will be reverified periodically during the program.
Patient authorization to share health information is required to receive ZYMFENTRA at no cost to the patient.
If authorized above, complete the prescription below.

ZYMFENTRA® (infliximab-dyyb)	Select Dosage Form	☐ 120 mg/mL solution in a single-dose prefilled pen , inject subcutaneously every 2 weeks	Quantity 1 (# of packs)	Refills 12
		☐ 120 mg/mL solution in a prefilled syringe with needle shield, inject subcutaneously every 2 weeks		

Prescriber Attestation/Authorization

I certify that the information provided in this ZYMFENTRA Enrollment Form is complete and accurate to the best of my knowledge. I have prescribed ZYMFENTRA 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 ZYMFENTRA, and providing my patient and me with other educational and support services associated with ZYMFENTRA. I agree that the Celltrion CONNECT program may contact me for additional information relating to ZYMFENTRA, 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, including BOXED WARNING, 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 six (6) 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 (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 (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, including BOXED WARNING, on page 4 and full Prescribing Information.

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Indication and Important Safety Information for ZYMFENTRA® (infliximab-dyyb)

What is the most important information I should know about ZYMFENTRA? ZYMFENTRA may cause serious side effects, including risk of infection and cancer.

- **Risk of infection:** ZYMFENTRA can lower the ability of your immune system to fight infections. Serious infections have happened in patients receiving ZYMFENTRA. These infections include tuberculosis (TB) and infections caused by viruses, fungi, or bacteria that have spread throughout the body. Some patients have died from these infections.
 - Your doctor should test you for TB before starting ZYMFENTRA, and should monitor you closely for signs and symptoms of TB during treatment.
 - If you have an infection, any sign of an infection including a fever, cough, flu-like symptoms, or have open cuts or sores on your body, call your doctor right away. ZYMFENTRA can make you more likely to get infections or make any infection that you have worse.
- **Risk of cancer:** There have been cases of unusual cancers in children and teenage patients using tumor necrosis factor (TNF) blocker medicines, such as ZYMFENTRA.
 - For people receiving TNF blocker medicines, the chances of getting lymphoma or other cancers may increase.
 - Some people receiving TNF blockers developed a rare type of cancer called hepatosplenic T-cell lymphoma. This type of cancer often results in death. Most of these people were male teenagers or young men. Also, most people were being treated for Crohn's disease or ulcerative colitis with a TNF blocker and another medicine called azathioprine or 6-mercaptopurine.
 - People who have been treated for Crohn's disease or ulcerative colitis for a long time may be more likely to develop lymphoma. This is especially true for people with very active disease.
 - Some people treated with infliximab products have developed certain kinds of skin cancer. If any changes in the appearance of your skin or growths on your skin occur during or after your treatment, tell your doctor.
 - Patients with chronic obstructive pulmonary disease (COPD), a specific type of lung disease, may have an increased risk for getting cancer while being treated with ZYMFENTRA.
 - Tell your doctor if you have ever had any type of cancer. Discuss with your doctor any need to adjust medicines you may be taking.

Do not take ZYMFENTRA if you:

- Have had an allergic reaction to ZYMFENTRA, other infliximab products, any murine proteins, or any of the ingredients in ZYMFENTRA.

Before you receive ZYMFENTRA, tell your doctor about all your medical conditions, including if you:

- Have an infection.
- Have other liver problems including liver failure.
- Have heart failure or other heart conditions.
- Have or have had any type of cancer.
- Have COPD, a specific type of lung disease.
- Have or have had a condition that affects your nervous system such as multiple sclerosis or Guillain-Barré syndrome, or if you experience any numbness or tingling, or if you have had a seizure.
- Have recently received or are scheduled to receive a vaccine. Adults should have all their vaccines brought up to date before starting treatment with ZYMFENTRA.
- Are pregnant or plan to become pregnant, are breastfeeding or plan to breastfeed.

What should I avoid while taking ZYMFENTRA?

- Do not take ZYMFENTRA together with other medicines called biologics that are used to treat the same conditions as ZYMFENTRA.

What are the possible side effects of ZYMFENTRA?

ZYMFENTRA can cause serious side effects, including:

- **Serious infections:**
 - Tell your doctor right away if you have any signs of an infection, including a fever, tiredness (fatigue), a cough, flu-like symptoms, or warm, red, or painful skin.

- Your doctor will examine you for TB and perform a test to see if you have TB.
- If you are a chronic carrier of the hepatitis B virus, the virus can become active while you are being treated with ZYMFENTRA. In some cases, patients have died as a result of hepatitis B virus being reactivated. Your doctor should do a blood test for hepatitis B virus before you start treatment, while you are being treated, and for several months after you finish treatment. Tell your doctor if you have symptoms such as feeling unwell, poor appetite, tiredness (fatigue), fever, skin rash, or joint pain.

• **Liver injury:**

- Some patients receiving infliximab products have developed serious liver problems. Tell your doctor if you have jaundice (skin and eyes turning yellow), dark, brown-colored urine, pain on the right side of your stomach area (right-sided abdominal pain), fever, or extreme tiredness (severe fatigue).

• **Heart failure:**

- If you have a heart problem called congestive heart failure, your doctor should check you closely while you are receiving ZYMFENTRA. Your congestive heart failure may get worse while you are receiving ZYMFENTRA. Be sure to tell your doctor of any new or worse symptoms including shortness of breath, swelling of ankles or feet, or sudden weight gain.
- Treatment may need to be stopped if you get new or worse congestive heart failure.

• **Blood problems:**

- In some patients receiving infliximab products, the body may not make enough of the blood cells that help fight infections or help stop bleeding. Tell your doctor if you have a fever that does not go away, bruise or bleed very easily, or look very pale.

• **Allergic reactions:**

- Signs of an allergic reaction can include hives (red, raised, itchy patches of skin), difficulty breathing, chest pain, high or low blood pressure, fever, and chills.
- Tell your doctor right away if you have any of these signs of delayed allergic reaction such as fever, rash, headache, sore throat, muscle or joint pain, swelling of the face and hands, or difficulty swallowing.

• **Nervous system disorders:**

- Tell your doctor if you have changes in your vision, numbness or tingling in any part of your body, seizures, or weakness in your arms or legs.
- Some patients have experienced a stroke within approximately 24 hours of their infusion with infliximab products. Tell your doctor right away if you have symptoms of a stroke which may include numbness or weakness of the face, arm or leg, especially on one side of the body; sudden confusion; trouble speaking or understanding; sudden trouble seeing in one or both eyes; sudden trouble walking; dizziness; loss of balance or coordination; or a sudden, severe headache.

• **Lupus-like syndrome:**

- Your doctor may decide to stop treatment if you develop symptoms such as chest discomfort or pain that does not go away, shortness of breath, joint pain, or a rash on the cheeks or arms that gets worse in the sun.

The most common side effects include COVID-19, joint pain, respiratory infections such as sinus infections and sore throat, diarrhea, injection site reactions, high blood pressure, headache, urinary tract infections, abdominal pain, dizziness, and abnormal liver enzymes.

INDICATIONS

ZYMFENTRA is a prescription medicine used as an injection under the skin (subcutaneous injection) by adults for the maintenance treatment of moderately to severely active ulcerative colitis or moderately to severely active Crohn's disease following treatment with an infliximab product given by intravenous infusion (IV).

Call your doctor for medical advice about side effects. You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

Please see the Medication Guide and talk with your healthcare provider.



Please see full Prescribing Information, including BOXED WARNING, by scanning the QR Code.

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