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

REMEMBER — Send your completed application to the 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 **"Healthcare 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, dental, mental health and substance abuse 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 2,600+ 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.

NeedyMeds also offers information on diagnosis-based camps and retreats, recreational programs, scholarships, government programs, $4 generic drug programs, and more.

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. Use the card to get discounts on lab tests and also to save 40% on durable medical equipment. To date, our drug discount card has saved patients over $300,000,000. Check out the following page to learn more.

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

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

Rich Sagall, MD
President, NeedyMeds

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.

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.

You can also save an extra 5% on affordable lab tests and online results. No doctor's order or insurance needed. Visit www.needymeds.org/L2L for more information.

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
50 Whittemore St.
Gloucester, MA 01930

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

AFSTYLA® Antihemophilic Factor (Recombinant), Single Chain
Enrollment Form

PRINT AND FAX COMPLETED FORM TO 1-844-727-2757
FOR QUESTIONS, PLEASE CALL 1-800-676-4266

AFSTYLA Connect℠

AFSTYLA SUPPORT SERVICES

At CSL Behring, we believe everyone should have access to therapy. For AFSTYLA we provide support services to help you get the treatment you need. Please check the box below to select the service(s) you are interested in and complete this form. (See page 2 for service descriptions)

☐ **Co-Pay Assistance** ☐ **Free Trial** ☐ **Benefit Investigation** ☐ **CSL Behring Assurance℠**

PATIENT Sections 1, 2 & 3 Must Be Completed for All Service Requests

1 Patient Information (REQUIRED)

Patient name _____ DOB ___/___/___ SSN (last 4 digits only) ___ ___ ___ ___ Sex ☐ M ☐ F

Street address _____ City _____ State _____ ZIP _____

Home phone _____ ☐ OK to leave message Mobile phone _____ ☐ OK to leave message Email _____

Current therapy status: ☐ Existing AFSTYLA patient ☐ Switch from another Factor VIII therapy _____ ☐ Other _____

2 Patient Insurance Information (REQUIRED) Please attach copies of both sides of patient's insurance card(s), if available.

☐ **Check if patient does not have insurance** (Patient must have insurance to be eligible for Free Trial and Assurance℠)

Primary insurance _____

Insurance phone _____ Policy # _____

Policyholder name _____ Policyholder DOB ___/___/___

Secondary insurance _____

Insurance phone _____ Policy # _____

Policyholder name _____

Policyholder DOB ___/___/___

Pharmacy plan _____ Group # _____ Policy # _____ Rx BIN # _____ Rx PCN # _____

3 Data Privacy Notice (REQUIRED)

I have read and understand the "DATA PRIVACY NOTICE" section of the instructions on Page 2. My signature also signifies that the information on this form is accurate and complete.

PATIENT SIGNATURE _____ Date _____

PARENT OR GUARDIAN SIGNATURE (for patients under 18 years old) _____ Date _____

In addition, I authorize the disclosure of my health information to the following designated individual (optional):

Designated Individual (print name) _____ Relationship _____

PRESCRIBER

I AM REQUESTING: (please check appropriate box) ☐ **AFSTYLA FREE TRIAL PROGRAM** ☐ **AFSTYLA FREE TRIAL & BENEFIT INVESTIGATION**

A Prescriber Information

Prescriber name _____ State license # _____ NPI # _____

Tax ID # _____ DEA _____ PTAN _____

Facility name _____ Facility address _____ City _____ State _____ ZIP _____

Office contact _____ Phone _____ Fax _____ Email _____

Ship to: ☐ Patient home ☐ Facility

B Prescription and Dosing Information

Rx: AFSTYLA For Prophylaxis
If you are requesting a Prophylactic trial, please fill out the below section.
All requests must be for a 4 week trial period.

- **Patients ≥12 years of age: 20–50 IU/kg body weight twice or three times per week.**
- **Patients <12 years of age: 30–50 IU/kg body weight twice or three times per week. More frequent or higher doses may be required in children.**

Patient weight _____ kg Dosage _____ IU/kg Frequency of dosing ☐ 2x/week ☐ 3x/week

☐ Other If other selected, please specify requested dosing frequency _____

Number of refills (If using pharmacy referral) _____ ☐ D66 Congenital Factor VIII Disorder

Rx: AFSTYLA On-Demand
If you are requesting an On-Demand trial dose, the request must be for 2 acute doses of AFSTYLA from a range of 20 – 50 IU/kg per dose. (max 100 IU/kg per dose).

- **Minor or Moderate Bleed:** Treat to 30 - 60 IU/dl % to circulating factor
- **Major Bleed:** Treat to 60 - 100 IU/dl % to circulating factor

Patient weight _____ kg Dosage _____ IU/kg Frequency of dosing _____

☐ D66 Congenital Factor VIII Disorder

No medical exceptions will be offered for the On-Demand dosing program.

C Prescriber Authorization (REQUIRED)

PRESCRIBER SIGNATURE _____ **DATE** _____

By signing above, I certify that:

- I have discussed with the above-named patient or the patient's legal guardian that CSL Behring sponsors a program through which CSL Behring will make a limited free supply of AFSTYLA available to the patient. The patient desires to participate in this CSL Behring program and receive the free product.
- I certify that the requested product is medically necessary for this patient and that the patient has no free trial history with this product.
- I have received the necessary written authorization from the patient or the patient's legal guardian to release to CSL Behring and its contracted agents, working solely on behalf of patient, the medical and/or other patient information included in this form relating to the patient referenced above for the purposes of participating in programs and services offered through AFSTYLA Connect, which may include any of the following:
  – participating in the AFSTYLA Trial Program
  – seeking reimbursement through AFSTYLA Connect
  – 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
- If I have requested free trial product, I will not directly or indirectly sell, resell, trade, barter or return for credit the requested product, or seek reimbursement for them from any source whatsoever, including any public or private third-party program.

CSL Behring
Biotherapies for Life®

Enrollment Form Instructions

THANK YOU FOR YOUR INTEREST IN AFSTYLA SUPPORT SERVICES
PLEASE CALL **1-800-676-4266** WITH QUESTIONS

AFSTYLA SUPPORT SERVICES

At CSL Behring, we believe everyone should have access to therapy. For AFSTYLA we provide support services to help you get the treatment you need.

Co-pay Assistance: Patients meeting eligibility requirements* may receive up to $12,000 in Co-Pay support.

**Patient must have coverage for AFSTYLA under a private, commercial plan. Patients covered by state or federally funded programs are excluded (Medicare, Medicaid, PCIP, Tricare, SCHIPs, etc). Patient must be a resident of the United States. Product only is supplied per the Package Insert. Product must be purchased from a Specialty Pharmacy, Hemophilia Treatment Center, or Outpatient Hospital to be eligible. CSL Behring reserves the right to modify, limit, or discontinue all or any portion of the program without notice. Annual benefit may be up to $12,000 per enrollment year.*

Free Trial: Patients meeting eligibility requirements† can receive:

-One 30 day free trial of AFSTYLA if prescribed for prophylaxis ***OR***
-Two acute doses of AFSTYLA for on-demand trial. No medical exceptions will be offered for the on-demand dosing program.

†*Only patients who have never previously received an AFSTYLA Free Trial are eligible. All insured patients are eligible for AFSTYLA Free Trial, including patients with Medicare and Medicaid. Free Trial product must be used on-label.*

Benefit Investigation: We will contact an insurance carrier on a patient's behalf to obtain coverage and patient costs for AFSTYLA.

Assurance℠: The CSL Behring Assurance℠ program can help people who rely on AFSTYLA to continue to receive treatment if a lapse in commercial insurance coverage occurs. Call 1-800-676-4266 for more details.

PATIENT INSTRUCTIONS

1 Complete Sections 1 and 2 on the Enrollment Form.

2 Read DATA PRIVACY NOTICE—Sign Section 3 on the Enrollment Form.

PATIENT-SIGNED DATA PRIVACY NOTICE FOR CSL Behring's Support Programs:

By signing this authorization, I authorize my health plans, physicians and staff, other healthcare providers, and pharmacy providers (collectively, my "Providers") to disclose information, including but not limited to, personal health information about me or my minor child, including information related to my or my child's medical condition, treatment, care management, and health insurance coverage and claims, any prescription (including fill/refill information), and any other information disclosed in connection with the Services (as defined below) ("Personal Health Information"), to CSL Behring and its representatives, agents, and contractors, including CSL Behring's support program(s) (collectively "CSL Behring Entities") for the purposes of:

(1) establishing eligibility for insurance benefits including but not limited to coverage for prescription drugs;
(2) evaluation and enrollment in one or more financial assistance program(s) offered by CSL Behring Entities, such as a co-pay mitigation program and/or patient assistance programs (if one or more of such programs apply to my treatment with a CSL Behring therapy;
(3) enrollment in available patient services programs offered by CSL Behring Entities;
(4) communication about my treatment with me or my Providers, including by contacting me directly to facilitate the dispensing of medication and scheduling shipments and refill reminders;
(5) providing product support and adherence services through CSL Behring Entities;
(6) evaluating the effectiveness of CSL Behring's support program(s); and
(7) any other related support, education, and assistance services related to my treatment with CSL Behring therapy and/or living with my disease (collectively, the "Services").

Further, I authorize any of the CSL Behring Entities to contact me by mail, telephone and/or SMS/text message, or e-mail for relevant follow-up to any of the aforementioned Services. CSL Behring Entities include but are not limited to brand specific support through hub service providers, pharmacy service providers, nurse self-infusion training providers and/or nurse adherence providers, as well as other entities under contract with CSL Behring to support these or similar aspects of the Services. I understand that these CSL Behring Entities may collect Personal Health Information from me for the purposes listed above, and that such collection is subject to CSL Behring's Privacy Policy.

I understand that once my Personal Health Information or other personal information is disclosed to the CSL Behring Entities under this authorization, it may no longer be protected by state and/or federal privacy laws and may be further disclosed by the CSL Behring Entities. However, I understand that the CSL Behring Entities will disclose my Personal Health Information only for the limited purposes described above, or as I may further authorize in writing, or as permitted or required by law. I understand that data related to my enrollment in any CSL Behring program may be collected, analyzed and shared among CSL Behring Entities. I also understand that CSL Behring Entities may receive compensation from CSL Behring in connection with the Services.

I understand that my pharmacy Providers, including those Providers who dispense free trials as part of the Services or commercially-reimbursed doses of CSL Behring products, may disclose to the CSL Behring Entities certain Personal Health Information regarding the dispensing of my prescription and that such disclosure may result in remuneration to my pharmacy Provider(s). If necessary or if requested by my prescriber, I authorize CSL Behring Entities to forward my prescription to a dispensing pharmacy on my behalf.

I understand that I may refuse to sign this authorization. I understand, however, that if I do not sign this authorization, I may not be able to receive Services through CSL Behring Entities. I understand that my treatment with a CSL Behring therapy (other than participation in a free trial program), payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this authorization. I understand that Services provided by CSL Behring are not insurance and that CSL Behring has the right to rescind, revoke or amend any service at any time without notice.

I understand that I am entitled to a copy of this authorization.

I understand that if CSL Behring Entities loans me durable medical equipment or other medical equipment through the Services, CSL Behring reserves the right to seek reimbursement from me for all unreturned DME or equipment.

I understand that I may change my mind and cancel this authorization at any time by writing a letter requesting such cancellation to CSL Behring c/o Patient Services P.O. Box 61501 King of Prussia, PA 19406 or by calling the CSL Behring Customer Affairs toll free number 1-888-508-6978 and that this cancellation will end my participation in the Services but will not apply to any information already used or disclosed through this authorization before notice of the cancellation is received by CSL Behring Entities. This authorization expires five (5) years from the date signed, or earlier, if required by state law. CSL Behring will not retain my information beyond the maximum period allowed by law.

I understand that, under certain circumstances, by law I may have certain rights regarding CSL Behring's use of my or my minor child's data. I may have the right to receive information about what data CSL Behring has collected about me or my minor child. I may have the right to ask CSL Behring to delete certain personal information about me or my minor child, but only when CSL Behring does not have a legal reason for retaining such personal information. I understand that if I exercise these rights, I will be asked to verify my identity, that if someone else will exercise my rights on my behalf, that they will need to prove that they have my permission to do so. I understand that to exercise my rights, I may contact CSL Behring through https://privacyinfo.csl.com/ or toll free by phone at (833) 704-0018. For more information about how CSL Behring handles personal information, I understand that I can view CSL Behring's privacy policy at https://www.cslbehring.com/privacy-policy.

PRESCRIBER INSTRUCTIONS—Sections 1 and 2 MUST ALSO BE COMPLETED

1 Complete Prescriber Information in Section A of the Enrollment Form.

2 Complete the Patient's Dosing Information in Section B of the Enrollment Form, including confirmation of diagnosis code.

3 Read and Sign Prescriber Authorization in Section C of the Enrollment Form.

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