

Patient Assistance Program

APPLICATION FORM



Monday - Friday, 8 AM - 8 PM ET / Phone: (877) 812-6662
Fax: (877) 431-6444 / www.CelltrionConnect.com

INSTRUCTIONS FOR COMPLETION

Fill out the form on your computer, then print and sign the form. Fax all pages and any supporting documentation and clinic notes to Celltrion CONNECT®: 1-877-431-6444

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 Method ☐ 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 Information:
Alternate Contact Name Relationship to Patient
Primary Phone ☐ Cell ☐ Home Secondary Phone ☐ Cell ☐ Home

The Celltrion CONNECT® Patient Assistance Program is for uninsured patients only. Please confirm the patient does not have insurance. ☐

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, 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 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 1-877-431-6444. 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. ☐

Please see Important Safety Information on page 5 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 **PATIENT ASSISTANCE PROGRAM (PAP) CONSENT**

I certify that I cannot afford my medication, and I affirm that my answers and my proof-of-income documents are complete, true, and accurate to the best of my knowledge. I will promptly contact the Celltrion Patient Assistance Program within thirty (30) days if my financial status or health insurance coverage changes. I will not seek to have this medicine or any cost from it counted in my Medicare Part D out-of-pocket expenses for prescription drugs. I will not seek reimbursement or credit for the medicine(s) from my prescription insurance provider, payor, or government health benefit program, including Medicare Part D plans, for Celltrion medications that I receive from the Celltrion Patient Assistance Foundation. I will notify my insurance provider of the receipt of any medicines through the Celltrion Patient Assistance Program. I have a signed copy of a current and completed Patient Authorization to Share Health Information on record with my healthcare provider so that my healthcare provider may share health information about me with Celltrion's assistance programs, Celltrion USA, Inc., and the Celltrion Patient Assistance Foundation.

I understand that the information I provide will be used by Celltrion, the Celltrion Patient Assistance Foundation, and parties acting on their behalf to determine eligibility, to manage and improve Celltrion's assistance programs, to communicate with me about my experience with Celltrion's assistance programs, to help me understand my insurance coverage and help me access certain Celltrion medicines through my insurance, and/or to send materials and other helpful information and updates relating to Celltrion programs.

I understand that: Completing this enrollment form does not guarantee that I will qualify for Celltrion's assistance programs. Celltrion may contact my insurer, to help me understand my insurance coverage for certain products and may provide me with support to obtain coverage through my insurer, including prior authorization and appeals support (if necessary and available). Celltrion may verify the accuracy of the information I have provided and may ask for more financial and insurance information. Any medicines supplied by Celltrion's assistance programs shall not be sold, traded, bartered, or transferred. Celltrion reserves the right to change or cancel Celltrion's assistance programs, or terminate my enrollment, at any time. The support provided through this program is not contingent on any future purchase. If I decide to enroll in a Medicare Part D plan and am eligible for the Celltrion Patient Assistance Program, I will inform the Celltrion Patient Assistance Foundation by calling 1-877-812-6662. If I receive notice that I have been auto enrolled in a Medicare Part D plan, I will immediately notify the Celltrion Patient Assistance Foundation.

 ☐ By checking this box, the patient agrees to PAP consent and agrees to the Terms and Conditions specified above.

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 1-877-812-6662, 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

PATIENT FINANCIAL VERIFICATION AUTHORIZATION

I understand that by checking the "I Agree" box immediately following this notice, I am providing "written instructions" to Celltrion CONNECT® and/or its agents and contractors under applicable federal and/or state law authorizing them to perform electronic income verification by obtaining information from my personal credit profile or other information from Experian Health. I authorize Celltrion CONNECT® and/or their agents and contractors to obtain such information solely to validate my income for the purposes of determining my eligibility for patient assistance. As a soft credit check, it will not impact my credit score.

 ☐ **I AGREE** to the terms above for electronic income verification using Experian Health.

☐ **I DO NOT AGREE** with the terms above and do not wish to have my income verified by using Experian Health. I understand that I will be asked to provide supporting documentation to authenticate my income and eligibility. If additional income documentation is required, the following documents are acceptable for income verification:

• Social Security/Disability benefit statement, monthly check, or 1099 • Previous year tax return or W-2 statement • Unemployment or disability determination letter

PATIENT INCOME VERIFICATION**Annual Gross Income** (Including salary/wages, Social Security income, disability income, and any other income):**Household Size** (Number of members including you):

 ☐ By checking this box, the patient agrees to income information specified here.

Please see Important Safety Information on page 5 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

PRESCRIPTION INFORMATION - All fields required.

Product

 STEQEYMA® (ustekinumab-stba)

Diagnosis Code:

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

☐ IV Loading Dose
☐ Subcutaneous Maintenance Dose

Date of Anticipated Infusion Induction Dose (if known)

Date of Last Dose (if known)

Initial Therapy		Maintenance Therapy
Weight Range	Dose	☐ 90 mg single-dose prefilled syringe administered subcutaneously 8 weeks after the initial intravenous dose, then every 8 weeks thereafter
≤55 kg	☐ 260 mg (2 x 130 mg/26 mL vials) given as a single intravenous infusion	Qty: Refills:
>55 kg to 85 kg	☐ 390 mg (3 x 130 mg/26 mL vials) given as a single intravenous infusion	
>85 kg	☐ 520 mg (4 x 130 mg/26 mL vials) given as a single intravenous infusion	

For Patients With Plaque Psoriasis or Psoriatic Arthritis

☐ 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 6 years of age and older	<60 kg	☐ mg (0.75 mg/kg) administered subcutaneously initially and 4 weeks later	☐ mg (0.75 mg/kg) administered subcutaneously every 12 weeks Qty: Refills:
	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:
	>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 6 years of age and older	<60 kg	☐ mg (0.75 mg/kg) administered subcutaneously initially and 4 weeks later	☐ mg (0.75 mg/kg) administered subcutaneously every 12 weeks Qty: Refills:
	≥60 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 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:

PRESCRIBER ATTESTATION/AUTHORIZATION

By signing this document, the prescriber attests that they have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under the Health Insurance Portability and Accountability Act of 1996 and state law to release protected health information, including that contained on this form, to Celltrion and its employees or agents for the purposes relating to Celltrion's patient support program, including assisting the patient with benefits verification, prior authorization/appeals assistance, dispensing and delivery of the medication, financial assistance resources and information, such as co-pay support or free drug programs, for which the patient may be eligible, and other support for Celltrion's medication.

The provider certifies that they have obtained consent from the patient or the patient's caregiver to be contacted by Celltrion, Celltrion CONNECT®, and parties acting on their behalf at the phone number(s) provided regarding the purposes described above and for other non-marketing purposes.

The provider certifies that they are the prescriber of STEQEYMA to the patient and that the therapy is medically necessary. The provider authorizes Celltrion to act on their behalf to transmit this prescription by any means necessary to the pharmacy chosen by the patient.

SIGN & DATE

Prescriber Signature and Date (no stamps)

Dispense as Written/Brand Medically Necessary

May Substitute/Product Selection Permitted

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

Date

Date

Please see Important Safety Information on page 5 and full Prescribing Information.

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PATIENTS ELIGIBLE FOR THE CELLTRION CONNECT® PATIENT ASSISTANCE PROGRAM (PAP)

The Celltrion CONNECT PAP is designed to provide free product to qualified individuals who are uninsured. Celltrion CONNECT will help activate the PAP for eligible participants.

To receive PAP benefits, the patient must enroll in the program and meet the following eligibility requirements:

- Patient has no insurance:
 - Uninsured includes all payor types
 - The patient must have tried all other insurance options for coverage. Some examples of other insurance coverage include private insurance, HMOs, Medicaid, Medicare, state pharmacy assistance programs, veterans assistance, and any other social service agency support.
 - This program excludes patients whose medication is reimbursed in whole or in part by any type of government insurance (eg, Medicare, Medicaid, TRICARE, or any other federal or state program). Patients who have Medicare Parts A and B only (no Medicare Part D) are still excluded.
- Patient must have a valid prescription from a licensed healthcare provider (HCP) for an on-label indication.
- Patient must have an adjusted annual household income of $\leq 400\%$ of the federal poverty level (FPL).
- Income verification:
 - Electronic income verification (eIV) will be conducted by the program. No asset review will be required; however, patients will need to provide proof of income if eIV does not match what the patient has reported (proof of income could include one of the following: W-2s, tax returns (1040, 1099), 3 months of pay stubs).
- Patient must show proof of residency by providing a valid United States or the Commonwealth of Puerto Rico address, and product must be administered and shipped to locations in the United States or the Commonwealth of Puerto Rico. Patient must have lived in the United States or the Commonwealth of Puerto Rico for at least 6 months.
- Diagnosis and dosing are consistent with FDA-approved indication for SteQeyma.
- Patients with insurance plans or employers participating in an alternate funding program (also sometimes referred to as patient advocacy programs, specialty networks, SHARx, Paydhealth, or Payer Matrix, among other names) are not eligible for PAP.
 - These programs require patients to apply to a manufacturer's PAP or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of relevant products, or that otherwise denies, restricts, eliminates, delays, alters, or withholds any insurance benefits or coverage contingent upon application to, or denial of eligibility for, specialty drug prescription coverage through the alternate funding program.
 - Patients must promptly contact the Celltrion CONNECT PAP if their financial status or insurance coverage changes.
- Electronic benefits verification (eBV) will be conducted by the program every 6 months to determine coverage changes.
- You may not seek payment for the value of medicines received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account
- This program offer may not be used with any other coupon, discount, prescription savings card, free trial, or other offer. Offer good only in the United States or the Commonwealth of Puerto Rico. Void where prohibited, taxed, or limited by law.
- Program terms will expire at the end of each calendar year and may change or end without notice.
- Eligibility rules are subject to change at any time.

Please see Important Safety Information on page 5 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.

Indications and Important Safety Information 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.