Ryplazim®
plasminogen, human-tvmh

PATIENT ENROLLMENT FORM

Ryplazim® Support Services
Phone: 888-262-8040
Fax: 408-419-1768

SPECIALTY PHARMACY INFORMATION

Preferred pharmacy (please select one):

- ☐ **Nufactor** P: 800-323-6832 F: 855-270-7347
- ☐ **TAP** P: 866-767-4883 F: 516-876-0200
- ☐ **CVS** P: 866-792-2731 F: 800-323-2445
- ☐ **Soleo** P: 844-547-8600 F: 380-257-2419

BENEFITS INVESTIGATION

Benefit investigation or verification requested: ☐ Yes ☐ No

☐ **MedMonk** P: 888-262-8040 F: 408-419-1768

PATIENT INFORMATION (required)

Patient name:

Date of birth: Sex: ☐ M ☐ F

Address:

City: State: Zip code:

Phone: Email:

Preferred method of contact: ☐ Phone ☐ Email

Best time to contact: ☐ Morning (8 AM—10 AM ET) ☐ Day (10 AM—5 PM ET) ☐ Evening (5 PM—8 PM ET)

If the patient is under 18

Primary contact/caregiver name:

Relationship to patient:

Phone:

Email:

INSURANCE INFORMATION (required)
Attach a copy of the front and back of all applicable insurance cards, if available

☐ Patient does not currently have insurance. ☐ Copy of the patient's insurance card(s) are attached.

Please complete the required information below only if not attaching a copy of the patient's insurance card(s) to this form.

Primary insurance type: ☐ Private/commercial ☐ Medicaid – State ☐ Other

Primary insurance name:

Beneficiary/cardholder name:

Cardholder relationship to patient:

Policy ID #

Prior authorization required? ☐ Yes ☐ No

Co-pay assistance eligibility? ☐ Yes ☐ No

KEDRION BIOPHARMA

Ryplazim® plasminogen, human-tvmh

PATIENT ENROLLMENT FORM

Ryplazim® Support Services
Phone: 888-262-8040
Fax: 408-419-1768

Patient Name: _____

CLINICAL INFORMATION (required)

The healthcare provider is responsible for sending the prescription to one of the specialty pharmacies listed at the top of page 1.
Providers must submit a Statement of Medical Necessity along with any prescription orders that document the diagnosis and explanation of the disease.

☐ Check here if office visit notes are attached/included

Diagnosis (ICD-10)

E88.02 Plasminogen deficiency type 1:	☐ Yes	☐ No	☐ Unsure
H10.22 Pseudomembranous conjunctivitis:	☐ Yes	☐ No	☐ Unsure
H10.51 Ligneous conjunctivitis:	☐ Yes	☐ No	☐ Unsure
Does the patient have a history of bleeding diathesis and take medications that interfere with normal coagulation?	☐ Yes	☐ No	☐ Unsure
Does the patient have confirmed or suspected airway disease with tracheobronchial lesions?	☐ Yes	☐ No	☐ Unsure

Other diagnosis and/or important clinical information? Please describe:

Has the patient ever been treated with RYPLAZIM?: ☐ Yes ☐ No ☐ Unsure

If yes, date of last treatment: If yes, next dose due:

What other treatments has the patient received? Please list:

Allergies? Please list:

Patient height (cm): Patient weight (kg):

Date height and weight were recorded:

RYPLAZIM® PRESCRIBING INFORMATION

Prescribed dose of RYPLAZIM: _____mg/kg

Dispense quantity and refills: _____vial(s) with_____refill(s)

Infusion frequency: _____mg/kg ☐ Q2D ☐ Q3D ☐ Q4D ☐ Other_____

Per the RYPLAZIM label, recommended dose is 6.6 mg/kg of body weight infused every 2 to 4 days.

Route of intravenous administration

☐ Peripheral ☐ Other (please describe):

Start date:

KEDRION BIOPHARMA

OTHER DRUG ORDERS (dispense quantity sufficient for month supply unless otherwise noted)

- ☐ Decline
- ☐ Sterile water for injection 20 mL vial (or other available size): Use as directed to reconstitute Ryplazim. Dispense 1 month supply. Refill for same period as Ryplazim.
- ☐ Sodium chloride 0.9% 10 mL PFS: Use as directed to prime filter, confirm IV patency, and flush IV access post infusion. Refill for same period as Ryplazim.
- ☐ Lidocaine/prilocaine 2.5%/2.5% cream 30 gm (or other available size): Apply topically 60 min. pre-needle insertion prn discomfort. Dispense 1 month supply. Refill for same period as Ryplazim.
- ☐ Implanted port adult/pedi > 15 kg:

  1) Sodium chloride 0.9% 10 mL PFS: 5 to 10 ml pre/post use & 10 to 20ml post-blood draw
  2) Heparin 100 units/ml syr: 5 ml post last NS & daily if accessed; monthly if de-accessed.

- ☐ Other. Please write in any additional orders _____

OTHER ORDERS (dispense sufficient quantity)

- ☐ Ancillary supplies as necessary to administer Ryplazim and other medications, including equipment, devices and disposables.

THERAPY INITIATION AND SITE OF CARE

- ☐ Administer in office or clinic _____ visits
- ☐ Self-adminstration at home
- ☐ Nursing needed: Nurse to administer medications per physician orders. If IV route: nurse to obtain IV access via placement of peripheral IV catheter or butterfly needle and instruct patient or caregiver on IV access. If peripheral IV, may leave in place up to 5 days as long as no erythema or edema.
- ☐ Nursing needed: Instruct patient or caregiver to self-administer therapy

Number of skilled nursing visits to support at-home RYPLAZIM® infusion:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ PRN/as needed

Specialty pharmacy to coordinate nursing? ☐ Yes ☐ No

Site of care

☐ Physician office ☐ Infusion clinic ☐ Outpatient hospital ☐ Home infusion ☐ Other:_____

Therapy initiation plan for RYPLAZIM® infusions

- ☐ Patient/caregiver received in-office training, will self-administer first dose at home
- ☐ First dose will be administered clinical setting, followed by in-home skilled nursing support for _____ doses
- ☐ First dose will be administered clinical setting, patient/caregiver will be trained on self-administration and subsequent doses will be self-administered at home

Ryplazim®
plasminogen, human-tvmh

PATIENT ENROLLMENT FORM

Ryplazim® Support Services
Phone: 888-262-8040
Fax: 408-419-1768

Patient Name: _____

PRESCRIBER AUTHORIZATION (required)

☐ Dispense As Written / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute
Prescriber's Signature: Date:

☐ May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: Date:

☐ CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution"

ATTN: New York and Iowa providers, please submit electronic prescription

AUTHORIZING HEALTHCARE PROVIDER INFORMATION (required)

First name: Last name:

Address:

City: State: Zip code:

Practice phone: Practice fax:

Practice contact first and last name:

Practice contact phone: Practice contact email:

INFUSING OFFICE INFORMATION

☐ Same as provider (If different from provider, please complete)

Practice or facility name:

Contact first and last name:

Phone: Fax: Email:

PHYSICIAN AUTHORIZATION (required)

I certify that RYPLAZIM® is medically necessary for this patient. I will be supervising the patient's treatment accordingly. Non-approval of RYPLAZIM® may result in further deterioration of the patient's health and/or hospitalization. By signing below, I certify that I have received the necessary authorization from the patient to release the medical and/or patient information referenced on this form relating to the above-referenced patient to Kedrion Biopharma and its contracted agent or contractors working solely on behalf of the patient for the purpose of seeking reimbursement through RYPLAZIM Cares, verifying insurance coverage and/or the evaluation of the patient's eligibility for alternate sources of funding, patient support services, including materials fulfillment, and product fulfillment via specialty pharmacies.

Physician signature: Date:

Physician NPI #

KEDRION BIOPHARMA