

FAX: 1-877-937-2284

Acthar Start Form
Please complete Start Form and fax toll-free
TEL: 1-888-435-2284
Monday through Friday (8:00 am to 9:00 pm EST)
Saturday (9:00 am to 2:00 pm)

1. PATIENT INFORMATION	Patient has been notified of ref	ferral ■ YES ■ NO		
PATIENT FIRST NAME PATIENT I	MIDDLE INITIAL PATIENT LAST N	NAME	DATE OF BIRTH	GENDER
HOME ADDRESS		CITY	STATE	ZIP
SHIPPING ADDRESS (IF NOT HOME ADDRESS)	CARE OF (IF NOT ADDRESSED TO PATIENT)	CITY	STATE	ZIP
HOME PHONE	MOBILE OK TO TEXT	BEST TIME TO CALL	PREFERRED LANGUA	GE IF NOT ENGLISH
EMAIL ADDRESS	PATIENT REPRESENTATIVE	RELATIONSHIP	TELEPHONE	
2. INSURANCE INFORMATION	(PLEASE INCLUDE COPIES OF (CARDS)		
PHARMACY BENEFITS		SUBSCRIBER ID #	GROUP #	TEL#
PRIMARY MEDICAL INSURANCE	POLICY HOLDER RELATIONSHIP	SUBSCRIBER ID #	GROUP #	TEL#
3. HEALTHCARE PROVIDER (H	HCP) INFORMATION			
HCP FIRST NAME HCP LAST NAM SPECIALTY: NEPHROLOGY NEUROLOGY	ME HCP MIDDLE INITIAL	NPI # GROUP NPI # (IF A	APPLICABLE) STATE	LICENSE #
FACILITY NAME	TELEPHONE	FAX	ii omem ezac	JE INDIONIE
ADDRESS		CITY	STATE	ZIP
OFFICE CONTACT NAME	CONTACT TELEPHONE	EMAIL ADDRESS	PREFERRED METHOD	O OF COMMUNICATION
4. PRESCRIPTION: H.P. ACTHA	AR® GEL ND(C# 63004-8710-1 5 mL multido	ose vial containing 80	USP units per m
PRIMARY DIAGNOSIS: INITIATE PATIENT WITH: UNITS DOSE: ML SCHEDULE/FREQUENCY ADDITIONAL SPECIAL INSTRUCTIONS, OR TAPER	Y: QUANT	TITY OF 5 ML MULTIDOSE VIALS: REFILLS: _ ALLERGIES:	1	D-10: INTRAMUSCULATION: SUBCUTANEOU
SUPPLIES: SYRINGE SIZE: 1 mL 3 mL Other size	QUANTITY: NEEDLE SIZE: 20 g needle.	p, 1 inch 🔲 23 g needle, 1 inch 🔲 25 g needle, 1 in	Subcutaneous only nch 25 g needle, 5/8 inch 1	(other):QUANTITY:
PATIENT WEIGHT (FOR WEIGHT-BASED DOSING O	NLY): SUPPLY REFILLS: SHARPS	CONTAINER: OTHER SUPPLIES:		
HOME INJECTION TRAINING SERVICES By initialing here (original required) I request nursing service. I also understand that all re	S (HITS) that company-funded HITS services be arran- reasonable efforts will be made to schedule t	ged for my patient. I understand that HITS is the HITS training visit within 24 hours of the	for one instruction visit only a patient's receipt of drug ship	and NOT a home healt pment.
INITIALS	DATE			
I certify that H.P. Acthar® Gel is medically verify that the patient and healthcare pro with my practicing state's specific preso requirements could result in outreach to		ve reviewed this therapy with the patient n is complete and accurate to the best of oing, state specific prescription form, fax	t and will be monitoring the f my knowledge. I understa language, etc. Non-compli	nd that I must comp iance of state specif
Program, to perform a preliminary asse form. I understand that insurance verific	on ("UBC"), the current operator of the Ar essment of benefit verification for this pa cation is ultimately the responsibility of the ley and Mallinckrodt make no represental	atient and furnish information requested he provider and third-party reimburseme	by the patient's insurer the ent is affected by a variety	at is available on tl
	the Program or UBC may contact me or m receive this prescription via a designated armacy.			
HCP Prescriber Signature - Ple	ease sign ONE LINE below			

	FOI P	auent			БОВ:
6. DIAGNOSIS AND I	MEDICAL INFORMATION				
Diagnosis		Optic neuritis		:	Psoriatic arthritis
•	and responses to associated	Ī	•		
questions		Polymyositis	ophratia syndrama		Rheumatoid arthritis
Ankylosing spondylit	is	Please indicat	ephrotic syndrome e etiology:		Sarcoidosis
Dermatomyositis		Focal segm	ental glomerular sclerosi	s (FSGS)	Systemic lupus erythematosus Is Acthar to be used to treat an
Infantile spasms		IgA nephropathy (IgAN)		acute exacerbation?	
Has diagnosis been co	onfirmed by EEG?	Lupus neph	ritis	YES NO Must check one	
🔲 YES 🔲 NO		Membranou	us nephropathy (MN)		Lupus nephritis?
Patient's weight:		Other:			🗋 YES 📋 NO
Requested drug delive	ery date:				Uveitis
Multiple sclerosis					Other diagnosis
Is Acthar to be used to	treat an acute exacerbation?				
Exacerbation	Other Must check one				
Onset of acute exacer	bation Date:				
7 HISTORY OF COR	TICOSTEROID USE (IF APPL	ICABLE) DI EASE	ADD DETAILS IN SE	CTION 8 RE	FLOW
		IOABLL) I LLAGE	ADD DETAILS IN SE	OTION O DE	
Please check all that ap	• •		biocotowaid was mot twic	ماد مد میرام ام	following googles
	ed with the following response(s				e following response(s):
expected with Acthar	ed, but same response not		rticosteroid use is contra avenous access is not p		·
•	or allergic to corticosteroids	OR	ient has known intolerar		•
Patient intolerant to co	_				
		Ott	ner:		
8. CONCURRENT M					
6. CONCORNENT W	LDICATIONS				
9. RELEVANT TREAT	MENT HISTORY (INCLUDING	RECENT STERC	OID HISTORY)		
Therapy Name	Dose	Start Date	Stop Date		o Outcome With Detail
			(if applicable)	(ex. type	of outcome)
(Attach additional pages	as necessary)				
OTHER RELEVANT	CLINICAL INFORMATION				
HCD SIGNATURE-P	FOURED FOR DOCUMENTA	TION			
HOP SIGNATURE: R	EQUIRED FOR DOCUMENTA	THOIN			
NAME			SIGNATURE		DATE



For completion by patient or their representative

Patient Name:	DOB	:

10. PATIENT AUTHORIZATION(S)

For Patient Review and Completion. If patient is not available, authorization will be obtained from patient by Acthar Support and Access Team upon receipt of referral.

By signing this authorization, I authorize my physician(s), my health insurance company, my pharmacy providers and Mallinckrodt ARD Inc., the distributor of Acthar ("Mallinckrodt"), and its agents, authorized designees and contractors, including Mallinckrodt reimbursement support personnel and United BioSource Corporation ("UBC") or any other operator of the Acthar Support and Access Program on behalf of Mallinckrodt (collectively, "Designated Parties"), to use and disclose to other Designated Parties health information relating to my medical condition, treatment, and insurance coverage (my "Health Information") in order for them to (1) provide certain services to me, including reimbursement and coverage support, patient assistance and access programs, medication shipment tracking, and home injection training, (2) provide me with support services and information associated with my Acthar therapy, (3) for internal business purposes, such as for marketing research, internal financial reporting and operational purposes, and (4) to carry out the Designated Parties' respective legal responsibilities.

Once my Health Information has been disclosed to the Designated Parties, I understand that it may be re-disclosed by them and no longer protected by federal and state privacy laws. However, the Designated Parties agree to protect my Health Information by using and disclosing it only for the purposes detailed in this authorization or as permitted or required by law.

I understand that I may refuse to sign this authorization and that my physician and pharmacy will not condition my treatment on my agreement to sign this authorization form, and my health plan or health insurance company will not condition payment for my treatment, insurance enrollment or eligibility for insurance benefits on my agreement to sign this authorization form. I understand that my pharmacies and other Designated Parties may receive payment in connection with the disclosure of my Health Information as provided in this authorization. I understand that I am entitled to receive a copy of this authorization after I sign it.

I may revoke (withdraw) this authorization at any time by mailing a letter to Acthar Support and Access, 255 Technology Park, Lake Mary, FL 32746. Revoking this authorization will end further disclosure of my Health Information to Designated Parties by my pharmacy, physicians and health insurance company when they receive a copy of the revocation, but it will not apply to information they have already disclosed to the Designated Parties based on this authorization. I also know I may cancel my enrollment in a patient support program at any time in writing by contacting Mallinckrodt via fax at 877-937-2284.

This authorization is in effect for 1 year or until the conclusion of any ongoing coverage support, whichever is longer, once I have signed it unless I cancel it before then.

PATIENT NAME OR LEGAL REPRESENTATIVE

PATIENT SIGNATURE

IF LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT

DATE

I authorize Mallinckrodt and its agents to receive, use, and disclose my health information relating to my medical condition, treatment, insurance coverage, and contact information from me, my healthcare providers, my pharmacies, and my health insurance company in order to (1) contact me about participation in Acthar patient programs, (2) provide me with educational or other informational materials, (3) administer its education and other patient-related programs, (4) conduct surveys that request my feedback, and (5) for Mallinckrodt to carry out its legal responsibilities in connection with these education and support programs. I agree to let Mallinckrodt or its agents contact me in the future about these offerings. Once my health information has been disclosed to the education, informational and/or support program I choose to participate in, I understand that it may be redisclosed by Mallinckrodt or its agents, and they are authorized to use or disclose this information in the manner described here and as permitted by this authorization or as otherwise permitted or required by law, and that federal and state privacy laws may no longer protect the information. However, Mallinckrodt and its agents agree to protect my health information by using and disclosing it only for the purposes described in this authorization or as permitted or required by law. This authorization will remain in effect until I cancel it which I may do so at any time by contacting Mallinckrodt via fax at 877-937-2284. Cancelling this authorization prior to my revocation). If I withdraw my permission, I know that this means I may no longer receive information on supplemental education or support programs. Once I withdraw my permission, no new information will be disclosed to Mallinckrodt or its agents, but Mallinckrodt and its agents may continue to use the information that was collected before I withdrew my permission as permitted by this authorization or as otherwise permitted or required by law. I may request a copy of this signed authoriz

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PATIENT SIGNATURE

IF LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT

DATE

Acthar Support and Access Program FAX: 1-877-937-2284 TEL: 1-888-435-2284

INDICATIONS AND USAGE

- Infantile spasms: H.P. Acthar Gel (repository corticotropin injection) is indicated as monotherapy for the treatment of infantile spasms in infants and children under 2 years of age
- Multiple Sclerosis: H.P. Acthar Gel (repository corticotropin injection) is indicated for the treatment of acute exacerbations of multiple sclerosis in adults. Controlled clinical trials have shown H.P. Acthar Gel to be effective in speeding the resolution of acute exacerbations of multiple sclerosis. However, there is no evidence that it affects the ultimate outcome or natural history of the disease
- Rheumatic Disorders: As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in: psoriatic arthritis, rheumatoid arthritis, including juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy), ankylosing spondylitis
- Collagen Diseases: During an exacerbation or as maintenance therapy in selected cases of: systemic lupus erythematosus, systemic dermatomyositis (polymyositis)
- Dermatologic Diseases: Severe erythema multiforme, Stevens-Johnson syndrome
- Allergic States: Serum sickness
- Ophthalmic Diseases: Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as: keratitis, iritis, iridocyclitis, diffuse posterior
 uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation
- Respiratory Diseases: Symptomatic sarcoidosis
- Edematous State: To induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

- Acthar should never be administered intravenously
- · Administration of live or live attenuated vaccines is contraindicated in patients receiving immunosuppressive doses of Acthar
- · Acthar is contraindicated where congenital infections are suspected in infants
- Acthar is contraindicated in patients with scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or the presence of a peptic
 ulcer, congestive heart failure, uncontrolled hypertension, primary adrenocortical insufficiency, adrenocortical hyperfunction or sensitivity to proteins of porcine origins

WARNINGS AND PRECAUTIONS

- The adverse effects of Acthar are related primarily to its steroidogenic effects
- · Acthar may increase susceptibility to new infection or reactivation of latent infections
- Suppression of the hypothalamic-pituitary-axis (HPA) may occur following prolonged therapy with the potential for adrenal insufficiency after withdrawal of the medication.

 Adrenal insufficiency may be minimized by tapering of the dose when discontinuing treatment. During recovery of the adrenal gland patients should be protected from the stress (e.g. trauma or surgery) by the use of corticosteroids. Monitor patients for effects of HPA suppression after stopping treatment
- Cushing's Syndrome may occur during therapy but generally resolves after therapy is stopped. Monitor patients for signs and symptoms
- Acthar can cause elevation of blood pressure, salt and water retention, and hypokalemia. Blood pressure, sodium and potassium levels may need to be monitored
- Acthar often acts by masking symptoms of other diseases/disorders. Monitor patients carefully during and for a period following discontinuation of therapy
- Acthar can cause GI bleeding and gastric ulcer. There is also an increased risk for perforation in patients with certain gastrointestinal disorders. Monitor for signs
 of bleeding
- Acthar may be associated with central nervous system effects ranging from euphoria, insomnia, irritability, mood swings, personality changes, and severe depression, and
 psychosis. Existing conditions may be aggravated
- · Patients with comorbid disease may have that disease worsened. Caution should be used when prescribing Acthar in patients with diabetes and myasthenia gravis
- · Prolonged use of Acthar may produce cataracts, glaucoma and secondary ocular infections. Monitor for signs and symptoms
- Acthar is immunogenic and prolonged administration of Acthar may increase the risk of hypersensitivity reactions. Neutralizing antibodies with chronic administration may lead to loss of endogenous ACTH activity
- . There is an enhanced effect in patients with hypothyroidism and in those with cirrhosis of the liver
- . Long-term use may have negative effects on growth and physical development in children. Monitor pediatric patients
- Decrease in bone density may occur. Bone density should be monitored for patients on long-term therapy
- Pregnancy Class C: Acthar has been shown to have an embryocidal effect and should be used during pregnancy only if the potential benefit justifies the potential risk to
 the fetus

ADVERSE REACTIONS

- Common adverse reactions for Acthar are similar to those of corticosteroids and include fluid retention, alteration in glucose tolerance, elevation in blood pressure, behavioral and mood changes, increased appetite and weight gain
- Specific adverse reactions reported in IS clinical trials in infants and children under 2 years of age included: infection, hypertension, irritability, Cushingoid symptoms, constipation, diarrhea, vomiting, pyrexia, weight gain, increased appetite, decreased appetite, nasal congestion, acne, rash, and cardiac hypertrophy. Convulsions were also reported, but these may actually be occurring because some IS patients progress to other forms of seizures and IS sometimes mask other seizures, which become visible once the clinical spasms from IS resolve

Other adverse events reported are included in the full Prescribing Information.

Please see accompanying full Prescribing Information.

