RYSTIGGO®
(rozanolixizumab-noli)
Injection For Subcutaneous Use

ONWARD

Start Form for
RYSTIGGO® (rozanolixizumab-noli) Injection For Subcutaneous Use

Instructions for Prescribers or Rendering Providers

To get a patient who has been prescribed RYSTIGGO started in ONWARD®, please follow these steps:

1. Complete the RYSTIGGO Start Form, providing all required information indicated on the form along with submission of the following clinical documentation to support patient access to treatment:
   - Clinical notes supporting patient's diagnosis
   - MGFA clinical classification
   - MG-ADL score
   - Anti-AChR and/or anti-MuSK antibody lab report(s)
   - Medication list (including current and previous therapies)
2. Have your patient read and sign the Patient Authorization sections of the Start Form (pages 4-5).
3. Fax the completed Start Form to 1-833-FAX-UCB1 (**1-833-329-8221**) or email it to **ucbonward@rxallcare.com.**

Instructions for Patients

If you're a patient who has been prescribed RYSTIGGO and you'd like to enroll in ONWARD, please follow these steps:

1. Read and sign the Patient Authorization sections of the Start Form (pages 4-5) to enroll in ONWARD.
2. If you would like us to communicate with you via email and/or text, make sure to check the appropriate consent boxes (page 4) and provide your email address and/or mobile phone number (page 2).
3. You will receive a call from ONWARD to discuss the support services being requested by you and/or your physician. Please note that when you receive this call, your caller ID may display ONWARD, 1-844-669-2731, or a phone number starting with an area code of 833.

If you have any questions, please call us at 1-844-ONWARD1 (**1-844-669-2731**). A program associate is available to help you **Monday through Friday, 8 AM to 8 PM, Eastern Time**.

RYSTIGGO® (rozanolixizumab-noli) Injection For Subcutaneous Use Start Form

FAX: 1-833-FAX-UCB1 (1-833-329-8221) | ENROLL ONLINE: ONWARDhcp-enroll-RYSTIGGO.com | EMAIL: ucbonward@rxallcare.com | QUESTIONS? CALL: 1-844-ONWARD1 (1-844-669-2731)

Step 1: Patient Information * Required field

☐ New to Therapy ☐ On Therapy

First Name* | Middle Initial | **Last Name***

Date of Birth* (MM/DD/YYYY) | **Phone Number*** ☐ Home ☐ Cell | Gender: M ☐ F ☐ Other ☐

Street Address* | Apt#

City* | **State*** | **ZIP*** | Preferred Language: ☐ English ☐ Spanish ☐ Other

Communication Preference: ☐ Email ☐ Phone ☐ Text | Email

☐ Please check here to authorize ONWARD® Care Coordinators to leave detailed messages (which may include health information) on your/your Authorized Patient Representative's voicemail.

Authorized Patient Representative Information

By providing this information, you authorize ONWARD to communicate with this person regarding your health condition and services provided by the program.

First Name | Last Name | Relationship to Patient

Phone ☐ Home ☐ Cell | Email

Primary Point of Contact (selection is required): ☐ Patient ☐ Authorized Patient Representative

STEP 2: Insurance Information * Required

NOTE: *You may attach copies of the front and back of the patient's insurance card(s) in lieu of completing this section.*

☐ Check here if patient does not have insurance	PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE PROVIDER		
INSURANCE PHONE#		
CARDHOLDER NAME		
RELATIONSHIP TO PATIENT		
MEMBER ID		
GROUP#		
BIN#		
PCN#		

STEP 3: Prescriber/Infusion Provider Information * Required field

Prescriber First Name* | **Prescriber Last Name***

Specialty | **NPI#*** | Tax ID#

Is this enrollment form being submitted by the infusion provider? ☐ Yes ☐ No

Infusion Provider | Infusion Provider NPI

Enrolling Provider Contact Information

Practice/Clinic Name*

Address*

City* | **State*** | **ZIP***

Office Phone#* | Office Fax#

Office Contact Name | Office Contact Email

Office Contact Phone# | Office Contact Communication Preference: ☐ Phone ☐ Email

STEP 4: Product Acquisition and Preferred Site of Care

Preferred Specialty Pharmacy

☐ CVS Specialty® ☐ KabaFusion ☐ Optum Infusion ☐ SoleoHealth

☐ Alivia Health (Puerto Rico only) Prescriber DEA #

RYSTIGGO® is available via a limited network which includes CVS Specialty, KabaFusion, Optum Infusion, SoleoHealth, and Alivia Health (Puerto Rico only).

Preferred Infusion Center/Infusion Provider

Name NPI#

Address City State ZIP

Preferred Site of Care:

☐ No preferred site of care; please provide in-network options.

☐ Patient has already been referred to a site of care.

STEP 5: Clinical Information * Required field

ICD-10 Diagnosis* ☐ G70.00 (Myasthenia gravis without acute exacerbation) ☐ G70.01 (Myasthenia gravis without acute exacerbation) ☐ Other

MGFA Classification (I, II, III, IV, V) **MG-ADL Score** **Date of Assessment**

AChR Antibody Test: ☐ Positive ☐ Negative ☐ Not Known MuSK Antibody Test: ☐ Positive ☐ Negative ☐ Not Known

Current Therapies:

- ☐ Eculizumab
- ☐ Efgartigimod
- ☐ Ravulizumab
- ☐ Oral corticosteroids
- ☐ Acetylcholinesterase inhibitors
- ☐ Rituximab
- ☐ IVIG
- ☐ Other
- ☐ Inebilizumab
- ☐ Nipocalimab
- ☐ SCIG
- ☐ PLEX
- ☐ RYSTIGGO (rozanolixizumab-noli)
- ☐ ZILBRYSQ® (zilucoplan)

Non-steroidal ISTs

- ☐ Azathioprine
- ☐ Cyclophosphamide
- ☐ Cyclosporine
- ☐ Methotrexate
- ☐ Tacrolimus
- ☐ Mycophenolate

Previous Therapies:

- ☐ Eculizumab
- ☐ Efgartigimod
- ☐ Ravulizumab
- ☐ Oral corticosteroids
- ☐ Acetylcholinesterase inhibitors
- ☐ Rituximab
- ☐ IVIG
- ☐ Other
- ☐ Inebilizumab
- ☐ Nipocalimab
- ☐ SCIG
- ☐ PLEX
- ☐ RYSTIGGO (rozanolixizumab-noli)
- ☐ ZILBRYSQ® (zilucoplan)

Non-steroidal ISTs

- ☐ Azathioprine
- ☐ Cyclophosphamide
- ☐ Cyclosporine
- ☐ Methotrexate
- ☐ Tacrolimus
- ☐ Mycophenolate

Medical Allergies: ☐ No allergies

STEP 6: Prescription Information * Required field

Patient First & Last Name* **Date of Birth*** (MM/DD/YYYY)

Prescriber to indicate prescribed RYSTIGGO dose:

MEDICATION	PATIENT WEIGHT	DOSING PER WEIGHT BAND	STRENGTH/ DOSAGE	DIRECTIONS FOR ADMINISTRATION	QTY	REFILLS*
RYSTIGGO (rozanolixizumab-noli)	____ kg	☐ Patient weight <50 kg	420 mg/3mL NDC: 50474-981-83	Use 1 vial via subcutaneous infusion once weekly for 6 weeks	6 vials	
	Date Weight Taken (MM/DD/YYYY) ____	☐ Patient weight ≥50 kg to <100 kg	560 mg/4mL NDC: 50474-982-84	Use 1 vial via subcutaneous infusion once weekly for 6 weeks	6 vials	
		☐ Patient weight ≥100 kg	840 mg/6mL NDC: 50474-983-86	Use 1 vial via subcutaneous infusion once weekly for 6 weeks	6 vials	

*Subsequent RYSTIGGO treatment cycles are administered based on clinical evaluation.

Infusion Order: ☐ I authorize the dispensing pharmacy to coordinate home health infusion nurse visits as necessary.

- I authorize home nurse visits to provide education related to infusion therapy, disease state, and subcutaneous nurse administration of RYSTIGGO, including dosing as per prescription orders.

Supplies Order: ☐ I authorize the dispensing pharmacy to provide supplies required to administer RYSTIGGO appropriate to the administration site of care.

Attestation and Signature

By signing below, I certify: 1) This information is accurate to the best of my knowledge; 2) I am disclosing this information to UCB, their affiliates, agents, representatives, business partners, and service providers (together "UCB") to help enable treatment for this Patient; 3) The Patient is aware of, has consented to, and has directed my disclosure of their information to UCB so that UCB may contact the Patient to further enable services for those purposes and that such consent and direction applies to disclosures made through the duration of the Patient's therapy; 4) I will not seek reimbursement from any third party for the support UCB provides; 5) The therapy is medically necessary; 6) I am licensed to prescribe the prescription medication identified in this form; 7) This prescription complies with my state-specific prescribing requirements; and 8) I appoint UCB as my agent, for the limited purpose of conveying this prescription by any means permitted under applicable law, solely to a dispensing pharmacy or infusion provider. PRESCRIBER SIGNATURE: **PRESCRIBER MUST MANUALLY SIGN AND DATE. RUBBER-STAMP SIGNATURE AND SIGNATURE BY OTHER OFFICE PERSONNEL FOR THE PRESCRIBER WILL NOT BE ACCEPTED.**

Print Prescriber First and Last Name:*

Prescriber Signature (Dispense as Written):* **Date (MM/DD/YYYY):***

No Stamp Signature

Patient Authorization

Please see next page for required HIPAA Authorization

❑ **PAP Consent (Required for the Patient Assistance Program):**
By checking here, applicants authorize ONWARD® PAP and its administrators to obtain a consumer report. The consumer report, and the information derived from public and other sources, will be used to estimate income as part of the process to decide eligibility to receive free medication from the ONWARD PAP. Upon request, the ONWARD PAP will provide applicants with the name and address of the consumer reporting agency that provides the consumer report. For additional questions about eligibility, please call ONWARD at 1-844-669-2731 (1-844-ONWARD1).

❑ **Text Message Consent Language:**
By checking here and providing your phone number below, you agree to receive text messages from UCB ONWARD for patient support. Message and data rates may apply. Message frequency will vary based on need. Text "**HELP**" to **844669** for help. Text "**STOP**" to **844669** to cancel. If you have questions, call 1-844-669-2731 (1-844-ONWARD1). For more information on how UCB will use your information, please view our privacy policy at www.ucb-usa.com/policy and our text messaging terms and conditions at www.ucbONWARD.com/Text-Terms-Conditions.

If giving consent, please provide your mobile number in Step 1: Patient Information to receive SMS communication.

❑ **Marketing Consent (Optional):**
By checking here & providing your email address and phone number below, you acknowledge you are a U.S. resident and give UCB and its business partners permission to send you information or contact you and/or your healthcare provider regarding your disease as well as information on other related treatments, products and services, and for marketing and informational purposes by phone, email, or mail. You understand that UCB or its business partners will not sell your name, address, email address, or any other information to another party for their own marketing use.

Please ensure an email address and phone number are provided in Step 1: Patient Information.

Patient Authorization to Use/Disclose Health Information (HIPAA Authorization) Required*

By signing this form, I hereby authorize each of my physicians, pharmacists (including any specialty pharmacy) that receives my prescription for a UCB medication, and other of my healthcare providers (together, "Providers") and each of my health insurers (together, "Insurers") to disclose information related to my medical condition and treatment (including prescription information), my health insurance coverage and policy number, my name, mailing and email addresses, telephone number, date of birth, and Social Security Number (together, "Protected Health Information"), to UCB, Inc. and its agents, service providers, contractors and representatives (together, "UCB"), so that UCB may:

(i) enroll me in, and contact me about, UCB medication support programs.
(ii) provide me with educational materials, information, and services related to UCB medications.
(iii) verify, investigate, assist with, and coordinate my coverage for a UCB medication with my Insurers and Providers.
(iv) conduct market analyses/research or other commercial activity, including aggregating my Protected Health Information with other data for such analyses.
(v) assist with analysis related to quality, efficacy, and safety for UCB medication, and, in some cases, contact you to follow up on adverse events in order to obtain additional information.
(vi) de-identify my Protected Health Information for use for any purpose under applicable law.

I understand that once my Protected Health Information has been disclosed to UCB, federal privacy laws may no longer protect the information and it may be subject to re-disclosure. I understand that one or more Provider and/or Insurer may receive payment from UCB for disclosing my Protected Health Information for some or all of the purposes listed above.

I understand that I am not required to sign this Patient Authorization to Use/Disclose Health Information Authorization, and that if I decline to sign, that will not affect my treatment (including the receipt of UCB medication), payment for treatment, insurance enrollment, or eligibility for insurance benefits, but it may mean that I will not receive the other services described above.

I understand that I may cancel (revoke) this Authorization at any time by calling ONWARD at 1-844-669-2731 (1-844-ONWARD1) or mailing a letter with my notice of withdrawal to ONWARD, 50 Bearfoot Road, Northborough, MA 01532.

UCB shall provide timely notification of my cancellation (revocation) to my Providers and Insurers. Once my Providers and Insurers receive and process the notice of cancellation (revocation) of this Authorization, my Providers and Insurers may no longer make disclosures of my Protected Health Information to UCB as permitted by this Authorization.

However, cancelling this Authorization will not affect any action(s) taken by my Providers or Insurers based on this Authorization before receipt of my notice of cancellation. This authorization expires five years from the date it was signed, or such earlier date as required by applicable state law unless I cancel it beforehand. I understand that I have the right to receive a copy of this Authorization when it is signed.

I agree to this Patient Authorization Form.

Print Patient First and Last Name: _____

Date of Birth: _____

Patient or Authorized Patient Representative Signature

Signature:* _____

Date:* _____

(If applicable) Print Authorized Patient Representative First and Last Name: _____

Relationship to Patient: _____