Beacon Infusion
Healthcare Services

Headquarters Location:
1075 Stephenson Ave, Suite D-2, Oceanport, NJ 07757
Telephone: (833) 223-2266 Fax: (732) 329-2322

TEPEZZA MEDICATION ORDER

Please complete all attached pages and submit to Horizon Therapeutics via fax at 833-469-8333.

The forms must be as complete as possible, including a weight-based dose in milligrams. Kindly include a clear copy of the patient's insurance information.

The first page must be signed by the prescriber, and the second page signed by the patient.

Completing all lines of the worksheet will significantly ease the authorization process. Once the case is transferred to us, we will contact your office to obtain supporting documentation (including lab results and medical records).

Thank you!

Patient Enrollment Form

Once complete, submit by **Fax 1-833-469-8333** or email **TEPEZZAHPS@horizontherapeutics.com**

HORIZON Patient Services™ | TEPEZZA® teprotumumab-trbw

Complete all gray boxes, including physician's signature and date, to initiate patient enrollment process.

For support, call Horizon Patient Services at 1-833-5-TEPEZZA (1-833-583-7399).

Patient Information (* indicates a required field)

First name* **Last name***

Sex: ◯ Male ◯ Female **Date of birth*:** ____/____/____ (MM/DD/YYYY)

Primary language Email address

Primary Telephone* Consent to leave voice message at patient and/or alternate contact telephone? ◯ Yes ◯ No

◯ Home ◯ Cell Consent to send text message? ◯ Yes ◯ No

Address*

City* **State*** **ZIP Code***

Alternate contact name Alternate contact telephone

Diagnosis (* indicates a required field) (Required for benefits investigation)

Primary diagnosis code*: Please select one.

◯ E05.00 — Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism)

◯ Other ICD-10 Code: _____

Date of Thyroid Eye Disease (TED) Diagnosis: ____/____/____

Additional disease manifestation codes: _____

Insurance Information (* indicates a required field)

Primary insurance* Secondary insurance

Policy #* Policy #

Policyholder's first and last name* Policyholder's first and last name

Insurance company telephone* Insurance company telephone

Group #* Group #

Policyholder's DOB*: ____/____/____ (MM/DD/YYYY) Policyholder's DOB: ____/____/____ (MM/DD/YYYY)

Please include *front and back* copy of insurance card(s) along with this form. Clinical documentation may be necessary to support prior authorization process.

◯ UNINSURED: Patient is ineligible for any health insurance, including Medicare and Medicaid, or has been denied by third-party payer. Please evaluate them for Patient Assistance Program. (Proof of income is required.)

State requirements: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

Physician Certification (Required - please see certification language on the next page)

PHYSICIAN SIGNATURE (REQUIRED) PHYSICIAN SIGNATURE

> Dispense as written Substitutions allowed

Date: ____/____/____ (MM/DD/YYYY) Written or e-signature only; stamps not acceptable.

◯ I certify that the above therapy is medically necessary for the treatment of documented Thyroid Eye Disease (TED)

The above signature grants permission to share records with the co-management team.

Physician Information (* indicates a required field)

First name* **Last name***

Address

City Select State State ZIP Code

NPI #* **Tax ID #*** **State license #***

Clinic/hospital affiliation

Office contact name

Office contact telephone* **Fax***

Email address

Preferred communication: ◯ Telephone ◯ Email

Physician specialty: _____

Co-Managing Physicians:

◯ Endocrinologist: _____ ◯ Ophthalmologist: _____

◯ Other specialty (please specify): _____

Infusion Facility

Do you have a preferred infusion facility? ⊗ Yes ◯ No If yes, please fill out the preferred infusion facility information below. If no, Horizon Patient Services will provide options for your patient.

Beacon Infusion Healthcare Services
Facility name

Whichever location is most convenient for the patient.
Facility address

City Select State State ZIP Code

833-223-2266
Telephone

732-329-2322
Fax

Facility NPI # Facility tax ID #

Prescription Information (Required for specialty pharmacy benefit or home infusion)

Medication: TEPEZZA® (teprotumumab-trbw) for injection, for intravenous use // 500-mg vial

Duration: 1 infusion every 3 weeks for a total of 8 infusions. Administer the first 2 infusions over 90 minutes. Subsequent infusions may be reduced to 60 minutes if well tolerated.

Dose*: Week 0: _____ mg (10 mg/kg) 21 day supply; 1 prescription; no refill

Week 3: _____ mg (20 mg/kg) 21 day supply; 1 prescription; 6 refills; q3wk

Weight*: _____ ◯ kg ◯ lbs

Allergies*: _____ or ◯ No known drug allergies (NKDA)

Route of administration: Peripheral IV ◯ Authorize administration supplies as needed

Please attach a list of concurrent medications.

Fluids for reconstitution/administration: Reconstitute each vial with 10 mL of Sterile Water for Injection, USP. Administer via an infusion bag containing 0.9% Sodium Chloride Solution, USP. For doses <1800 mg, use a 100 mL bag. For doses ≥1800 mg, use a 250 mL bag.

◯ **Nursing orders:** Provide skilled nursing visit to administer medication, provide education, and assess patient (required for home infusion).

To access additional support services, patients can sign on the next page or Horizon Patient Services can follow up to obtain a patient signature for you.

Please see Important Safety Information on next page and see Full Prescribing Information at TEPEZZAhcp.com.

Physician Certification: I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I understand that Horizon Therapeutics USA, Inc. and its affiliates and their respective employees or agents (collectively, "Horizon") will use this information to administer the Horizon Patient Services™ program (the "Program"), which provides assistance to patients in verifying insurance coverage for Horizon TED Medications and assistance in initiating or continuing Horizon TED Medications, as prescribed. By my signature, I also certify that my patient or his/her personal representative has provided a signed HIPAA authorization that allows me to share protected health information with Horizon for purposes of the Program. I appoint the Program, on my behalf, to proceed with services and convey this prescription to the dispensing pharmacy, to the extent permitted under state law. I further understand and agree that (a) any medication or service provided through the Program as a result of this form is for the named patient only and is not being made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use Horizon TED Medications, or any other Horizon product or service, for any other person, (b) my decision to prescribe Horizon TED Medications was based solely on my professional determination of medical necessity, and (c) I will not seek reimbursement for any medication or service provided by or through the Program from any government program or third-party insurer. I understand that Horizon may modify or terminate the Program at any time without notice. The completion and submission of coverage- or reimbursement-related documentation are the responsibility of the patient and healthcare provider. Horizon makes no representation or guarantee concerning coverage or reimbursement for any item or service. On behalf of the patient, Horizon expects physician to coordinate with Horizon Patient Services to provide, to the best of the physician's ability, in network infusion services and work with Horizon Patient Services to effectively communicate both in network and out of network choices and the corresponding financial obligations of the patient connected to each choice. Should the physician knowingly perform out of network services without the knowledge and consent of the patient, the physician cannot balance bill the patient for the out of network services.

By filling out and signing this form, the enrollment process in Horizon Patient Services has initiated; however, your patient must sign a Patient Authorization to complete enrollment in Horizon Patient Services. Please note that your patient will not benefit from the services and support offered by Horizon Patient Services unless your patient signs a Patient Authorization, consenting to receiving such services. If your patient does not sign the Patient Authorization contained within this form, Horizon will contact the patient to determine whether the patient is interested in signing a separate Patient Authorization.

Patient Consent for Patient Information, Enrolling in Services and Accessing Financial Support (referred to as "Patient Authorization")

Please read and provide signature in Patient Authorization section below

I hereby authorize my healthcare providers, my health insurance carriers, and my pharmacies to use and disclose my individually identifiable health information, including my medical records, insurance coverage information, and my name, address and telephone number to Horizon Therapeutics USA, Inc. and its affiliates and their respective agents and representatives (collectively, "Horizon"), including third parties authorized by Horizon to administer drug support and to dispense drugs (collectively, "Horizon Patient Services") for the following purposes: (1) to establish eligibility for benefits; (2) to communicate with my healthcare providers and me about my treatment or condition and related products; (3) to facilitate the provision of products, supplies, or services by a third party including, but not limited to, specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; (5) to enroll me in eligible patient support programs offered by Horizon Patient Services and/or Horizon, including nursing or patient access support services (government-reimbursed programs may not be eligible for all support services offered; please contact Horizon Patient Services for determination); and (6) to send me marketing information or offer me products and services related to my treatment or condition (or other products or services in which I might be interested) and to contact me occasionally to obtain my feedback (for market research purposes only) about my treatment, my condition, or my experience with Horizon and/or Horizon Patient Services otherwise as required or permitted by law. I understand the pharmacies may receive a fee from Horizon in exchange for (1) providing me with certain materials and information described above, and (2) using or disclosing certain health information pursuant to this Authorization.

I understand that Horizon, as well as my healthcare providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment, or other care, to sign this Authorization. I understand that I am entitled to a copy of this Authorization.

I understand that information disclosed pursuant to this Authorization in some cases may be redisclosed by the recipient and no longer protected by HIPAA or other privacy laws. But Horizon has agreed to use and disclose my information only for purposes of operating the program. I understand that I may cancel this Authorization at any time by mailing a signed letter requesting such cancellation to Horizon Patient Services, 1 Horizon Way, Deerfield, IL 60015, but that this cancellation will not apply to any information used or disclosed by my healthcare providers and/or health insurance carriers based on this Authorization before they are notified that I have cancelled it. Unless required by state law, this Authorization is valid for whichever is greater: (a) the duration of remaining on this treatment or (b) 10 years from the date signed below. A photocopy of this Authorization will be treated in the same manner as the original.

Patient Authorization

> _____ Date: ____/____/____

Patient signature
Please read consent above.

(MM/DD/YYYY)

_____ Date of birth: ____/____/____

Printed full name

(MM/DD/YYYY)

For coordination support or assistance obtaining patient signature, speak with Horizon Patient Services at 1-833-5-TEPEZZA.

INDICATION

TEPEZZA is indicated for the treatment of Thyroid Eye Disease.

IMPORTANT SAFETY INFORMATION

Warnings and Precautions

Infusion Reactions: TEPEZZA may cause infusion reactions. Infusion reactions have been reported in approximately 4% of patients treated with TEPEZZA. Reported infusion reactions have usually been mild or moderate in severity. Signs and symptoms may include transient increases in blood pressure, feeling hot, tachycardia, dyspnea, headache, and muscular pain. Infusion reactions may occur during an infusion or within 1.5 hours after an infusion. In patients who experience an infusion reaction, consideration should be given to premedicating with an antihistamine, antipyretic, or corticosteroid and/or administering all subsequent infusions at a slower infusion rate.

Preexisting Inflammatory Bowel Disease: TEPEZZA may cause an exacerbation of preexisting inflammatory bowel disease (IBD). Monitor patients with IBD for flare of disease. If IBD exacerbation is suspected, consider discontinuation of TEPEZZA.

Hyperglycemia: Increased blood glucose or hyperglycemia may occur in patients treated with TEPEZZA. In clinical trials, 10% of patients (two-thirds of whom had preexisting diabetes or impaired glucose tolerance) experienced hyperglycemia. Hyperglycemic events should be managed with medications for glycemic control, if necessary. Monitor patients for elevated blood glucose and symptoms of hyperglycemia while on treatment with TEPEZZA. Patients with preexisting diabetes should be under appropriate glycemic control before receiving TEPEZZA.

Adverse Reactions

The most common adverse reactions (incidence ≥5% and greater than placebo) are muscle spasm, nausea, alopecia, diarrhea, fatigue, hyperglycemia, hearing impairment, dysgeusia, headache, and dry skin.

For additional information on TEPEZZA, please see Full Prescribing Information at TEPEZZAhcp.com.

HORIZON

TEPEZZA®
teprotumumab-trbw

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Tepezza Authorization Information Worksheet

Patient Name: _____ DOB: _____ Today's Date: _____

Kindly provide as much of the following information as possible to enable us to more efficiently obtain insurance authorization for your patient's Tepezza therapy. If you are missing any of this information, please either provide us with the contact information for the patient's other provider(s) who we can contact this information, or take steps for your office staff to arrange for it (such as ordering lab tests). If you have any questions, please do not hesitate to contact us. *Thank you!*

Patient weight (specify lbs or kg): _____ Patient height: _____

Most recent Clinical Activity Score (CAS): _____ Date of this CAS: _____

Patient's Thyroid Eye Disease (TED) is: active inactive

Patient's (TED) grade is: mild moderate moderate-to-severe severe

Please provide information on the patient's TED symptoms:

- Moderate or severe soft-tissue involvement: Yes No
- Diplopia: Yes No
- Lid Retraction: Yes No (If yes, how many mm? _____)
- Exophthalmos / Proptosis: Yes No (If yes, how many mm above normal for race and gender? _____)

Has the patient previously been treated with Tepezza? Yes No (If yes, how many treatments? _____)

Has the patient previously had orbital decompression surgery for their TED? Yes No (If yes, when? _____)

Is the patient's TED condition sight threatening if surgery is not immediately obtained? Yes No

Has the patient previously had orbital radiation for their TED? Yes No (If yes, when? _____)

Does the patient have corneal decompensation that is unresponsive to medical management? Yes No

Please provide information on steroid use for the patient's TED symptoms:

- Has the patient tried steroids but had unsatisfactory results: Yes No
- Are steroids contraindicated in this patient? Yes No (If yes, why? _____)

Is the patient diabetic? Yes No (If yes, is it under control? Yes No)

Does the patient have any reduction in visual acuity due to optic neuropathy in the past 6 months? Yes No

Is the patient planning to concurrently use any other biological immunomodulator? Yes No
(If yes, which medication(s)? _____)

Attach laboratory blood test results for Free-T3 and Free-T4 levels. Other thyroid laboratory results may be sent, but these two specific tests are required by most carriers. Results should not be more than 90 days old.

Provider Name: _____ Signature: _____ Date: _____