

<b>1</b> <i>Prescribing Physician Information</i>	Name (First, Last) _____		Site Name _____		
	Street Address _____		City _____	State _____	Zip Code _____
	(_____) _____	(_____) _____	Office Contact _____		
	Telephone _____		Fax _____		
	State License # _____		National Provider ID # _____		

<b>2</b> <i>Patient Information</i>	Name (First, Middle Initial, Last) _____				<input type="checkbox"/> Male	<input type="checkbox"/> Female
	DOB: Month/Day/Year _____	Age (years) _____	Last 4 digits of Social Security # _____	Email Address _____		
	Street Address _____		City _____	State _____	Zip Code _____	
	(_____) _____	(_____) _____	(_____) _____			
	Home Telephone _____		Mobile Telephone _____		Work Telephone _____	
	Caregiver Name (First, Last) _____		Relationship to Patient _____		Caregiver Telephone _____	

<b>3</b> <i>Insurance Information</i>	<b>Please attach copies of both sides of patient's insurance card(s)</b>			<input type="checkbox"/> <b>Check if patient does not have insurance</b>		
	Primary Insurance _____			Insurance Telephone _____		
	Policy ID # _____	Group # _____	Policy Holder Name (First, Last) and Relationship to Patient _____			
	Pharmacy Plan Name _____			Pharmacy Plan Telephone _____		
	Policy ID # _____	Group # _____	Rx Bin # _____	Rx PCN # _____		
	Secondary Insurance _____			Insurance Telephone _____		
Policy ID # _____	Group # _____	Policy Holder Name (First, Last) and Relationship to Patient _____				

<b>4</b> <i>FIRAZYR Prescription, Training Request/Waiver, and Prescribing Physician Signature</i>	<b>Prescription:</b> FIRAZYR <sup>®</sup> (icatibant injection) <input type="checkbox"/> ICD-10 D84.1 (HAE) <input type="checkbox"/> Other: _____	
	<b>Dose:</b> One (1) subcutaneous injection 30 mg	
	<b>Directions:</b> Administer one 30-mg subcutaneous injection in the abdominal area	
	<b>Dispense:</b> <input type="checkbox"/> Three (3) syringes (NDC 54092-702-03) <input type="checkbox"/> One (1) syringe (NDC 54092-702-02) <b>Refill:</b> _____	
	<b>Special Instructions:</b> _____	
	<b>Special Precautions (eg, allergies):</b> _____	
	I appoint Shire, Human Genetic Therapies, Inc., its affiliates and their representatives (collectively "Shire") to convey on my behalf the prescription described herein to a pharmacy, if applicable.	
	<b>Training Request/Waiver (check one box below):</b> <input type="checkbox"/> YES, please provide my patient and/or his/her caregiver with training on the proper self-administration of FIRAZYR. <input type="checkbox"/> NO, I or another health care provider have trained the patient and/or caregiver on the proper self-administration of FIRAZYR.	
<b>Prescriber Signature:</b> _____ (stamps not acceptable)	<b>DISPENSE AS WRITTEN</b>	
	<b>Date:</b> _____	

<b>5</b> <i>Patient Authorization to Share Personal Health Information and OnePath Enrollment</i>	<b>Patient Authorization to Share Personal Health Information</b>	
	I authorize any health plan, physician, health care professional, hospital, clinic, pharmacy provider or other health care provider (collectively, "Health Care Providers") to disclose my personal health information, including information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription, personal health information obtained by Health Care Providers prior to the date of this authorization ("Personal Health Information"), to Shire, Human Genetic Therapies, Inc., its affiliates and their representatives, agents, and contractors (collectively, "Shire") and to receive financial remuneration from Shire in exchange, for the following purposes: for Shire to provide product support services, including coordination of benefits and therapy; reimbursement support; investigating insurance coverage; communicating with me by mail, email, or telephone about my medical condition, treatment, care management, and health insurance; and internal use by Shire, including data analysis. I understand that my Personal Health Information disclosed under this authorization may be re-disclosed by Shire and no longer protected by federal privacy laws. I understand, however, that Shire agrees to undertake reasonable efforts to maintain my Personal Health Information in a secure manner and not to disclose it to third parties without a legitimate reason for doing so. I understand that I may refuse to sign this Authorization and that my treatment, payment, enrollment or eligibility for benefits, including my access to therapy, is not conditioned on my signing this Authorization. I understand that I am entitled to a signed copy of this Authorization. This Authorization expires one year from the date of execution, or one year after the date of my last prescription, whichever is later. I understand that I may revoke this Authorization at any time by sending written notice of revocation to OnePath, 300 Shire Way, Lexington, MA 02421, which becomes effective upon receipt by any Health Care Provider subject to federal privacy laws, except to the extent that action already has been taken in reliance on this Authorization.	
	<b>OnePath Enrollment</b> (must check box below to be enrolled in product support services through OnePath)	
	<input type="checkbox"/> I certify that all of the information provided on this form is complete and accurate. I authorize Shire to collect Personal Health Information from me, my caregivers, and Health Care Providers, and to use and disclose such Personal Health Information to provide product support services, including but not limited to coordination of benefits and therapy; reimbursement support; investigating insurance coverage; communicating with me by mail, email, or telephone about my medical condition, treatment, care management, and health insurance.	
	<b>Patient Signature:</b> _____ (If patient is a minor)	<b>Date:</b> _____
	<b>Parent/Guardian Signature:</b> _____	<b>Date:</b> _____

FIRAZYR<sup>®</sup> (icatibant injection) is indicated for the treatment of acute attacks of hereditary angioedema (HAE) in adults 18 years of age and older. FIRAZYR clinical trials evaluated patients with only Type 1 or Type 2 HAE. Please see full Prescribing Information available from Shire representative or at firazyr.com.

## ADDITIONAL GUIDANCE FOR COMPLETION OF FORM

### 1 Prescribing Physician Information, 2 Patient Information, and 3 Insurance Information

- Fill out completely
- Do not submit to Shire any documentation of labs, clinical history, or other documents supporting the prior authorization process

### 4 FIRAZYR Prescription, Training Request/Waiver, and Prescribing Physician Signature

- FIRAZYR® (icatibant injection) is dispensed in 2 ways (please check 1 option): 3 syringes or 1 syringe
- Please indicate the number of refills
- Check the appropriate box to specify whether you would like your patient to be trained by Shire on proper self-administration or whether training has already occurred
- This is a prescription; a physician's signature and date are required

### 5 Patient Authorization to Share Personal Health Information and OnePath Enrollment

- The patient signature is required to allow personal health information to be shared by third parties to Shire to facilitate access to FIRAZYR (insurance benefits, self-administration training, transfer Rx to Specialty Pharmacy Provider, etc.)
- **Checking the OnePath Enrollment box allows patients to receive product support services from Shire, if eligible**
  - Benefits investigation
  - Co-pay support (when applicable) and information about third-party financial assistance programs, as necessary
  - Injection training (if applicable)
  - Enrollment in OnePath–Case Manager assignment and product support services

#### WHAT HAPPENS NEXT?

- Once the completed form has been submitted to OnePath®, a dedicated Case Manager will be assigned to your eligible patient
- The Case Manager will contact the patient directly to inform him or her of the services available through OnePath and to begin the insurance verification process
- The Case Manager will work with the insurance company to determine insurance benefits
  - If applicable, OnePath will assess the patient's eligibility for co-pay support and any other means that will assist the patient in accessing FIRAZYR
- If requested, the Case Manager will set up Shire-provided self-administration training services

