# Information to Help Complete the Universal Enrollment and Prescription Form

The Universal Enrollment and Prescription Form acts as both a prescription for SYNAGIS® (palivizumab) and consent to enroll in SYNAGIS CONNECT®, Sobi's patient support program. This can be completed as a paper form and faxed to SYNAGIS CONNECT® or to the preferred specialty pharmacy, or it can be completed electronically through the CoverMyMeds® portal.

If SYNAGIS CONNECT® has previously received an Authorization for the Transition of Care and Parent/Caregiver Consent form for your patient from the neonatal intensive care unit, your office will be provided a partially completed version of this form via fax or CoverMyMeds® if your office uses the CoverMyMeds® portal.

Make sure all fields are complete before sending the form back to SYNAGIS CONNECT® or to the preferred specialty pharmacy.

SYNAGIS CONNECT®

**Universal Enrollment and Prescription Form**

SYNAGIS® PALIVIZUMAB

• Enroll online at www.CoverMyMeds.com. • Fax to SYNAGIS CONNECT® at **1.800.201.4938**.

○ Buy-and-Bill Benefit ○ Preferred Specialty Pharmacy ____________

PATIENT/CAREGIVER INFORMATION

**PATIENT INFORMATION** ○ Please indicate if multiple births.

Last Name: ____ First Name: ____ Middle Initial: ____
Date of Birth*: ___/___/___ Sex: ○ Male ○ Female *Patient weight information is collected in the prescription section.

**PARENT/CAREGIVER INFORMATION**

Last Name: ____ First Name: ____ Middle Initial: ____
Street: ____ Unit: ____ City: ____ State: ____ ZIP Code: ____
Home Phone #: ____ Mobile Phone #: ____
Email: ____ Preferred Contact Method: ○ Phone ○ Text ○ Email
Best Time to Call: ○ Morning ○ Afternoon ○ Evening Preferred Language: ____

○ **Enroll me in the SYNAGIS Copay Program.** Eligibility requirements apply.
○ I authorize **SYNAGIS CONNECT®** to send text messages when appropriate and hereby agree to receive this type of communication. Standard data and message rates may apply.
○ I authorize **SYNAGIS CONNECT®** to leave a detailed message, including the name of my child's prescription, SYNAGIS.

**INSURANCE INFORMATION** Please provide a copy of all insurance cards (front and back). ○ No Insurance

Policyholder Full Name: ____ Policyholder Date of Birth: ___/___/___
Primary Medical Insurance: ____
Insurance Phone #: ____ Group #: ____ ID #: ____
Secondary Medical Insurance: ____
Insurance Phone #: ____ Group #: ____ ID #: ____
Prescription Insurance: ____ RxGrou[illegible] RxBIN: ____ RxPCN: ____

▼ FOR HEALT[illegible]E ONLY ▼

FPO

PRESCRIBER INFORMATION AND PRESCRIPTION DETAILS

**PRESCRIBER INFORMATION**

Last Name: ____ First Name: ____ Office/Institution Name: ____
Street: ____ Suite: ____ City: ____ State: ____ ZIP Code: ____
NPI #: ____ DEA #: ____ Tax ID #: ____
Medicaid Provider ID #: ____
Office Contact Name: ____ Phone #: ____
Fax #: ____ Email: ____

**PRESCRIBER AUTHORIZATION:** My signature certifies that the person named on this form is my patient; that the information provided, to the best of my knowledge, is complete and accurate; and that therapy with SYNAGIS is medically necessary. I certify that I have obtained the written authorization of my patient's parent or caregiver in accordance with all applicable state and federal laws to release the individually identifiable health information included on this form to Sobi and SYNAGIS CONNECT® patient support program and I understand that the information that I provide on this form will be used by the program for purposes of verifying my patient's insurance coverage and eligibility; coordinating the dispensing of my patient's prescription medicine; and introducing SYNAGIS CONNECT® support services to my patient, including contacting my patient's parent/caregiver by telephone or mail for these purposes. I authorize SYNAGIS CONNECT® to transmit the above prescription to the appropriate specialty pharmacy for my patient. I understand that I am under no obligation to prescribe any Sobi products and that I have not received nor will I receive any benefit from Sobi for doing so. I will not seek reimbursement from any third-party payer or government entity for any product provided free of charge by SYNAGIS CONNECT®.

Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form.

SIGN HERE **Prescriber Signature** ____ **Date** ____

**CLINICAL INFORMATION** Attach any required clinical notes.

○ Prematurity: ____ weeks'/days' GA (eg, 32.3)
ICD-10: ____

Birth Weight: ____kg
Current Weight: ____kg
Date of Weight: ___/___/___

○ Bronchopulmonary dysplasia/chronic lung disease
○ Age <12 months ○ Age 12 months to <24 months
Supplemental oxygen (dates): ____
Chronic corticosteroids (drugs/dates): ____
Diuretic therapy (drug/dates): ____
Bronchodilators (drugs/dates): ____
ICD-10: ____

○ Hemodynamically significant congenital heart disease
○ Age <12 months ○ Age 12 months to <24 months
ICD-10: ____
○ Other conditions:
Description: ____
Diagnosis: ____
ICD-10: ____

NICU/Hospital dose administered: ○ No ○ Yes Date(s): ____ Needs by date: ____ Expected date of first/next injection: ____
Current medications: ____ Known allergies: ____
Deliver to: ○ Office/Clinic ○ Patient's Home ○ Other ____
**Home Health Agency Services Requested for Injection Administration** ○ No ○ Yes **Preferred Home Health Agency** ____

| MEDICATION | STRENGTH | DOSE & DIRECTION | QUANTITY & REFILLS |
|---|---|---|---|
| SYNAGIS® (palivizumab) | 50 mg and/or 100 mg vials | Inject 15 mg/kg IM one time per 28-30 days | Quantity: QS to achieve 15 mg/kg dose \| Refills: ____ |
| ○ OPTIONAL: Epinephrine | 1:1000 amp | Inject 0.01 mg/kg SC as directed for anaphylaxis | Quantity: ____ Refills: ____ |

○ Ancillary supplies

*Stamp Signature Not Allowed*

SIGN HERE **Prescriber Signature** ____ **Date** ____
*Dispense as Written*
**OR**
**Prescriber Signature** ____ **Date** ____
*Substitution Permitted*

**PARENT/CAREGIVER CONSENT CONTINUED ON NEXT PAGE**
Not Required for Submission



Healthcare professionals can select Buy-and-Bill or Preferred Specialty Pharmacy.

Patient weight will be documented toward the bottom of this page for prescribed dosage under Clinical Information.

Parents/caregivers can choose to fill in the red circles to consent to

- Enroll in the Copay Program, if eligible
- Receive text messages from SYNAGIS CONNECT®
- Receive detailed voice messages from SYNAGIS CONNECT®

If any option is chosen, both signatures for consent are **required** on page 2.

A second signature from the prescriber is required to consent to the Prescriber Authorization.

The Clinical Information section includes details pertaining to diagnosis and a reminder to attach clinical documentation.

- The Prescription section covers either strength of SYNAGIS at QS to achieve the 15 mg/kg dose
- Prescription for epinephrine is optional
- The prescriber can choose to fill in the red circle to include ancillary supplies as needed for administration, such as syringes, with the prescription
- The prescriber can determine dosage strength based on the patient's weight

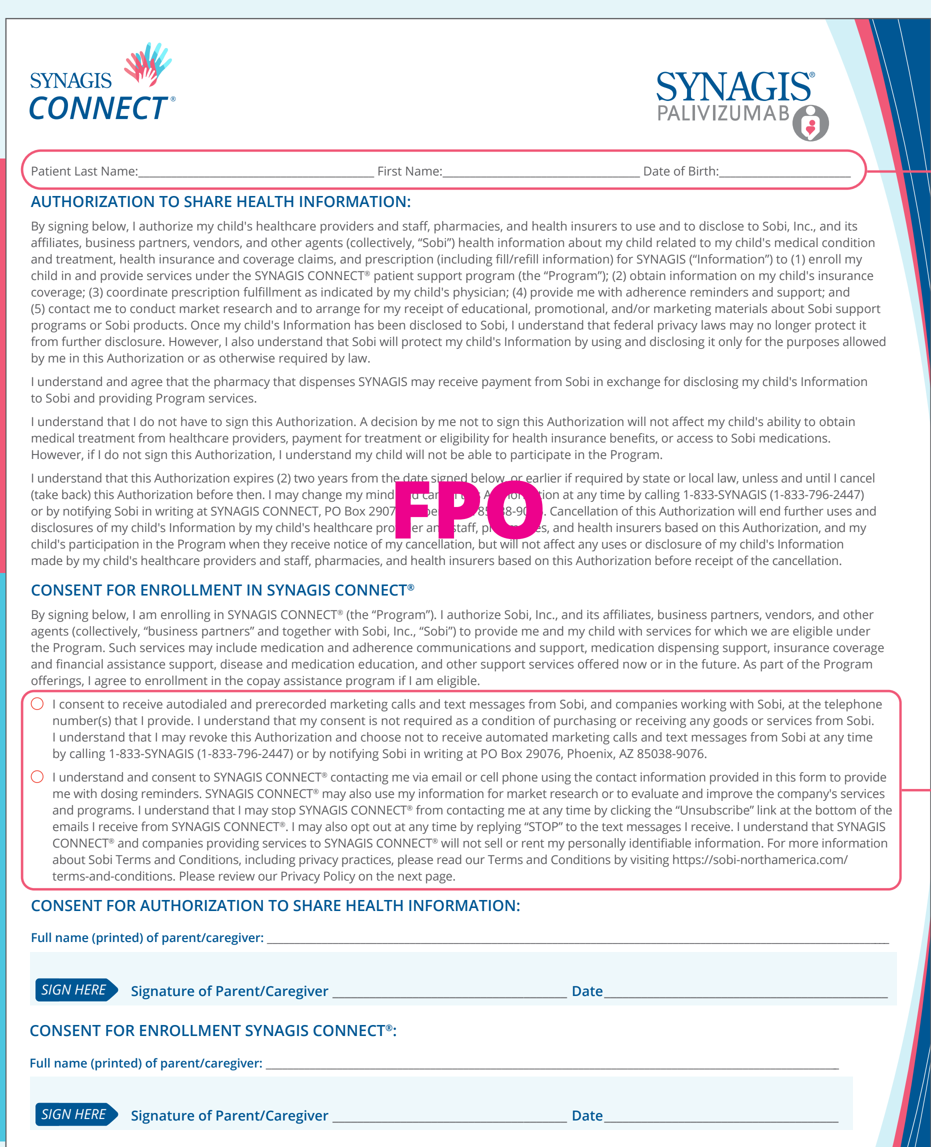
Prescriber signature required for **either** Dispense as Written **or** Substitution Permitted. Stamp signatures are not allowed.

All attempts should be made to obtain parent/caregiver consent on page 2. If the parent/caregiver cannot be reached, this page can be sent separately and SYNAGIS CONNECT® will reach out to the parent/caregiver to obtain consent.

# Information to Help Complete the Universal Enrollment and Prescription Form

The Authorization to Share Health Information and Consent for Enrollment in SYNAGIS CONNECT® must **each** be signed in order for SYNAGIS CONNECT® to provide services.

If necessary, this page can be omitted from initial submission if attempts to connect with the patient's parent/caregiver fail. If parent/caregiver is not available to sign, SYNAGIS CONNECT® will reach out to obtain parent/caregiver consent.



SYNAGIS CONNECT®

SYNAGIS® PALIVIZUMAB

HIPAA AUTHORIZATION

Patient Last Name:__________________ First Name:__________________ Date of Birth:__________________

AUTHORIZATION TO SHARE HEALTH INFORMATION:

By signing below, I authorize my child's healthcare providers and staff, pharmacies, and health insurers to use and to disclose to Sobi, Inc., and its affiliates, business partners, vendors, and other agents (collectively, "Sobi") health information about my child related to my child's medical condition and treatment, health insurance and coverage claims, and prescription (including fill/refill information) for SYNAGIS ("Information") to (1) enroll my child in and provide services under the SYNAGIS CONNECT® patient support program (the "Program"); (2) obtain information on my child's insurance coverage; (3) coordinate prescription fulfillment as indicated by my child's physician; (4) provide me with adherence reminders and support; and (5) contact me to conduct market research and to arrange for my receipt of educational, promotional, and/or marketing materials about Sobi support programs or Sobi products. Once my child's Information has been disclosed to Sobi, I understand that federal privacy laws may no longer protect it from further disclosure. However, I also understand that Sobi will protect my child's Information by using and disclosing it only for the purposes allowed by me in this Authorization or as otherwise required by law.

I understand and agree that the pharmacy that dispenses SYNAGIS may receive payment from Sobi in exchange for disclosing my child's Information to Sobi and providing Program services.

I understand that I do not have to sign this Authorization. A decision by me not to sign this Authorization will not affect my child's ability to obtain medical treatment from healthcare providers, payment for treatment or eligibility for health insurance benefits, or access to Sobi medications. However, if I do not sign this Authorization, I understand my child will not be able to participate in the Program.

I understand that this Authorization expires (2) two years from the date signed below, or earlier if required by state or local law, unless and until I cancel (take back) this Authorization before then. I may change my mind [illegible] FPO [illegible]tion at any time by calling 1-833-SYNAGIS (1-833-796-2447) or by notifying Sobi in writing at SYNAGIS CONNECT, PO Box 2907[illegible] 85[illegible]8-90[illegible]. Cancellation of this Authorization will end further uses and disclosures of my child's Information by my child's healthcare pro[illegible]er an[illegible] staff, p[illegible]es, and health insurers based on this Authorization, and my child's participation in the Program when they receive notice of my cancellation, but will not affect any uses or disclosure of my child's Information made by my child's healthcare providers and staff, pharmacies, and health insurers based on this Authorization before receipt of the cancellation.

SYNAGIS CONNECT ENROLLMENT CONSENT

CONSENT FOR ENROLLMENT IN SYNAGIS CONNECT®

By signing below, I am enrolling in SYNAGIS CONNECT® (the "Program"). I authorize Sobi, Inc., and its affiliates, business partners, vendors, and other agents (collectively, "business partners" and together with Sobi, Inc., "Sobi") to provide me and my child with services for which we are eligible under the Program. Such services may include medication and adherence communications and support, medication dispensing support, insurance coverage and financial assistance support, disease and medication education, and other support services offered now or in the future. As part of the Program offerings, I agree to enrollment in the copay assistance program if I am eligible.

○ I consent to receive autodialed and prerecorded marketing calls and text messages from Sobi, and companies working with Sobi, at the telephone number(s) that I provide. I understand that my consent is not required as a condition of purchasing or receiving any goods or services from Sobi. I understand that I may revoke this Authorization and choose not to receive automated marketing calls and text messages from Sobi at any time by calling 1-833-SYNAGIS (1-833-796-2447) or by notifying Sobi in writing at PO Box 29076, Phoenix, AZ 85038-9076.

○ I understand and consent to SYNAGIS CONNECT® contacting me via email or cell phone using the contact information provided in this form to provide me with dosing reminders. SYNAGIS CONNECT® may also use my information for market research or to evaluate and improve the company's services and programs. I understand that I may stop SYNAGIS CONNECT® from contacting me at any time by clicking the "Unsubscribe" link at the bottom of the emails I receive from SYNAGIS CONNECT®. I may also opt out at any time by replying "STOP" to the text messages I receive. I understand that SYNAGIS CONNECT® and companies providing services to SYNAGIS CONNECT® will not sell or rent my personally identifiable information. For more information about Sobi Terms and Conditions, including privacy practices, please read our Terms and Conditions by visiting https://sobi-northamerica.com/terms-and-conditions. Please review our Privacy Policy on the next page.

CONSENT FOR AUTHORIZATION TO SHARE HEALTH INFORMATION:

Full name (printed) of parent/caregiver: __________________

SIGN HERE Signature of Parent/Caregiver __________________ Date __________________

CONSENT FOR ENROLLMENT SYNAGIS CONNECT®:

Full name (printed) of parent/caregiver: __________________

SIGN HERE Signature of Parent/Caregiver __________________ Date __________________

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Patient name and date of birth must be on each page.

Parents/caregivers can choose to fill in the red circles to consent to receive marketing calls and text messages from SYNAGIS CONNECT®.

# Information to Help Complete the Universal Enrollment and Prescription Form

Patient Last Name:________________________________ First Name:__________________________ Date of Birth:__________________

## SOBI, INC. PRIVACY POLICY

### GENERAL

Sobi, Inc. respects the privacy of every individual who visits http://www.sobi-northamerica.com (the "Web Site"). This Privacy Policy outlines the information Sobi, Inc. will collect and how we will use that information.

### PERSONALLY IDENTIFIABLE INFORMATION

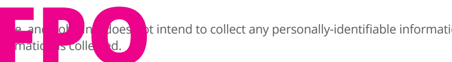
There may be cases where Sobi, Inc. will ask you for personally-identifiable information such as your name, mailing address, and email address. For example, we may request personally-identifiable information when you participate in a survey, contest, or other service that requires registration or subscription. Sobi, Inc. will not collect any personally-identifiable information about you unless you provide it to us voluntarily.

When you view the website, we may store some information on your computer. This information will be in the form of a "cookie" or similar file and will help us to offer increased personalization and functionality. With most internet browsers, you can erase cookies from your computer hard drive, block all cookies, or receive a warning before a cookie is stored. Please refer to your browser instructions or help screen to learn more about these functions.

Except as stated in this Privacy Policy, or as otherwise stated at the time personally-identifiable information is gathered, we will not provide personally-identifiable information to third parties who are not under the direction and control of Sobi, Inc..

### CHILDREN

The Web Site is not directed at individuals under thirteen years of age and Sobi, Inc. does not intend to collect any personally-identifiable information from such individuals, unless otherwise stated at the time such information is collected.




### INFORMATION COLLECTED AUTOMATICALLY

Sobi, Inc. may also automatically collect non-personally-identifiable information about your use of the Web Site, such as the domain from which you access the Internet (for example, aol.com, if you are connecting from an America Online account), the date and time you access the Web Site, and the Internet address of the website from which you linked directly to our Web Site. This information will not be linked to personally-identifiable information. Sobi, Inc. may use this information to analyze and enhance the Web Site and may aggregate this information and share such aggregated information with business partners, sponsors and other third parties.

### LINKS TO OTHER WEB SITES

The Web Site may allow links to various other web sites. Sobi, Inc. assumes no responsibility for the information practices of sites you are able to access through the Web Site. These links to other sites do not imply affiliation or endorsement of a linked site.

### SECURITY

The importance of security for all personally-identifiable information associated with visitors to the Web Site is of utmost concern to us. Unfortunately, no data transmission over the Internet can be guaranteed to be secure. As a result, Sobi, Inc. cannot ensure or warrant the security of any information you transmit to us, and you do so at your own risk. Once we receive your personally-identifiable information, we will take reasonable efforts to ensure its security on our systems.

### YOUR ACCEPTANCE OF THESE TERMS

By using the Web Site, you signify your assent to the Sobi, Inc. Privacy Policy. If you do not agree to this Policy, please do not use the Web Site. Your continued use of the Web Site following the posting of changes to these terms will mean you accept those changes. Sobi, Inc. will, however, use personally-identifiable information only in accordance with the version of the Privacy Policy under which the information was collected.

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Not Required for Submission



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