ONWARD® PATIENT START FORM GUIDE

RYSTIGGO®
(rozanolixizumab-noli)
Injection For Subcutaneous Use
140 mg/mL

ONWARD

As you complete the patient Start Form for RYSTIGGO Injection for Subcutaneous Use, refer to this helpful guide.

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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 ☑ New to Therapy ☐ On Therapy

First Name:* Jane Middle Initial: M Last Name:* Smith
Date of Birth:* (MM/DD/YYYY) 08-13-1981 Phone Number:* 913-338-2234 ☐ Home ☑ Cell Gender: M ☐ F ☑ Other ☐
Street Address:* 1234 Carter Street Apt#:
City:* Kansas City State:* KS ZIP:* 66101 Preferred Language: ☑ English ☐ Spanish ☐ Other:
Communication Preference: ☑ Email ☐ Phone ☐ Text Email: janemarysf@gmail.com
☑ 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	BSBC	
INSURANCE PHONE#	913-550-1234	
CARDHOLDER NAME	Jane M Smith	
RELATIONSHIP TO PATIENT	Self	
MEMBER ID	1234567-8904	
GROUP#	3456	
BIN#	1234	
PCN#	7891	

STEP 3: Prescriber/Infusion Provider Information * Required
Prescriber First Name:* Jessica Prescriber Last Name:* Barry
Specialty: Neurology NPI#:* 5678912345 Tax ID#: 1234567893
Is this enrollment form being submitted by the infusion provider? ☐ Yes ☐ No
Infusion Provider: Cathy Mackey Infusion Provider NPI:

Enrolling Provider Contact Information:
Practice/Clinic Name:* ABC Infusion Center
Address:* 2635 XYZ Street
City:* Kansas City State:* KS ZIP:* 66401
Office Phone#:* 913-902-2038 Office Fax#:
Office Contact Name: John Doe Office Contact Email:
Office Contact Phone#: 913-902-2038 Office Contact Communication Preference: ☐ Phone ☐ Email

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STEP 4: Product Acquisition and Preferred Site of Care
Preferred Specialty Pharmacy:
☐ CVS Specialty® ☑ KabaFusion ☐ Optum Infusion ☐ SoleoHealth ☐ Alivia Health (Puerto Rico only) State License #: 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
ICD-10 Diagnosis:* ☑ G70.00 (Myasthenia gravis without acute exacerbation) ☐ G70.01 (Myasthenia gravis with acute exacerbation) ☐ Other:
MGFA Classification (I, II, III, IV, V): III MG-ADL Score: 19 Date of Assessment: 07/10/2024
AChR Antibody Test: ☐ Positive ☐ Negative ☐ Not Known MuSK Antibody Test: ☐ Positive ☐ Negative ☐ Not Known

Current Therapies:		Non-steroidal ISTs	Previous Therapies:		Non-steroidal ISTs
☐ Eculizumab	☐ Inebilizumab	☐ Azathioprine	☐ Eculizumab	☐ Inebilizumab	☐ Azathioprine
☐ Efgartigimod	☐ Nipocalimab	☐ Cyclophosphamide	☐ Efgartigimod	☐ Nipocalimab	☐ Cyclophosphamide
☐ Ravulizumab	☐ SCIG	☐ Cyclosporine	☐ Ravulizumab	☐ SCIG	☐ Cyclosporine
☑ Oral corticosteroids	☐ PLEX	☐ Methotrexate	☑ Oral corticosteroids	☐ PLEX	☐ Methotrexate
☐ Acetylcholinesterase inhibitors	☐ RYSTIGGO (rozanolixizumab-noli)	☐ Tacrolimus	☑ Acetylcholinesterase inhibitors	☐ RYSTIGGO (rozanolixizumab-noli)	☐ Tacrolimus
☑ Rituximab	☐ ZILBRYSQ® (zilucoplan)	☐ Mycophenolate	☐ Rituximab	☐ ZILBRYSQ® (zilucoplan)	☐ Mycophenolate
☑ IVIG			☑ IVIG		
☐ Other:			☐ Other:		

Medical Allergies: ☐ No allergies

Print Prescriber First and Last Name:* Jessica Barry
Prescriber Signature (Dispense as Written):* Jessica Barry No Stamp Signature Date (MM/DD/YYYY):* 08/21/2024

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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).

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Patient or Authorized Patient Representative Signature
Signature:* Jane Smith
Date:* 08/02/2024
(If applicable) Print Authorized Patient Representative First and Last Name:
Relationship to Patient:

1. Ensure patient's **phone number**, **date of birth**, and **address** are accurate to avoid complications or delays. Verify all information is correct before submitting.

2. **Patient's insurance information is required.** If submitting Start Form via fax, it's recommended to write out patient's insurance information (rather than attaching faxed copies) to avoid possible fax quality/unreadability issues.

   If the patient is uninsured, please check the appropriate box on form. This prevents having to wait for a follow-up outreach call requesting this information.

3. Infusion providers enrolling the patient into ONWARD need to complete the requested fields including contact information for your care site and NPI. This helps the program facilitate the patient's site of care communication.

4. Provide office contact information for the individual managing patient access to therapy including reimbursement, prior authorizations, access coordination, etc. A Rare Reimbursement Executive may reach out to you to clarify any critical information.

5. **MG-ADL, MGFA, and Serology test results are required** by most payers for approval decisions. Providing clinical notes and lab results with the ONWARD Start Form supports efficient referral processing.

6. **Prescriber's signature and date** are required to process the enrollment and prescription information submitted through ONWARD. Missing signature and date may delay access to treatment.

7. If the patient would like to be considered for the Patient Assistance Program (PAP), please ensure the patient-authorized PAP consent form is submitted with this form.

8. **Patient signature and date** are required for enrollment. If not included, ONWARD will reach out directly to the patient to obtain electronic consent which may delay processing.

Can we help?

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.

Inspired by patients. Driven by science.

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