State of Illinois
Illinois Department of Public Health

Ryan White Part B ADAP Medication Assistance Program (MAP)

Application for Pre Approval of Trogarzo™ (ibalizumab-uiyk) Injection (Infusion) Assistance

(click on the name to take you directly to the specific Prescribing Guidelines)

To be eligible for Assistance for Trogarzo, a client must meet all of the following:

1. Be currently enrolled in IL ADAP/MAP and eligible to receive services. Client should also be enrolled in Part B Case Management services if assistance is needed with auxiliary costs (i.e., office visit and infusion cost).
2. Have been denied medication coverage by their insurance plan (if applicable). If client has insurance, insurance will be billed first and if denied, ADAP/MAP will coordinate benefits.
3. Eligible patients must have a history of multi-drug resistant HIV infection, and attach documentation of resistance in at least two-drug classes.

Complete the following:

Applicant's Name _____
Legal First Middle Last

Social Security Number _____ **Date of Birth** _____

Address _____

City _____ **State** _____ **ZIP Code** _____

Medical facility/infusion center where infusion will be taking place: _____

Name of Provider who will administer drug to the client: _____

Who will assume responsibility for drug upon shipment arrival? _____

Address where drug will be sent: _____

NOTE: A limit of 20 clients can be approved for Trogarzo assistance at a given time.
****Trogarzo must be shipped directly to a medical facility/infusion site. Trogarzo will not be shipped directly to the client.***
*****Physicians will be notified if applicant is approved and should coordinate shipment location and frequency with the Program's contracted dispensing pharmacy.***

Provider Name: (Print) _____ **Clinic:** _____

Phone Number: _____ **Fax Number:** _____

Medical Provider Signature: _____

Provider must acknowledge the following with initials:

_____ Patient has been counseled on the high cost of treatment and is willing to be 100% adherent to treatment regimen.

Submit to: Illinois Department of Public Health
525 W. Jefferson St., 1st Floor, Springfield, IL 62761

or Fax to: 217-785-8013

IDPH USE ONLY: Authorization Approved? ❑ YES ❑ NO Authorization Number: _____

Authorization Effective Date: _____ Authorization Expiration Date: _____
Based on ADAP/MAP eligibility

TROGARZO™ Enrollment Form

Trogarzo™
(ibalizumab-uiyk)
Injection
200 mg/1.33 mL (150 mg/mL)

To enroll, Fax all documents to 1-855-836-3069.
Please ensure all sections of Form are completed in full, with supporting documents included.
Questions? Contact a Patient Care Coordinator at 1-833-23-THERA (1-833-238-4372), Mon-Fri 8AM-8PM ET

1. Patient Information

First Name _____ Date of Birth MM / DD / YY Gender ☐ M ☐ F
Last Name _____ Preferred Language ☐ English ☐ Other _____
Address _____ Telephone _____
City _____ State (select) Email _____
ZIP _____ SSN (last 4 digits) _____ Best time to contact ☐ AM ☐ PM ☐ Other _____

Alternate Contact/Caregiver _____ Telephone _____
Relationship to Patient _____ ☐ OK to leave message

2. Prescriber Information

First Name _____ NPI # _____
Last Name _____ Tax ID # _____
Specialty _____ Medicaid # _____
Office/Clinic/Institution _____ Office Contact _____
Address _____ Office Telephone _____
City _____ Office Fax _____
State (select) ZIP _____ Office Email _____

3. Prescription

☐ **Rx: TROGARZO™** (Ibalizumab-uiyk)
NDC: 62064-122-02
– 2 single-dose vials (200 mg/1.33 mL)

Prescription Type:
☐ New ☐ Continuing Therapy ☐ Restart

☐ **Loading Dose:** 1 dose of 2,000 mg (10 vials) diluted in 250 mL of 0.9% NaCl, IV infusion over 30 min with 30 mL post-infusion flush

☐ **Maintenance Dose:** 800 mg (4 vials) diluted in 250 mL of 0.9% NaCl, IV infusion over 15 min with 30 mL post-infusion flush, every 2 weeks for _____ doses
Quantity: Dispense 1 month supply ☐ Refills _____

Diagnosis (ICD-10): ☐ B20 ☐ Other _____

Fluids for Reconstitution/Administration: ☐ 0.9% NaCl 10 mL syringe ☐ 0.9% NaCl 250 mL bag
As needed per TROGARZO™ PI and pharmacy protocol ☐ 0.9% NaCl Flush 50 mL or 100 mL bag

☐ Nursing Orders: Provide skilled nursing visit to administer medication, assess patient's status and response to therapy

4. Prescriber Authorization and Signature

I certify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed TROGARZO™ based on my judgment of medical necessity and I will be supervising the patient's treatment. I have received the necessary authorization prior to the transmittal of health information to Theratechnologies Inc., and parties working with Theratechnologies Inc., to perform a preliminary assessment of insurance verification and determine patient eligibility for the THERA patient support™ program. I authorize the forwarding of this prescription to a dispensing specialty pharmacy on behalf of myself and the patient. I understand that neither I nor the patient should seek reimbursement for any free product received under the program.

Special Note: The physician is to comply with their state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance of state-specific requirements could result in outreach to the prescriber.

Select one option:
☐ Prescriber's Signature (no stamps; **Dispense As Written**) _____ Date MM / DD / YY

OR

☐ Prescriber's Signature (no stamps; **Substitution Permissible**) _____ Date MM / DD / YY

5. Insurance Information

☐ **Patient does not have insurance**

OR

☐ **Patient has insurance**

Please complete the information below and include copies of front and back of insurance card(s)

☐ Primary Medical Insurance _____ Policy # _____

Cardholder Name _____ Cardholder Date of Birth MM / DD / YY

Relationship to Cardholder _____

☐ Secondary Medical Insurance _____ Policy # _____

Cardholder Name _____ Cardholder Date of Birth MM / DD / YY

Relationship to Cardholder _____

☐ Prescription Drug Insurer/Pharmacy Benefit Manager (PBM) _____

Telephone _____ Policy # _____

Rx BIN # _____ Rx Group # _____ Rx PCN # _____

6. Site of Care

Initial Dose: (select one option)

☐ Infusion Center _____

☐ Prescribing Physician Office _____

☐ Home Infusion

All Subsequent Dosing: (select one option)

☐ Same as Initial Dose

☐ Different _____

☐ Authorization for Ancillary Supplies: Needles, syringes, etc., as needed for administration

☐ Drug/Food Allergies _____ ☐ NKDA

☐ Medication History Included

Please attach complete antiretroviral list along with concomitant medication history

THERA patient support™

7. Patient Authorization and Signature

Patient Authorization to Use and Disclose Protected Health Information

I authorize health care providers and their staff involved in my care to disclose my Protected Health Information (as defined below), including but not limited to my medical record and other health information on my completed Statement of Medical Necessity form or other forms, records that may contain information created by other persons, entities, physicians, and health care providers information concerning HIV/AIDS diagnosis and treatment, including HIV test results, as well as information regarding substance use disorder treatment services and mental health services (excluding psychotherapy notes) (collectively, "Protected Health Information"), to Theratechnologies Inc. and its agents, representatives, and direct and indirect service providers (collectively, "Theratechnologies"), so that Theratechnologies may:

1. Facilitate the filling of my prescription for and the delivery and administration of Theratechnologies products, including disclosing or redisclosing Protected Health Information to pharmacies;
2. Assist me in obtaining insurance coverage for Theratechnologies products, including disclosing or redisclosing Protected Health Information to health plans; and
3. Contact me by mail, email, and/or telephone to enroll me in, and administer, programs that provide support services.

☐ **In addition, by checking this box, I authorize Theratechnologies to:**

4. Provide me with free educational information and marketing materials; and
5. Conduct surveys to measure my satisfaction with Theratechnologies products and services.

To accomplish these purposes, I further authorize Theratechnologies to share information, including HIV/AIDS information, between and among the entities defined in this Authorization as Theratechnologies. I understand that once my Protected Health Information is disclosed pursuant to this authorization, it may no longer be protected by the federal privacy law and regulations known as "HIPAA" or state privacy laws and may be the subject to further disclosure by Theratechnologies and third parties with whom Theratechnologies may share the information. However, other state and federal laws may prohibit the recipient from disclosing specially protected information such as certain HIV/AIDS-related information, substance use disorder treatment information, and mental health information.

I understand that I may refuse to sign this authorization. My refusal will not affect my ability to receive Theratechnologies products, treatment, payment, enrollment in a health plan, or eligibility for benefits but my refusal may limit my ability to receive certain support services that are provided by Theratechnologies.

I understand that health care providers may receive compensation, remuneration, or other value as a result of their use and disclosure of my Protected Health Information as described in this authorization.

I understand that this authorization will remain in effect for 10 years from the date of my signature, unless limited by state laws and regulations or I revoke it in writing earlier by contacting Theratechnologies c/o THERA patient support™, P.O. Box 390, Somerville, NJ 08876.

If I revoke this authorization, health care providers will stop using and disclosing my Protected Health Information for the purposes outlined in this authorization, but the revocation will not affect prior use or disclosure of my Protected Health Information in reliance on this authorization. I have the right to receive a copy of this authorization after I sign it.

I understand that the support services provided by Theratechnologies that are described in this authorization can be changed at any time, without prior notification.

Patient Name _____ Date of Birth MM / DD / YY

Address _____ Telephone _____

Patient or Authorized Representative Signature _____ Date MM / DD / YY

If Signed by an Authorized Representative:
Authorized Representative Name _____

Basis for Authority _____

NOTICE TO RECIPIENT OF INFORMATION:

HIV Related Information: To the extent that HIV-related information has been provided to you, such information has been disclosed to you from records whose confidentiality may be protected by federal and state law. Such laws may prohibit you from making any further disclosure of the HIV-related information without the specific written consent of the person to whom it pertains, or as otherwise permitted by said laws. When obtaining such written consent, you must expressly identify that HIV-information is being disclosed (a general authorization for the release of the entire medical file, for example is **NOT** sufficient for this purpose). An oral disclosure shall be accompanied or followed by such notice within ten days.