COMPASS℠
Comprehensive Personalized Patient Prescription Advocacy & Support Services

Phone: 877-305-7704
Fax: 877-305-7706
www.compassforpatients.com

ACTIMMUNE® (Interferon gamma-1b) SERVICE REQUEST FORM

Please fax the completed form to 877-305-7706. **Patients must also complete Page 2**.

Patient Information (*indicates required field)

Patient Name*: _____ DOB*: ___/___/___ Gender*: ☐ Male ☑ Female
Address*: _____ Email: _____
City*: _____ State*: _____ *Zip Code: _____ Primary Language; if not English: _____
Phone: (___) _____ Alternate (Cell) Phone: _____
Caregiver/Alternate Contact Name: _____ Preferred Contact Time: ☐ Morning ☐ Afternoon ☑ Evening
Caregiver Relationship: _____ Phone: _____ Is your patient currently on ACTIMMUNE®? ☐ Yes ☑ No
Preferred Contact: ☐ Patient ☐ Caregiver If Yes, provide last date of use: _____

Insurance Information (*indicates required field) **Please attach copies of insurance card/s, if available.**

Primary Insurance Company*: _____ Phone*: (___) _____
Policy Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Other Policy #*: _____ Group #*: _____
Policy Holder Name*: _____ Relationship: _____ DOB: ___/___/___
Secondary Insurance Company: _____ Phone*: (___) _____
Policy Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Other Policy #: _____ Group: _____
Policy Holder Name: _____ Relationship: _____ DOB: ___/___/___
Prescription Card Carrier Name*: _____ Phone: (___) _____
Identification #*: _____ BIN #: _____ Policy/Group #: _____
Policy Holder Name*: _____ Relationship: _____ DOB: ___/___/___

Diagnosis and Prescription Information (ALL fields required)

☑ Chronic Granulomatous Disease (CGD) (ICD-9: 288.1)
☐ Severe, malignant osteopetrosis (ICD-9: 756.52)
☐ Other: _____ (ICD-9: _____)

Rx: ACTIMMUNE® (Interferon gamma -1b)
100mcg (2 million IU)/0.5ml, single-use vials

Sig: _____ mcg SubQ: _____ (frequency of dosing)
Vial Qty: ☑ 12 ☐ Other: _____ Refills: _____

Anticipated Start Date: _____
Injection Setting: ☐ Physician's Office ☐ Home ☐ Other: _____

Ancillary Supplies:
Syringe: ☐ 1mL ☐ 0.5mL Qty: ☑ 12 ☐ Other: _____
Needle: ☐ 29g 1/2 in ☐ 30g 1/2 in Qty: ☐ 12 ☐ Other: _____
Alcohol Swabs: Qty: ☐ 12 ☐ Other: _____

I certify that therapy is medically necessary and that this information is accurate to the best of my knowledge.
Prescriber's Signature: _____ Date: _____
(No Stamps Allowed)

Prescriber Information (*indicates required field)

First and Last Name*: _____ Credentials: _____
NPI #*: _____ State License #: _____ State Issued: ____ Tax ID*: _____ Specialty*: _____
Practice/Facility Name*: _____ Primary Contact Name*: _____
Address*: _____ City*: _____ State*: _____ Zip Code*: _____
Phone*: (___) _____ Fax: (___) _____ Prescriber Email: _____
Referring Physician: _____

Prescriber Acknowledgment: I authorize COMPASS℠ administered by Lash Group, Inc. ("Lash") to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use and disclose any information about any of my patients enrolled with COMPASS℠ to the insurer of such patients and to obtain any information about such patients, including any protected health information (as defined in 45 CFR 160.103), from the insurer, including eligibility and other benefit coverage information, for my payment and/or healthcare operation purposes. I authorize Lash to contact the patient to report coverage information and to inform them about the financial assistance programs offered by COMPASS℠. Lash may de-identify any and all protected health information of my patients, provided that the de-identification complies with the requirements set forth in 45 CFR 164.514(b). As my business associate, Lash is required to comply with, and by my signature hereto and that of Lash, each agrees to comply with the terms of the Business Associate Agreement ("BAA") at www.lashgroup.com/BAA and Lash will safeguard any protected health information that it obtains from me or on my behalf, and will use and disclose this information only for the purposes specified in BAA or as otherwise permitted by law.
I permit COMPASS℠ to correspond with and submit applicable paperwork to health insurance providers on behalf of my office with respect to their prior authorization processes. I understand that Vidara Therapeutics, manufacturer of ACTIMMUNE®, provides funding for COMPASS℠ and the services performed by the program.

Prescriber Name: _____ Prescriber Signature*: _____ Date*: _____
(No Stamps Allowed)

Vidara THERAPEUTICS™

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Patient Name:_____ **DOB:**____/____/_____

Please sign both the HIPPA Authorization and Patient Consent & Program Opt-In Sections before returning.

Patient Consent & Program Services Opt-In

By signing this consent, I authorize the release of information provided in this Service Request Form to the COMPASS℠ Program for the provision of education, training, and ongoing support on the use of ACTIMMUNE® (Interferon gamma-1b). COMPASS℠ may provide me with educational or product-related informational materials. I authorize COMPASS℠ to contact me with educational materials related to my ACTIMMUNE® treatment or about other services related to the COMPASS℠ program. If I do not wish to receive information related to ACTIMMUNE® or The COMPASS℠ Program, I understand that I may call the COMPASS℠ Program toll-free number, 877-305-7704 at any time.

Yes, I agree to receive the additional services I have selected below and I further authorize the COMPASS℠ Program (the "Program") to contact me by phone, mail, or email to provide information about other support services the Program offers. This signature signifies that I have agreed to opt-in to receive the service I selected below:

The COMPASS℠ Program Additional Patient Service Offerings (at no cost)

☐ Clinical Nurse Program - Yes, I would like a Registered Nurse from COMPASS℠ to contact me.

☐ Sharps Container - Yes, I would like to receive a Sharps Container with return postage to dispose of my used syringes.

☐ Email Prescription Refill Reminders

Email Address(s):_____

☐ Text Prescription Refill Reminders†

Cell Phone Number(s):_____

†**I understand that my cell phone carrier's standard rates may apply for text messages to my cell phone.**

The signature below denotes that I am over the age of 18 and that I authorize the COMPASS℠ Program to send emails and/or text reminders to my cell phone and/or email address I have listed above.

Patient/Personal Representative Signature*:_____ Date*:_____

Patient/Personal Representative Printed Signature:_____

Relationship (Personal Representative), if applicable (parent, power of attorney, etc):_____

HIPAA Authorization

By signing this Authorization, I authorize my health plans, physicians and pharmacy providers ("Health Plans and Providers") to use and disclose my personal health information or the personal health information of the patient/minor child for whom I am the parent or legal guardian relating to my/my child's medical conditions, treatment, care management, and health insurance for ACTIMMUNE® (Interferon gamma-1b), as well as all information provided on this form and any prescription ("Personal Health Information"), to The Lash Group, Inc. as administrator of the Comprehensive Personalized Patient Prescription Advocacy & Support Services Program ("COMPASS℠ Program") of Vidara Therapeutics and its representatives, agents, and contractors (collectively "The Lash Group") for the following purposes: (1) to establish eligibility for benefits; (2) to communicate with health care providers and me about my/my child's medical care; (3) to facilitate the provision of products, supplies or services by a third party including, but not limited to, specialty pharmacies; (4) to register me in any applicable product registration program required for my/my child's treatment (5) for me to receive the communications from The Lash Group regarding my participation in or experience with the COMPASS℠ Program. I understand and agree that my/my child's specialty pharmacy (Accredo, Curascript, CVS Caremark, Walgreens or other specialty pharmacies) may receive remuneration from Vidara Therapeutics in exchange for disclosing my/my child's Personal Health Information to The Lash Group, for sharing de-identified information to Vidara Therapeutics and for using my Personal Health Information to communicate with me about the COMPASS℠ Program services in addition to providing me with therapy support services subsidized by Vidara Therapeutics. I understand that my/my child's Personal Health Information disclosed under this authorization may be redisclosed by The Lash Group and is no longer protected by federal privacy laws. I understand that I may refuse to sign this Authorization and that my/my child's treatment, payment, enrollment or eligibility for benefits, is not conditioned on my signing this Authorization. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to The Lash Group, Inc., 9717 Key West Avenue, Rockville, MD 20850, but that this cancellation will not apply to any information used or disclosed by my Health Plans and Providers based on this Authorization before they learn that I have cancelled it. This Authorization expires one (1) year from the date signed below, or as required by law.

A photocopy of this authorization will be treated in the same manner as the original.

Patient/Personal Representative Signature*:_____ Date*:_____

Patient/Personal Representative Printed Signature:_____

Relationship (Personal Representative), if applicable (parent, power of attorney, etc):_____

Vidara THERAPEUTICS™