

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 2 options for enrollment:

Option 1: Submit through the Portal

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

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

OR

Option 2: 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

Requested Services

Please check all that apply:

- | | | | |
|--|---|--|---|
| ☐ All Services | ☐ Benefit Verification | ☐ Prior Authorization Support | ☐ Co-pay Support for Commercially Insured Patients |
| ☐ Appeals Support | ☐ Medical Claims Support | For co-pay assistance only, visit www.CelltrionCARES.com to enroll | |

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				
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 .					
Primary Insurance		Policyholder Name			
Primary Policy #		Primary Group #		Policyholder Date of Birth	/ /
Secondary Insurance		Policyholder Name			
Secondary Policy #		Secondary Group #		Policyholder Date of Birth	/ /

Please see Important Safety Information on page 4 and full Prescribing Information, including BOXED WARNING.

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

Clinical Information - All fields marked with an * are required.

*Primary Diagnosis

- ☐ M05. Rheumatoid Arthritis (RA) ☐ M08. Polyarticular Juvenile Idiopathic Arthritis (PJIA) in patients 2 years of age and older ☐ D89. Cytokine Release Syndrome (CRS)
- ☐ M31. Giant Cell Arteritis (GCA) ☐ M08. Systemic Juvenile Idiopathic Arthritis (SJIA) in patients 2 years of age and older ☐ U07.1. Coronavirus Disease 2019 (COVID-19)

Other (specify ICD-10 Code and description): Please provide secondary ICD-10 Code, if applicable:

Prior Therapies

Has the patient started treatment with a tocilizumab medication? ☐ Yes If yes, treatment dates: to ☐ No If no, anticipated date of treatment:

AVTOZMA® (tocilizumab-anoh) Prescribing Information - All fields required.

Fulfillment Method:

Site of Care ☐ Prescriber's Office ☐ Hospital Outpatient ☐ Other

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

Address City State Zip Phone () -

AVTOZMA IV Infusion Order:

IV Dosing Guidance

Adult Rheumatoid Arthritis (RA)	- Initial 4 mg per kg every 4 weeks - Increase to 8 mg per kg every 4 weeks based on clinical response
Giant Cell Arteritis (GCA)	6 mg per kg every 4 weeks in combination with a tapering course of glucocorticoids
Polyarticular Juvenile Idiopathic Arthritis (PJIA)	<30 kg: 10 mg per kg every 4 weeks ≥30 kg: 8 mg per kg every 4 weeks
Systemic Juvenile Idiopathic Arthritis (SJIA)	<30 kg: 12 mg per kg every 2 weeks ≥30 kg: 8 mg per kg every 2 weeks
Cytokine Release Syndrome (CRS)	≤30 kg: 12 mg per kg administered by a 60-minute intravenous infusion ≥30 kg: 8mg per kg administered by a 60-minute intravenous infusion
Coronavirus Disease 2019 (COVID-19)	8 mg per kg administered by a 60-minute intravenous infusion

Sig: Infuse mg Patient weight kg

Frequency

- ☐ Once every 2 weeks
- ☐ Once every 4 weeks
- ☐ Other

Dispense AVTOZMA Vials

☐ 80 mg dose ☐ 200 mg dose ☐ 400 mg dose

Refills

Prescriber Attestation/Authorization

I certify that the information provided in this AVTOZMA Enrollment Form is complete and accurate to the best of my knowledge. I have prescribed AVTOZMA 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 AVTOZMA, and providing my patient and me with other educational and support services associated with AVTOZMA. I agree that the Celltrion CONNECT program may contact me for additional information relating to AVTOZMA, including but not limited to via email, fax, and telephone.

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

Please see Important Safety Information on page 4 and full Prescribing Information, including BOXED WARNING.

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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

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 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

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, 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

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Indications and Important Safety Information for AVTOZMA® (tocilizumab-anoh)

INDICATIONS

AVTOZMA® (tocilizumab-anoh) is a prescription medicine used for the treatment of:

- Adults with moderately to **severely active rheumatoid arthritis (RA)**, after at least one other medicine called a Disease-Modifying Anti-Rheumatic Drug (DMARD) has been used and did not work well.
- Adults with **giant cell arteritis (GCA)**.
- People with **active Polyarticular Juvenile Idiopathic Arthritis (PJIA)** ages 2 and above.
- People with **active Systemic Juvenile Idiopathic Arthritis (SJIA)** ages 2 and above.
- People ages 2 years and above who experience severe or life-threatening **Cytokine Release Syndrome (CRS)** following chimeric antigen receptor (CAR) T cell treatment.
- Hospitalized adults with **coronavirus disease 2019 (COVID-19)** receiving systemic corticosteroids and requiring supplemental oxygen or mechanical ventilation. AVTOZMA is not approved for subcutaneous use in people with COVID-19.

It is not known if AVTOZMA is safe and effective in children with PJIA or SJIA under 2 years of age or in children with conditions other than PJIA or SJIA.

IMPORTANT SAFETY INFORMATION

AVTOZMA can cause serious side effects, including:

Serious infections, which may lead to death. AVTOZMA can weaken your immune system, increasing the risk of infections or worsening existing ones. Your doctor will test for tuberculosis (TB) before starting treatment. If you have COVID-19, your doctor should monitor you for signs and symptoms of new infections during and after treatment with AVTOZMA. After starting AVTOZMA, call your doctor right away if you have any symptoms of an infection such as fever, chills, cough, or other signs of infection.

Tears (perforation) in your stomach or intestines. Some people taking AVTOZMA get tears in their stomach or intestine. This happens most often in people who also take nonsteroidal anti-inflammatory drugs (NSAIDs), corticosteroids, or methotrexate. Get medical help right away if you have stomach pain that does not go away, and a change in your bowel habits

Liver problems. Some people have experienced serious life-threatening liver problems, which required a liver transplant or led to death. Your doctor will monitor your liver function. Call your doctor if you experience tiredness, loss of appetite, nausea, dark urine, or yellowing of the skin or eyes.

Changes in certain laboratory test results. Your doctor should do blood tests before and during treatment with AVTOZMA. Make sure you get all your follow-up blood tests done as

ordered by your doctor. Your doctor may stop your AVTOZMA treatment for a period of time or change your dose of medicine if needed because of changes in these blood test results.

Cancer. AVTOZMA may increase your risk of certain cancers by changing the way your immune system works. Tell your doctor if you have ever had any type of cancer.

Do not take AVTOZMA if you are allergic to tocilizumab or any of its ingredients.

Before taking AVTOZMA, tell your doctor about all your medical conditions, including if you:

- Have infections (with or without a fever), liver problems, or a history of stomach/intestinal ulcers or cancer.
- Have diabetes, HIV, or a weak immune system. People with these conditions have a higher chance for infections.
- Have or had hepatitis B, tuberculosis (TB), have been in close contact with someone with TB, live or have lived or traveled to certain parts of the country (such as the Ohio and Mississippi River valleys and the Southwest).
- Have had an allergic reaction to tocilizumab products or any of its ingredients.
- Have or had a condition that affects your nervous system, such as multiple sclerosis.
- Have had a recent or scheduled vaccine (you should not receive live vaccines while on AVTOZMA).
- Plan to receive surgery or a medical procedure.
- Are pregnant, planning to become pregnant, or breastfeeding. AVTOZMA may harm your unborn baby. It is not known if AVTOZMA passes into your breast milk.

Also, tell your doctor about all of the medicines you take, including prescription, over-the-counter medicines, vitamins and herbal supplements. AVTOZMA and other medicines may affect each other causing side effects. Know the medicines you take. Keep a list of them to show to your healthcare provider and pharmacist when you get a new medicine.

The most common side effects include: upper respiratory tract infections (such as colds), headache, high blood pressure, injection site reactions, and increased liver enzyme levels.

These are not all the possible side effects. Call your doctor right away if you have any symptoms of an infection or experience any side effects.

You may report side effects by calling Celltrion USA Inc. at 1-800-560-9414, FDA at 1-800-FDA-1088, or visit www.fda.gov/medwatch.

For more information about AVTOZMA, see full Prescribing Information, including BOXED WARNING.

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