NeedyMeds
www.needymeds.org

Find help with the cost of medicine

Thank you for downloading this patient assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER - Send your completed application to address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the **"Patient Savings"** tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.

- **Free, Low Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low cost, and sliding scale medical and dental clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.

- **Coupons, Rebates & More** — You can use the NeedyMeds website to find nearly 2,000 cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.

- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. To date, our drug discount card has saved patients over $244,000,000. Check out the next page to learn more.

Feel free to call our toll-free helpline if you have any questions. You can reach us at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thanks for using NeedyMeds! Please let us know if we can do anything else to help you afford the costs of your healthcare.

Richard J. Sagall, MD
President, NeedyMeds

NeedyMeds.org
P.O. Box 219
Gloucester, MA 01931

Helpline: 1-800-503-6897
Email: info@needymeds.org

www.needymeds.org

Clip the card and save

NeedyMeds
NeedyMeds.org

DRUG DISCOUNT CARD

BIN: 020750
RX PCN: NMeds
RX GRP: PDFPDF
ID: NMNA019309901930

Customer Care
1-888-602-2978

This is a drug discount program, not an insurance plan.

NeedyMeds Drug Discount Card
www.needymeds.org

Patient: You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com.

Pharmacist: Administered by Medical Security Company, LLC, Tucson, AZ.

Pharmacy Help Desk: 1-800-404-1031.

Powered by ScriptSave® WellRx

- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family
- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

You can also save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
PO Box 219
Gloucester, MA 01931

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

Reset Form

RUCONEST SOLUTIONS
Expertise. Delivered personally.

Patient Enrollment Form
Fax completed forms to: 1-855-423-5757

RUCONEST®
C1esterase inhibitor (recombinant)

1. Prescription

Preferred Specialty Pharmacy (optional):
☐ Accredo ☐ AllianceRx Walgreens Prime ☐ CVS Caremark ☐ Humana SP ☐ Option Care ☐ Orsini

Patient Name.....
DOB.....
Diagnosis: ICD-10-CM D84.1 (Defects in the complement system [HAE])

Prescription: RUCONEST 2100 international units (IU)/vial injection (50 international units (IU)/kg), Max 4200 international units (IU)

DIRECTIONS: Administer.....international units (IU) as a slow IV injection over 5 min prn for attacks. No more than 2 doses within a 24-hour period

Doses Per Shipment
☐ 4 doses (8 vials) ☐ 8 doses (16 vials)
☐ 16 doses (32 vials) ☐ .....doses (..... vials)

Refill 1 x year, unless noted otherwise
☐ 3 Refills ☐ 6 Refills ☐ 12 Refills ☐ ..... Refills

ANCILLARY ORDERS: Dispense infusion supplies with each prescription.
Dispense: One (1) vial of Sterile Water for Injection 14 mL per 2100 international units (IU) vial of RUCONEST

Flushing Orders
☐ Normal saline 3 mL or 5 mL intravenous (peripheral line) or 10 mL intravenous (central line) before and after infusion, or as needed for line patency
☐ Heparin 10 units/mL (#3mL or #5mL) use as a final flush for central line (QS)
☐ Heparin 100 units/mL (#3mL or #5mL) use as a final flush for central line (QS)

Anaphylaxis Order Specialty pharmacy to provide anaphylactic kit per provider protocol. Substitution permitted unless DAW specified .....

Epinephrine #2 pack ☐ 0.15mg ☐ 0.3mg **Refills:.....**
Inject SQ or IM as needed for anaphylaxis reaction times one dose.
May repeat x 1 in 5 to 15 minutes if symptoms persist. SP to provide at first dispense.

SPECIAL INSTRUCTIONS.....
Drug/Non-Drug Allergies ..... ☐ No Known Allergies Concurrent Medications.....

MD Sign
Dispense as written **PRESCRIBER** ..... Print.....Date .....
Substitution permitted **PRESCRIBER**..... Print.....Date .....

I appoint Pharming Healthcare, Inc., RUCONEST SOLUTIONS, its affiliates, and their representatives on my behalf to convey this prescription described herein to the dispensing pharmacy. I understand that I may not delegate signature authority.

2. Optional Prescription for Bridge to Therapy Program for RUCONEST

Patient Name.....
DOB.....
Diagnosis: ICD-10-CM D84.1 (Defects in the complement system [HAE])

Prescription: RUCONEST 2100 international units (IU)/vial injection (50 international units (IU)/kg), Max 4200 international units (IU)

DIRECTIONS: Administer.....international units (IU) as a slow IV injection over 5 min prn for attacks. No more than 2 doses within a 24-hour period

Doses Per Shipment
☐ 2 doses (4 vials) ☐ .....doses (..... vials)

Refill 1 x year, unless noted otherwise ☐ **Refills.....**

ANCILLARY ORDERS: Dispense infusion supplies with each prescription.
Dispense: One (1) vial of Sterile Water for Injection 14 mL per 2100 international units (IU) vial of RUCONEST

Flushing Orders
☐ Normal saline 3 mL or 5 mL intravenous (peripheral line) or 10 mL intravenous (central line) before and after infusion, or as needed for line patency
☐ Heparin 10 units/mL (#3mL or #5mL) use as a final flush for central line (QS)
☐ Heparin 100 units/mL (#3mL or #5mL) use as a final flush for central line (QS)

SPECIALINSTRUCTIONS.....
Drug/Non-Drug Allergies .....
☐ No Known Allergies
Concurrent Medications.....

MD Sign
Dispense as written **PRESCRIBER** ..... Print.....Date .....
Substitution permitted **PRESCRIBER**..... Print.....Date .....

I appoint Pharming Healthcare, Inc., RUCONEST SOLUTIONS, its affiliates, and their representatives on my behalf to convey this prescription described herein to the dispensing pharmacy. I understand that I may not delegate signature authority.

3. Optional Specialty Pharmacy Nursing Orders

Skilled nursing visit as needed to provide patient education related to therapy, disease state, self and/or nurse administer of medication as prescribed. Select training or infusion options (some patients may need both)
☐ Provide ongoing self-administration training until patient/caregiver is independent with self infusion
☐ Provide ongoing nursing visits for on demand infusions (PRN) ☐ M-F - 8/5 pm ☐ 24/7
☐ Other .....

Location of Skilled Nursing
☐ Home
☐ Other.....

Visit frequency (based on medication order and dosage order) and patient's/caregiver's ability to self-administer .....
Inject epinephrine subcutaneously or intramuscularly for anaphylaxis reaction, may repeat in 5-15 minutes if no resolution. Call 911.

MD Sign
PRESCRIBER .....Date .....

RUCONEST SOLUTIONS
Expertise. Delivered personally.

Patient Enrollment Form

Fax completed forms to: 1-855-423-5757

RUCONEST®
C1esterase inhibitor (recombinant)

4. Patient Information

☐ **Attach copy of demographic/face sheet OR complete below**

Name..... ☐ Male ☐ Female SSN # ..... DOB.....

Patient Weight ..... Date of Weight .....

Check Preferred Phone # ☐ Work #..... ☐ Home #..... ☐ Cell #.....

Email ..... **Preferred Language** .....

Address ..... City/State/ZIP .....

Caregiver Name (first, last) ..... Relationship to Patient.....

Phone # ..... ☐ Okay to leave vm Caregiver email .....

5. Patient Insurance Information

☐ **Attach all insurance and prescription cards OR complete below**

Medical Insurance Card	**Prescription Drug Card**
Plan Name.....	PBM/Plan Name .....
Plan Phone #	Plan Phone # .....
Policy Holder Name	Member ID # .....
Member ID #.....	BIN # .....
Group #.....	PCN # ..... Group #.....

6. Prescriber Information

Provider Specialty: ☐ Allergy ☐ Dermatology ☐ GI ☐ Immunology ☐ Primary Care ☐ Other

Provider Name..... NPI # ..... TIN #.....

Medicaid Provider ID #..... State License # ..... PTAN #.....

Site Name .....

Address..... City/State/ZIP .....

Phone # ..... Fax # .....

Contact Name ..... Role ..... Phone # .....

7. Additional Communications by Pharming Healthcare

Please sign below if you agree to receive information about RUCONEST and live HAE educational programs. Pharming Healthcare, Inc. or any of the company affiliates may contact you via mail, email and/or phone. Your information will be kept confidential and will not be sold or leased to third parties.

Patient Sign

Signature..... **Date** .....

Please see accompanying full Prescribing Information.

Patient Enrollment Form

Fax completed forms to: 1-855-423-5757

1. I am participating in the RUCONEST SOLUTIONS Program ("Program") operated by Pharming Healthcare Inc. which provides me certain clinical and nursing support services related to my use of the biologic RUCONEST, manufactured by Pharming Healthcare Inc., for treatment of my HAE condition. The Program is administered by the Lash Group. This authorization will allow Pharming Healthcare Inc., the Lash Group, my pharmacy, healthcare providers, and health plan to use and disclose certain health information about me to facilitate my treatment with RUCONEST and to improve the Program for the benefit of future patients with HAE. I hereby authorize the use or disclosure of my protected health information (PHI) defined below for the purposes described in Section 5 below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive and use my PHI is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and there is a potential for my PHI to be subject to redisclosure by the recipients.

2. Persons/organizations who may disclose my PHI:
   - Pharming Healthcare Inc. and its authorized representatives ("Pharming")
   - Lash Group
   - My pharmacy(ies) providing the RUCONEST
   - My healthcare provider(s), including physicians and home care nurse educators
   - My health plan(s) providing medical care and prescription coverage

3. Persons/organizations who may receive and use my PHI:
   - Pharming Healthcare Inc. and its authorized representatives
   - Lash Group
   - My pharmacy(ies) that provide RUCONEST
   - My healthcare provider(s), including physicians and home care nurse educators
   - My health plan(s) providing medical care and prescription coverage

4. My PHI consists of the following information about me that may be used or disclosed:
   - Information I provided on the RUCONEST Enrollment Form
   - My healthcare records related to my treatment and HAE condition
   - My health insurance information regarding my coverage, copay, deductibles, and benefit options
   - My prescription information, such as status, fulfillment, and/or shipment of my medication
   - My hospital records for any hospitalization and information related to my transition of care

5. My PHI may be used and disclosed for the following purposes:
   - Administration of the Program
   - Internal data collection and reporting
   - Tracking items such as health/prescription plan coverage, patient cost, shipments of the RUCONEST, health plan coverage trends, use of the Program offerings
   - Nursing services for the purposes of improving the quality of the Program
   - Assessing ongoing and future needs of patients who are prescribed RUCONEST
   - Analyzing the quality, efficacy, and safety of RUCONEST

6. I understand that the specialty pharmacies that dispense my medication may be paid for sharing my PHI with the Program and Pharming so that the recipients may use it for the purposes specified in this authorization.

7. My authorization will remain in effect for two (2) years from the date of my signature unless I revoke it before then. I understand that I may be requested to provide my written authorization on an annual basis by the Program to support continued access to my PHI. I understand that after I have signed this authorization, I may revoke it at any time by sending a written notice to the RUCONEST SOLUTIONS Program at PO Box 221974, Charlotte, NC 28222-1974. The revocation goes in effect once it has been received by the RUCONEST SOLUTIONS Program, and my healthcare providers and health plan, but the revocation will not affect any of my PHI already disclosed in reliance on this authorization.

8. I understand that I can refuse to sign this authorization and it will not affect the start, continuation, or quality of my treatment from my healthcare provider, payment for my treatment or my eligibility for or enrollment in health coverage.

   However, I understand that if I choose not to sign this authorization or revoke it after signing this form, the Program will not be able to provide me with the support described above, after the date of revocation.

9. I understand that I am entitled to a copy of this Authorization after signing below.

Patient Sign

Signature of patient or patient's representative ..... Date .....
(if signed by someone other than the patient)

Print Name

....

Printed name of patient or patient's representative **Relationship to patient**