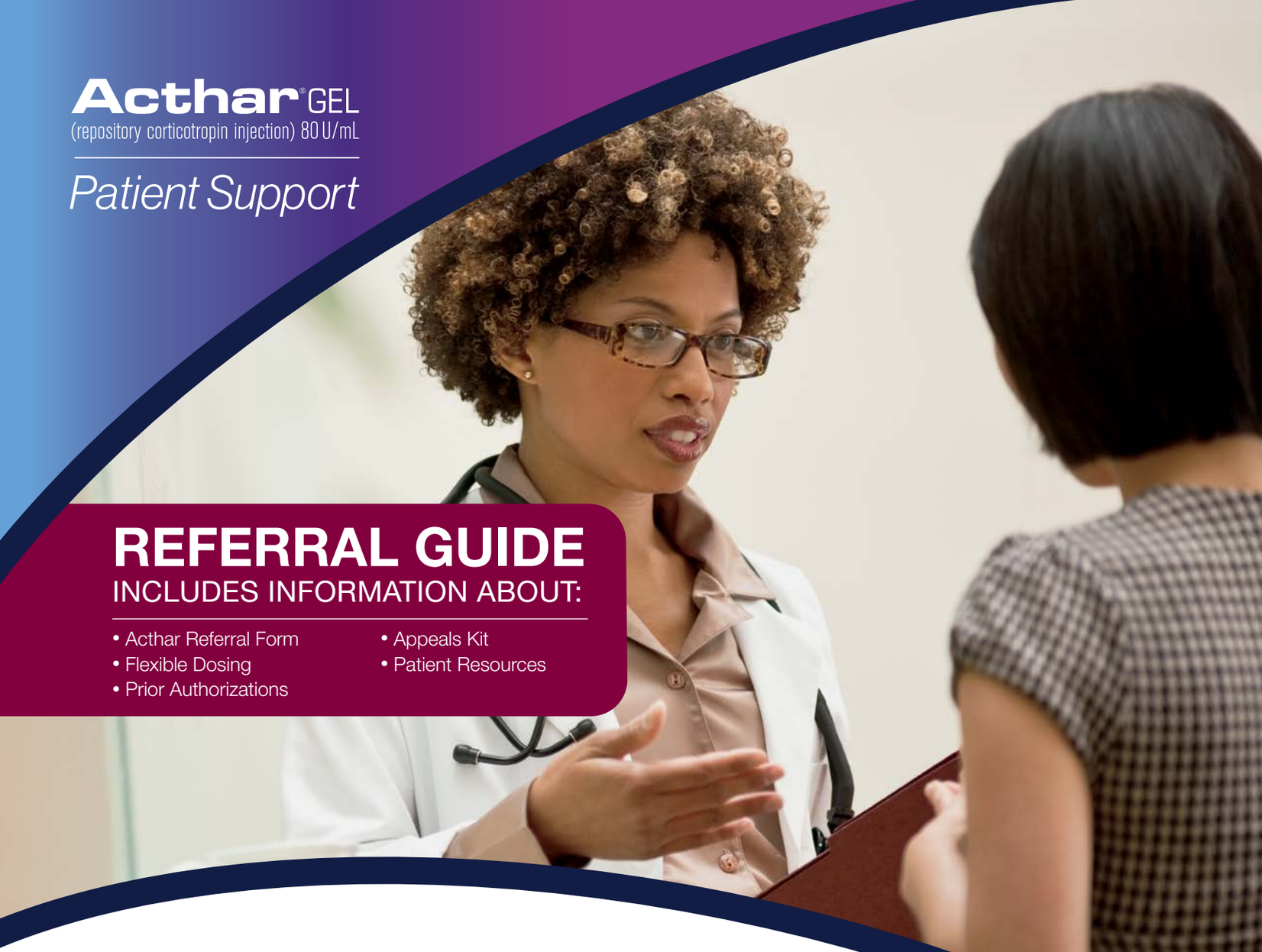
Acthar® GEL
(repository corticotropin injection) 80 U/mL

Patient Support



REFERRAL GUIDE

INCLUDES INFORMATION ABOUT:

- Acthar Referral Form
- Flexible Dosing
- Prior Authorizations
- Appeals Kit
- Patient Resources

INDICATIONS

Acthar® Gel is indicated for:

- Treatment during an exacerbation or as maintenance therapy in selected cases of dermatomyositis (polymyositis)
- Treatment during an exacerbation or as maintenance therapy in selected cases of systemic lupus erythematosus
- 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
- Symptomatic sarcoidosis
- 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
- Inducing a diuresis or a remission of proteinuria in nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus
- Treatment of acute exacerbations of multiple sclerosis in adults. Controlled clinical trials have shown Acthar 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
- Monotherapy for the treatment of infantile spasms in infants and children under 2 years of age

SELECT IMPORTANT SAFETY INFORMATION

Contraindications

Acthar is contraindicated:

- For intravenous administration
- In infants under 2 years of age who have suspected congenital infections
- With concomitant administration of live or live attenuated vaccines in patients receiving immunosuppressive doses of Acthar
- 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 origin

Please see additional Important Safety Information throughout and full Prescribing Information.

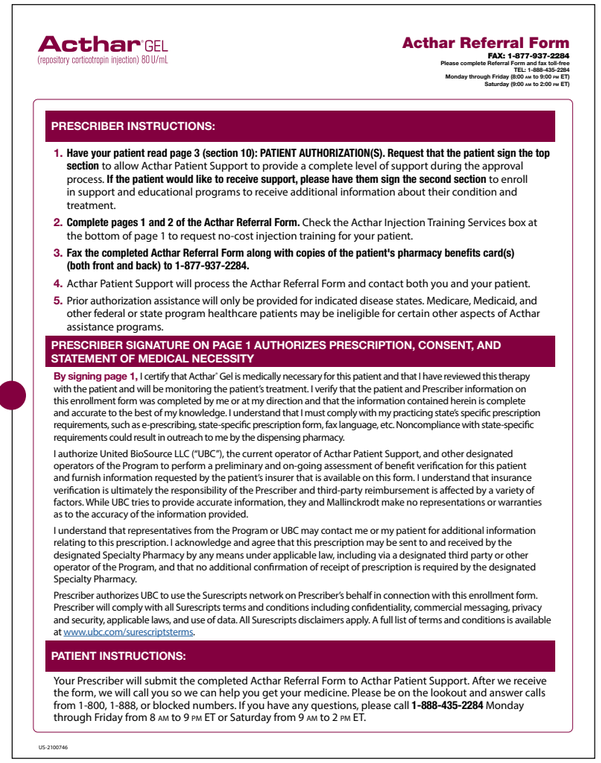
Completing the Acthar® Combo Referral Form

Instructions for submitting a complete and accurate Acthar Combo Referral Form

Note: The RHEUM Acthar Combo Referral Form is being used as the example; the Acthar Combo Referral Form for your specific therapeutic area may differ.

Prescriber consent language

- By signing this consent language, the Prescriber is: 1) agreeing to follow state-specific compliance guidance, 2) authorizing the HUB (UBC) to do a benefit verification for the patient, and 3) allowing the HUB to contact them or the patient to verify or complete the information required.



Acthar® GEL (repository corticotropin injection) 80 U/mL

Acthar Referral Form
FAX: 1-877-937-2284
Please complete Referral Form and fax toll-free
TEL: 1-888-435-2284
Monday through Friday (8:00 AM to 9:00 PM ET)
Saturday (9:00 AM to 2:00 PM ET)

PRESCRIBER INSTRUCTIONS:

1. **Have your patient read page 3 (section 10): PATIENT AUTHORIZATION(S). Request that the patient sign the top section** to allow Acthar Patient Support to provide a complete level of support during the approval process. **If the patient would like to receive support, please have them sign the second section** to enroll in support and educational programs to receive additional information about their condition and treatment.
2. **Complete pages 1 and 2 of the Acthar Referral Form.** Check the Acthar Injection Training Services box at the bottom of page 1 to request no-cost injection training for your patient.
3. **Fax the completed Acthar Referral Form along with copies of the patient's pharmacy benefits card(s) (both front and back) to 1-877-937-2284.**
4. Acthar Patient Support will process the Acthar Referral Form and contact both you and your patient.
5. Prior authorization assistance will only be provided for indicated disease states. Medicare, Medicaid, and other federal or state program healthcare patients may be ineligible for certain other aspects of Acthar assistance programs.

PRESCRIBER SIGNATURE ON PAGE 1 AUTHORIZES PRESCRIPTION, CONSENT, AND STATEMENT OF MEDICAL NECESSITY

By signing page 1, I certify that Acthar® Gel is medically necessary for this patient and that I have reviewed this therapy with the patient and will be monitoring the patient's treatment. I verify that the patient and Prescriber information on this enrollment form was completed by me or at my direction and that the information contained herein is complete and accurate to the best of my knowledge. I understand that I must comply with my practicing state's specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to me by the dispensing pharmacy.

I authorize United BioSource LLC ("UBC"), the current operator of Acthar Patient Support, and other designated operators of the Program to perform a preliminary and on-going assessment of benefit verification for this patient and furnish information requested by the patient's insurer that is available on this form. I understand that insurance verification is ultimately the responsibility of the Prescriber and third-party reimbursement is affected by a variety of factors. While UBC tries to provide accurate information, they and Mallinckrodt make no representations or warranties as to the accuracy of the information provided.

I understand that representatives from the Program or UBC may contact me or my patient for additional information relating to this prescription. I acknowledge and agree that this prescription may be sent to and received by the designated Specialty Pharmacy by any means under applicable law, including via a designated third party or other operator of the Program, and that no additional confirmation of receipt of prescription is required by the designated Specialty Pharmacy.

Prescriber authorizes UBC to use the Surescripts network on Prescriber's behalf in connection with this enrollment form. Prescriber will comply with all Surescripts terms and conditions including confidentiality, commercial messaging, privacy and security, applicable laws, and use of data. All Surescripts disclaimers apply. A full list of terms and conditions is available at www.ubc.com/surescriptsterms.

PATIENT INSTRUCTIONS:

Your Prescriber will submit the completed Acthar Referral Form to Acthar Patient Support. After we receive the form, we will call you so we can help you get your medicine. Please be on the lookout and answer calls from 1-800, 1-888, or blocked numbers. If you have any questions, please call **1-888-435-2284** Monday through Friday from 8 AM to 9 PM ET or Saturday from 9 AM to 2 PM ET.

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Front Cover

Prescription Referral Form questions? Contact your Immunology Sales Specialist

Or call **1-888-435-2284** to speak with your Case Manager.
Monday through Friday, 8 AM to 9 PM ET and Saturday, 9 AM to 2 PM ET

SELECT IMPORTANT SAFETY INFORMATION

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-adrenal (HPA) axis 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 axis suppression after stopping treatment
- Cushing's syndrome may occur during therapy but generally resolves after therapy is stopped. Monitor patients for signs and symptoms

Please see additional Important Safety Information throughout and full Prescribing Information.

The prescription

1. Patient information

- **Fill out patient information,** noting the days and times patient is likely to be available for a phone call from Acthar Patient Support. An alternative contact name should be added in case patient cannot be reached.

2. Insurance information

- **Complete insurance information.** Include copies of front and back of all medical and prescription insurance cards.

3. Prescriber information

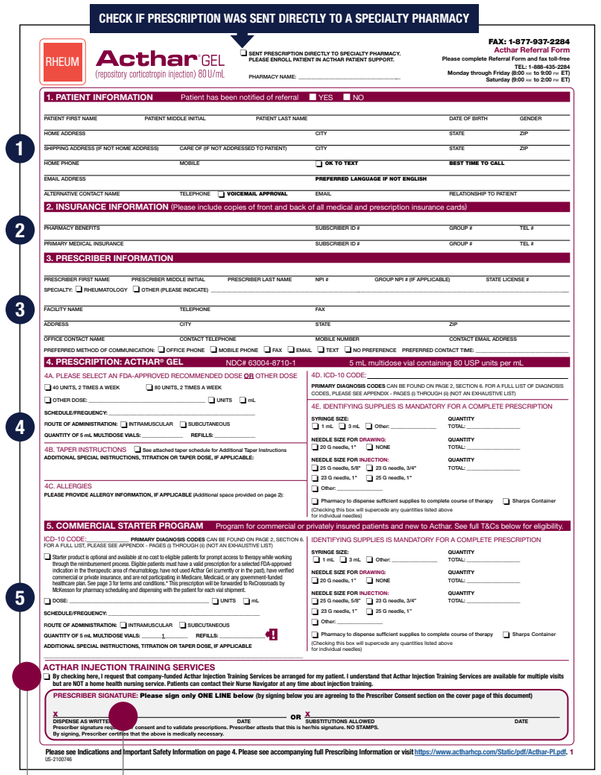
- **Fill in Prescriber information,** including preferred method of contact and most convenient times.

4. Prescription: Acthar Gel

- **Fill in important/critical prescription details**
- If applicable, include ICD-10 code from page 2, section 6. Additional codes may be pulled from the Appendix page(s), if applicable.
- **Dosing, frequency, route of administration, quantity, refills, and supply order are required fields.** Include taper instructions and/or allergies, if applicable.

5. Commercial starter program (for patients who qualify)

- Fill in important/critical prescription details for patients who are new to Acthar. If applicable, include ICD-10 code from page 2, section 6. Additional codes may be pulled from the Appendix page(s), if applicable.
- **Dosing, frequency, route of administration, refills, and supply order are required fields.** Include taper instructions, if applicable.



CHECK IF PRESCRIPTION WAS SENT DIRECTLY TO A SPECIALTY PHARMACY

RHEUM Acthar® GEL (repository corticotropin injection) 80 U/mL

❑ SENT PRESCRIPTION DIRECTLY TO SPECIALTY PHARMACY. PLEASE ENROLL PATIENT IN ACTHAR PATIENT SUPPORT.
PHARMACY NAME: _____

FAX: 1-877-937-2284
Acthar Referral Form
Please complete Referral Form and fax toll-free
TEL: 1-888-435-2284
Monday through Friday (8:00 AM to 9:00 PM ET)
Saturday (9:00 AM to 2:00 PM ET)

1. PATIENT INFORMATION Patient has been notified of referral ❑ YES ❑ NO

PATIENT FIRST NAME | PATIENT MIDDLE INITIAL | PATIENT LAST 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
EMAIL ADDRESS | PREFERRED LANGUAGE IF NOT ENGLISH
ALTERNATIVE CONTACT NAME | TELEPHONE | ❑ VOICEMAIL APPROVAL | EMAIL | RELATIONSHIP TO PATIENT

2. INSURANCE INFORMATION (Please include copies of front and back of all medical and prescription insurance cards)

PHARMACY BENEFITS | SUBSCRIBER ID # | GROUP # | TEL #
PRIMARY MEDICAL INSURANCE | SUBSCRIBER ID # | GROUP # | TEL #

3. PRESCRIBER INFORMATION

PRESCRIBER FIRST NAME | PRESCRIBER MIDDLE INITIAL | PRESCRIBER LAST NAME | NPI # | GROUP NPI # (IF APPLICABLE) | STATE LICENSE #
SPECIALTY: ❑ RHEUMATOLOGY ❑ OTHER (PLEASE INDICATE) _____
FACILITY NAME | TELEPHONE | FAX
ADDRESS | CITY | STATE | ZIP
OFFICE CONTACT NAME | CONTACT TELEPHONE | MOBILE NUMBER | CONTACT EMAIL ADDRESS
PREFERRED METHOD OF COMMUNICATION: ❑ OFFICE PHONE ❑ MOBILE PHONE ❑ FAX ❑ EMAIL ❑ TEXT ❑ NO PREFERENCE PREFERRED CONTACT TIME:

4. PRESCRIPTION: ACTHAR® GEL NDC# 63004-8710-1 5 mL multidose vial containing 80 USP units per mL

4A. PLEASE SELECT AN FDA-APPROVED RECOMMENDED DOSE OR OTHER DOSE
❑ 40 UNITS, 2 TIMES A WEEK ❑ 80 UNITS, 2 TIMES A WEEK
❑ OTHER DOSE: _____ ❑ UNITS ❑ mL
SCHEDULE/FREQUENCY: _____
ROUTE OF ADMINISTRATION: ❑ INTRAMUSCULAR ❑ SUBCUTANEOUS
QUANTITY OF 5 mL MULTIDOSE VIALS: _____ REFILLS: _____
4B. TAPER INSTRUCTIONS ❑ See attached taper schedule for Additional Taper Instructions
ADDITIONAL SPECIAL INSTRUCTIONS, TITRATION OR TAPER DOSE, IF APPLICABLE:
4C. ALLERGIES
PLEASE PROVIDE ALLERGY INFORMATION, IF APPLICABLE (Additional space provided on page 2):

4D. ICD-10 CODE: _____
PRIMARY DIAGNOSIS CODES CAN BE FOUND ON PAGE 2, SECTION 6. FOR A FULL LIST OF DIAGNOSIS CODES, PLEASE SEE APPENDIX - PAGES (I THROUGH (II (NOT AN EXHAUSTIVE LIST)
4E. IDENTIFYING SUPPLIES IS MANDATORY FOR A COMPLETE PRESCRIPTION
SYRINGE SIZE: ❑ 1 mL ❑ 3 mL ❑ Other: _____ QUANTITY TOTAL: _____
NEEDLE SIZE FOR DRAWING: ❑ 20 G needle, 1" ❑ NONE QUANTITY TOTAL: _____
NEEDLE SIZE FOR INJECTION: ❑ 25 G needle, 5/8" ❑ 23 G needle, 3/4" ❑ 23 G needle, 1" ❑ 25 G needle, 1" ❑ Other: _____ QUANTITY TOTAL: _____
❑ Pharmacy to dispense sufficient supplies to complete course of therapy ❑ Sharps Container
(Checking this box will supercede any quantities listed above for individual needles)

5. COMMERCIAL STARTER PROGRAM Program for commercial or privately insured patients and new to Acthar. See full T&Cs below for eligibility.

ICD-10 CODE: _____ PRIMARY DIAGNOSIS CODES CAN BE FOUND ON PAGE 2, SECTION 6. FOR A FULL LIST, PLEASE SEE APPENDIX - PAGES (I THROUGH (II (NOT AN EXHAUSTIVE LIST)
❑ Starter product is optional and available at no cost to eligible patients for prompt access to therapy while working through the reimbursement process. Eligible patients must have a valid prescription for a selected FDA-approved indication in the therapeutic area of rheumatology, have not used Acthar Gel (currently or in the past), have verified commercial or private insurance, and are not participating in Medicare, Medicaid, or any government-funded healthcare plan. See page 3 for terms and conditions.* This prescription will be forwarded to ReCreamsado by McKesson for pharmacy scheduling and dispensing with the patient for each vial shipment.
DOSE: _____ ❑ UNITS ❑ mL
SCHEDULE/FREQUENCY: _____
ROUTE OF ADMINISTRATION: ❑ INTRAMUSCULAR ❑ SUBCUTANEOUS
QUANTITY OF 5 mL MULTIDOSE VIALS: 1 REFILLS: 1
ADDITIONAL SPECIAL INSTRUCTIONS, TITRATION OR TAPER DOSE, IF APPLICABLE
IDENTIFYING SUPPLIES IS MANDATORY FOR A COMPLETE PRESCRIPTION
SYRINGE SIZE: ❑ 1 mL ❑ 3 mL ❑ Other: _____ QUANTITY TOTAL: _____
NEEDLE SIZE FOR DRAWING: ❑ 20 G needle, 1" ❑ NONE QUANTITY TOTAL: _____
NEEDLE SIZE FOR INJECTION: ❑ 25 G needle, 5/8" ❑ 23 G needle, 3/4" ❑ 23 G needle, 1" ❑ 25 G needle, 1" ❑ Other: _____ QUANTITY TOTAL: _____
❑ Pharmacy to dispense sufficient supplies to complete course of therapy ❑ Sharps Container
(Checking this box will supercede any quantities listed above for individual needles)

ACTHAR INJECTION TRAINING SERVICES
❑ By checking here, I request that company-funded Acthar Injection Training Services be arranged for my patient. I understand that Acthar Injection Training Services are available for multiple visits but are NOT a home health nursing service. Patients can contact their Nurse Navigator at any time about injection training.

PRESCRIBER SIGNATURE: Please sign only ONE LINE below (by signing below you are agreeing to the Prescriber Consent section on the cover page of this document)
X _____ DATE _____ OR X _____ DATE _____
DISPENSE AS WRITTEN | SUBSTITUTIONS ALLOWED
Prescriber signature required on page 1 for consent and to validate prescriptions. Prescriber attests that this is her/his signature. NO STAMPS.
By signing, Prescriber certifies that the above is medically necessary.

Please see Indications and Important Safety Information on page 4. Please see accompanying full Prescribing Information or visit https://www.actharhcp.com/Static/pdf/Acthar-PI.pdf. 1
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Page 1

Prescriber signature
- **Sign and date to initiate the Rx.** By signing, you are agreeing to the Prescriber Consent section on the cover page of this document.

Acthar injection training services
- Check box to request Acthar Injection Training Services for your patient.

Acthar® GEL (repository corticotropin injection) 80 U/mL
Patient Support

Completing the Acthar® Combo Referral Form (cont'd)

Diagnosis and medical information for use with payers

Note: The RHEUM Acthar Combo Referral Form is being used as the example; the Acthar Combo Referral Form for your specific therapeutic area may differ.

6. Diagnosis and medical information

- **This is a list of common ICD-10 codes. If applicable, a full list may be pulled from the Appendix page(s); however, the Appendix pages do not need to be faxed to Acthar Patient Support. If you are using an ICD-10 code that does not appear here but rather from the Appendix page(s), write the code under "OTHER DIAGNOSIS" in this section 6.**

How Acthar is prescribed for use

- If diagnosis is psoriatic arthritis, rheumatoid arthritis, including juvenile rheumatoid arthritis, or ankylosing spondylitis, please indicate how Acthar is being used.

Organ involvement

- Please select the organ(s) involved.

7. History of corticosteroid use

- If applicable, please check all boxes that apply. Details should be added in section 9 below.

8. Concurrent medications

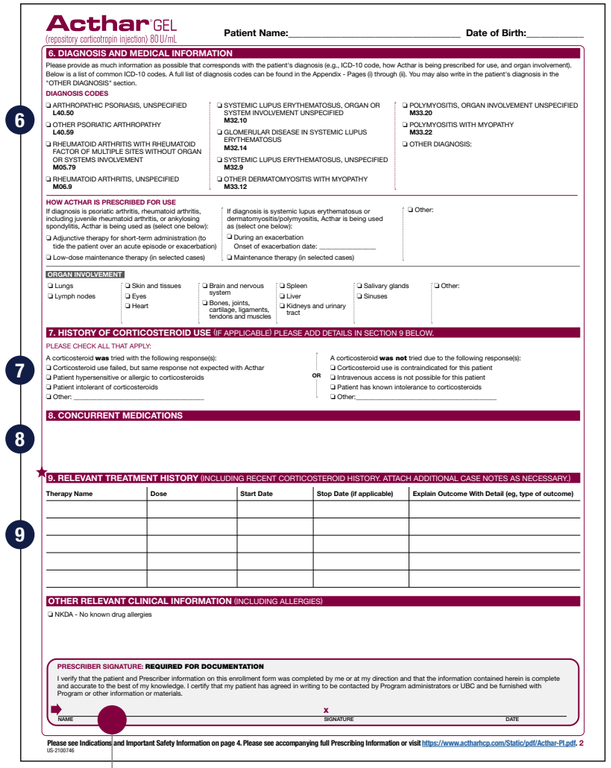
- Include all concurrent medications used to treat the condition for which Acthar is being prescribed.

9. Relevant treatment history

- Include all past treatments (including recent steroid history) used to treat the condition for which Acthar is being prescribed.
- Note dose, duration, dates used, and outcome of therapy.
- If therapy failed or patient discontinued, record reason why.

Other relevant clinical information

- Include other relevant clinical information (including allergies); if no known drug allergies, please check the "NKDA" box.



Acthar GEL (repository corticotropin injection) 80 U/mL

Patient Name:_____ Date of Birth:_____

6. DIAGNOSIS AND MEDICAL INFORMATION

Please provide as much information as possible that corresponds with the patient's diagnosis (e.g., ICD-10 code, how Acthar is being prescribed for use, and organ involvement). Below is a list of common ICD-10 codes. A full list of diagnosis codes can be found in the Appendix - Pages (i) through (ii). You may also write in the patient's diagnosis in the "OTHER DIAGNOSIS" section.

DIAGNOSIS CODES

- ❑ ARTHROPATHIC PSORIASIS, UNSPECIFIED **L40.50**
- ❑ OTHER PSORIATIC ARTHROPATHY **L40.59**
- ❑ RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF MULTIPLE SITES WITHOUT ORGAN OR SYSTEMS INVOLVEMENT **M05.79**
- ❑ RHEUMATOID ARTHRITIS, UNSPECIFIED **M06.9**
- ❑ SYSTEMIC LUPUS ERYTHEMATOSUS, ORGAN OR SYSTEM INVOLVEMENT UNSPECIFIED **M32.10**
- ❑ GLOMERULAR DISEASE IN SYSTEMIC LUPUS ERYTHEMATOSUS **M32.14**
- ❑ SYSTEMIC LUPUS ERYTHEMATOSUS, UNSPECIFIED **M32.9**
- ❑ OTHER DERMATOMYOSITIS WITH MYOPATHY **M33.12**
- ❑ POLYMYOSITIS, ORGAN INVOLVEMENT UNSPECIFIED **M33.20**
- ❑ POLYMYOSITIS WITH MYOPATHY **M33.22**
- ❑ OTHER DIAGNOSIS:

HOW ACTHAR IS PRESCRIBED FOR USE

If diagnosis is psoriatic arthritis, rheumatoid arthritis, including juvenile rheumatoid arthritis, or ankylosing spondylitis, Acthar is being used as (select one below):
- ❑ Adjunctive therapy for short-term administration (to hide the patient over an acute episode or exacerbation)
- ❑ Low-dose maintenance therapy (in selected cases)

If diagnosis is systemic lupus erythematosus or dermatomyositis/polymyositis, Acthar is being used as (select one below):
- ❑ During an exacerbation
  Onset of exacerbation date: _____
- ❑ Maintenance therapy (in selected cases)

- ❑ Other:

ORGAN INVOLVEMENT

- ❑ Lungs
- ❑ Lymph nodes
- ❑ Skin and tissues
- ❑ Eyes
- ❑ Heart
- ❑ Brain and nervous system
- ❑ Bones, joints, cartilage, ligaments, tendons and muscles
- ❑ Spleen
- ❑ Liver
- ❑ Kidneys and urinary tract
- ❑ Salivary glands
- ❑ Sinuses
- ❑ Other:

7. HISTORY OF CORTICOSTEROID USE (IF APPLICABLE) PLEASE ADD DETAILS IN SECTION 9 BELOW.

PLEASE CHECK ALL THAT APPLY.

A corticosteroid **was** tried with the following response(s):
- ❑ Corticosteroid use failed, but same response not expected with Acthar
- ❑ Patient hypersensitive or allergic to corticosteroids
- ❑ Patient intolerant of corticosteroids
- ❑ Other:_____

OR

A corticosteroid **was not** tried due to the following response(s):
- ❑ Corticosteroid use is contraindicated for this patient
- ❑ Intravenous access is not possible for this patient
- ❑ Patient has known intolerance to corticosteroids
- ❑ Other:_____

8. CONCURRENT MEDICATIONS

★ **9. RELEVANT TREATMENT HISTORY** (INCLUDING RECENT CORTICOSTEROID HISTORY. ATTACH ADDITIONAL CASE NOTES AS NECESSARY.)

Therapy Name	Dose	Start Date	Stop Date (if applicable)	Explain Outcome With Detail (eg, type of outcome)

OTHER RELEVANT CLINICAL INFORMATION (INCLUDING ALLERGIES)

❑ NKDA - No known drug allergies

PRESCRIBER SIGNATURE: **REQUIRED FOR DOCUMENTATION**

I verify that the patient and Prescriber information on this enrollment form was completed by me or at my direction and that the information contained herein is complete and accurate to the best of my knowledge. I certify that my patient has agreed in writing to be contacted by Program administrators or UBC and be furnished with Program or other information or materials.

➡ x
NAME SIGNATURE DATE

Please see Indications and Important Safety Information on page 4. Please see accompanying full Prescribing Information or visit https://www.actharhcp.com/Static/pdf/Acthar-PI.pdf. 2

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Page 2

Prescriber signature

- **Sign and date.** This is for clinical documentation purposes.

If you would prefer filling out forms online to print and fax, visit Actharhcp.com or Actharconsent.com to provide consent.

Case Manager: _____

Phone Number: _____

Email Address: _____

Patient authorizations

10. Patient authorizations

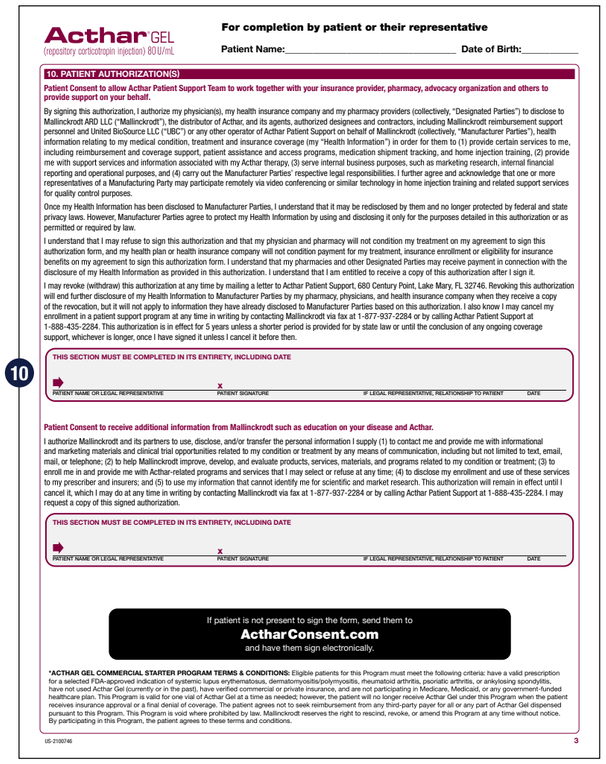
Your patient's signature:

- Allows them to take advantage of enhanced Access and Reimbursement Manager support.
- Allows the Specialty Pharmacy to share information about your patient's case back to the Acthar Patient Support Team.

EDUCATION AND SUPPORT AUTHORIZATION

- By having your patient sign, it allows the Acthar Patient Support Team to automatically enroll your patient into patient support and educational programs, including but not limited to receiving additional information about their condition and/or treatment.
- It also allows them to take part in surveys that can help shape the programs that are available to Acthar patients.

If the patient is not present in the office to sign, email them the Actharconsent.com URL, and they can sign electronically.



Acthar GEL (repository corticotropin injection) 80 U/mL

For completion by patient or their representative

Patient Name:_____ Date of Birth:_____

10. PATIENT AUTHORIZATION(S)

Patient Consent to allow Acthar Patient Support Team to work together with your insurance provider, pharmacy, advocacy organization and others to provide support on your behalf.

By signing this authorization, I authorize my physician(s), my health insurance company and my pharmacy providers (collectively, "Designated Parties") to disclose to Mallinckrodt ARD LLC ("Mallinckrodt"), the distributor of Acthar, and its agents, authorized designees and contractors, including Mallinckrodt reimbursement support personnel and United BioSource LLC ("UBC") or any other operator of Acthar Patient Support on behalf of Mallinckrodt (collectively, "Manufacturer 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) serve internal business purposes, such as marketing research, internal financial reporting and operational purposes, and (4) carry out the Manufacturer Parties' respective legal responsibilities. I further agree and acknowledge that one or more representatives of a Manufacturing Party may participate remotely via video conferencing or similar technology in home injection training and related support services for quality control purposes.

Once my Health Information has been disclosed to Manufacturer Parties, I understand that it may be redisclosed by them and no longer protected by federal and state privacy laws. However, Manufacturer 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 Patient Support, 680 Century Point, Lake Mary, FL 32746. Revoking this authorization will end further disclosure of my Health Information to Manufacturer 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 Manufacturer 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 1-877-937-2284 or by calling Acthar Patient Support at 1-888-435-2284. This authorization is in effect for 5 years unless a shorter period is provided for by state law or until the conclusion of any ongoing coverage support, whichever is longer, once I have signed it unless I cancel it before then.

10 THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY, INCLUDING DATE

➡ x
PATIENT NAME OR LEGAL REPRESENTATIVE PATIENT SIGNATURE IF LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT DATE

Patient Consent to receive additional information from Mallinckrodt such as education on your disease and Acthar.

I authorize Mallinckrodt and its partners to use, disclose, and/or transfer the personal information I supply (1) to contact me and provide me with informational and marketing materials and clinical trial opportunities related to my condition or treatment by any means of communication, including but not limited to text, email, mail, or telephone; (2) to help Mallinckrodt improve, develop, and evaluate products, services, materials, and programs related to my condition or treatment; (3) to enroll me in and provide me with Acthar-related programs and services that I may select or refuse at any time; (4) to disclose my enrollment and use of these services to my prescriber and insurers; and (5) to use my information that cannot identify me for scientific and market research. This authorization will remain in effect until I cancel it, which I may do at any time in writing by contacting Mallinckrodt via fax at 1-877-937-2284 or by calling Acthar Patient Support at 1-888-435-2284. I may request a copy of this signed authorization.

THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY, INCLUDING DATE

➡ x
PATIENT NAME OR LEGAL REPRESENTATIVE PATIENT SIGNATURE IF LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT DATE

If patient is not present to sign the form, send them to
ActharConsent.com
and have them sign electronically.

*ACTHAR GEL COMMERCIAL STARTER PROGRAM TERMS & CONDITIONS: Eligible patients for this Program must meet the following criteria: have a valid prescription for a selected FDA-approved indication of systemic lupus erythematosus, dermatomyositis/polymyositis, rheumatoid arthritis, psoriatic arthritis, or ankylosing spondylitis, have not used Acthar Gel (currently or in the past), have verified commercial or private insurance, and are not participating in Medicare, Medicaid, or any government-funded healthcare plan. This Program is valid for one vial of Acthar Gel at a time as needed; however, the patient will no longer receive Acthar Gel under this Program when the patient receives insurance approval or a final denial of coverage. The patient agrees not to seek reimbursement from any third-party payer for all or any part of Acthar Gel dispensed pursuant to this Program. This Program is void where prohibited by law. Mallinckrodt reserves the right to rescind, revoke, or amend this Program at any time without notice. By participating in this Program, the patient agrees to these terms and conditions.

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Page 3

Fax completed forms
1-877-937-2284

Be prepared for follow-up.

Your dedicated Case Manager at Acthar Patient Support will contact both your office and your patient.

CALL 1-888-435-2284 IF YOU HAVE ANY QUESTIONS.

SELECT IMPORTANT SAFETY INFORMATION

Warnings and Precautions (continued)

- Acthar can cause elevation of blood pressure, salt and water retention, and hypokalemia. Monitor blood pressure and sodium and potassium levels
- 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 gastrointestinal (GI) bleeding and gastric ulcer. There is also an increased risk for perforation in patients with certain GI disorders. Monitor for signs of perforation and bleeding
- Acthar may be associated with central nervous system effects ranging from euphoria, insomnia, irritability, mood swings, personality changes, and severe depression to psychosis. Existing conditions may be aggravated

Acthar® GEL
(repository corticotropin injection) 80 U/mL
Patient Support

Please see additional Important Safety Information throughout and full Prescribing Information.

Dosing Information

Acthar® Gel offers flexible dosing, with a recommended 40-80 units every 1-3 days across multiple indications. In MS, flexible dosing is also available, with a recommended 80-120 units daily for 2-3 weeks.

Recommended dosing from the label[1]

For RA, SLE, DM/PM, PsA, symptomatic sarcoidosis, nephrotic syndrome, and ophthalmic diseases: 40 to 80 units (0.5 to 1 mL) given intramuscularly or subcutaneously every 1 to 3 days.*†

For MS relapse: 80 to 120 units (1 to 1.5 mL) given intramuscularly or subcutaneously daily for 2 to 3 weeks.*†

For IS: 150 units/m^2 divided into twice daily intramuscular injections of 75 units/m^2 over a 2-week period.*‡
You can download the IS Dosing Calculator from the Apple App Store or Google Play Store.

- Acthar Gel is administered as a self-injection or by a caregiver, giving patients the flexibility to take it at home or wherever is best for them
- Acthar Gel is a gel preparation designed to provide a prolonged release of medication after injection

DM/PM=dermatomyositis/polymyositis; IS=infantile spasms; MS=multiple sclerosis; PsA=psoriatic arthritis; RA=rheumatoid arthritis; SLE=systemic lupus erythematosus.

*Acthar Gel is provided as a 5-mL multidose vial containing 80 USP units per mL.

†It may be necessary to taper the dose or increase the injection interval to gradually discontinue treatment.

‡Dosing should then be gradually tapered over a 2-week period to avoid adrenal insufficiency.

Dosage and frequency should be individualized according to the medical condition, severity of the disease, and initial response of the patient[1]

Additional dosing from clinical experience with Acthar Gel

Indication	Source	Injection route	Dose*	Schedule†
RA[2]	Phase 4, two-part, multicenter, randomized withdrawal study (N=259)	Subcutaneous	80 units (1 mL)	Twice weekly for 12 to 24 weeks
DM/PM[3]	Prospective, open-label proof-of-concept study (N=10)§	Subcutaneous	80 units (1 mL)	Twice weekly for 24 weeks
Symptomatic sarcoidosis[4]	Retrospective chart review (N=47)	Subcutaneous or intramuscular	40 to 80 units (0.5 to 1 mL)	Twice weekly for ≥6 months
Nephrotic syndrome[5-11]	Multiple clinical datasets	Subcutaneous	80 units (1 mL)	Twice weekly for 6 months
Keratitis[12]	Phase 4, multicenter, open-label study (N=36)	Subcutaneous	80 units (1 mL)	Twice weekly for 12 weeks

Funding to support some of these studies was provided by Mallinckrodt Pharmaceuticals.

This chart does not include all studies available. These studies are subject to various limitations.

§**Ten of the 11 enrolled patients completed the study. One patient dropped out due to heart block unrelated to the study drug and was not included in the efficacy analysis, as she did not complete the minimum 8 weeks of the study drug required for outcome assessment per study protocol.**

SELECT IMPORTANT SAFETY INFORMATION

Warnings and Precautions (continued)

- 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. Cases of anaphylaxis have been reported in the postmarketing setting. Neutralizing antibodies with chronic administration may lead to loss of endogenous ACTH and Acthar activity
- There may be 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 in patients on long-term therapy

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Acthar® Patient Support

With Acthar Patient Support, a dedicated team of experts is ready to help.

Immunology Sales Specialists

Your Sales Specialist will be able to answer questions about completing and submitting your Referral Form.

Access and Reimbursement Managers (ARMs)

Your ARM is your key resource, providing reimbursement education and local area support throughout the referral process.

Nurse Navigators

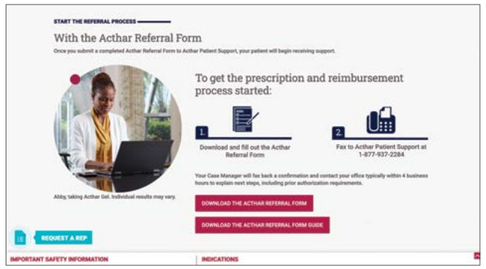
The Nurse Navigator serves as a supplemental support system for your patients. Nurse Navigators will never provide medical advice, but they can help patients understand the administration of Acthar Gel, fit Acthar Gel into their routine, and address any concerns or anxiety they may have about treatment.*

Case Managers

Your Case Manager is your patients' key access resource, helping to coordinate the reimbursement process (prior authorizations and appeals) as well as any additional services that your patient may be eligible for and would like to take advantage of. Additional services include, but are not limited to, assistance program support and injection training coordination.

*Nurse Navigators do not give medical advice and will direct patients to healthcare professionals for any treatment-related questions, including further referrals.

Acthar Referral Forms are available at **Actharhcp.com/referral-forms**



SELECT IMPORTANT SAFETY INFORMATION

Adverse Reactions

- Commonly reported postmarketing adverse reactions for Acthar include injection site reaction, asthenic conditions (including fatigue, malaise, asthenia, and lethargy), fluid retention (including peripheral swelling), insomnia, headache, and blood glucose increased
- The most common adverse reactions for the treatment of infantile spasms (IS) are increased risk of infections, convulsions, hypertension, irritability, and pyrexia. Some patients with IS progress to other forms of seizures; IS sometimes masks these seizures, which may become visible once the clinical spasms from IS resolve

Please see additional Important Safety Information throughout and full Prescribing Information.

Prior Authorizations (PAs)

When a PA for Acthar Gel is required by the health insurance company, verbal PAs or ePAs may offer a higher success rate and faster turnaround time than faxed PAs.

Work with your Access and Reimbursement Manager (ARM) and/or Case Manager (CM) to determine the preferred method to submit a PA.

Verbal PA

When available, a verbal PA offers many potential benefits, including:

- Eliminating or reducing paperwork, faxes, and callbacks
- Real-time answers to questions
- Less physician involvement needed down the road
- No scribing errors
- Most importantly, reduced process time, which may allow patients to get on therapy sooner

Electronic PA (ePA)/Faxed PA

There are a number of portals you may use to submit an electronic PA, such as CoverMyMeds.

Instructions:

- To initiate the PA process, fax the Acthar Referral Form to Acthar Patient Support, and make sure your email address is on the form
- ePAs may offer a higher success rate and faster turnaround time than faxed PAs. If an ePA is available, you will receive an email with a link to the ePA portal and a personal identification number (PIN)
- Click on the link and enter your national provider identifier (NPI) and PIN where indicated
- Once inside the portal, you will be able to electronically complete and submit the prior authorization
- If the submission is not immediately approved, expect to receive approval or denial after only 12 hours

Call **1-888-435-2284**
to speak with a Case Manager
Monday through Friday, 8 AM to 9 PM ET
Saturday, 9 AM to 2 PM ET

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Appeals Kit

When a patient's insurance provider denies coverage for Acthar® Gel, the Appeals Kit simplifies the process for you to create and submit a customized Letter of Medical Necessity (LMN).

Appeals Kits are available across all therapeutic areas and include:

Step-by-step instructions
detail how to complete the LMN template.

LMN checklist
lists critical information to include in an effective LMN.

LMN templates
provide sample language for you to customize when addressing an insurance denial.

Supporting resources
are available such as clinical trials, consensus documents, and publications to support why the Acthar Gel prescription may be medically necessary and may be included as part of the response to the health plan's denial.

Acthar Gel Prescribing Information is included as a resource.

Call **1-888-435-2284**
to request an Appeals Kit from your
Case Manager or contact your local ARM

Patient Resources

If an appeal is denied, there are resources available to help patients and their caregivers raise their voices, team up with their doctor, and write an appeals letter.

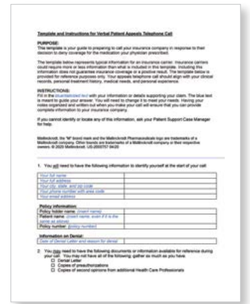
All are available to download at Acthar.com/resources

Spanish resources can also be found on the website.

Patient Bill of Rights

Patient Appeal Discussion Guide

Appeals Letter Template

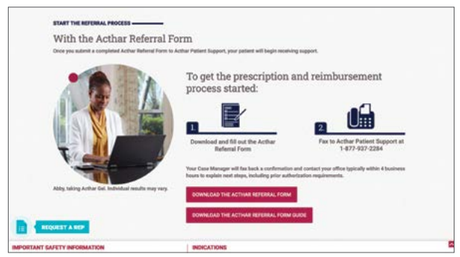


Patient Appeals Verbal Template

Nurse Navigator Leave Behind

Acthar Gel Patient Brochure

Additional resources are available to help patients start and continue treatment with Acthar Gel. Contact your Case Manager or ARM to order copies for your practice.



Acthar Patient Support at Actharhcp.com/support

From prescription to delivery, Acthar Patient Support is with you and your patients every step of the way.

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Please see Important Safety Information throughout and full Prescribing Information.

Assistance Options

Acthar Patient Support works closely with your office throughout the insurance approval process, keeping patients informed along the way. If assistance is needed, the following options may be available:

Your patients may be eligible for our $0 co-pay offer*

If your patients have commercial or private insurance, they may be able to enroll in the **Acthar Gel Commercial Co-pay Program** and pay as little as $0 for their Acthar Gel prescription. The program provides the following:

- **As little as $0 co-pay for eligible patients, up to $15,000 per calendar year** (see Terms and Conditions below)
- Convenient online enrollment via the new co-pay website

Your patients can enroll themselves in the Acthar Gel Commercial Co-pay Program at Acthar.com/copay

Uninsured/underinsured support

If patients are uninsured or underinsured, they may be able to receive assistance options through the **Acthar Patient Assistance Program**:

- Mallinckrodt provides Acthar Gel at no cost to eligible patients with a valid, on-label prescription for Acthar Gel who have no insurance, are underinsured, or are rendered uninsured
- Their Case Manager will transfer them to the Acthar Patient Assistance Program to determine eligibility
- This program is administered via a third-party organization

Acthar Patient Assistance Program eligibility criteria:

- Valid Acthar Gel prescription for an FDA-approved indication
- Permanent US resident
- Household income at or below 700% of the Federal Poverty Level
- Patients may be subject to random income verification to determine eligibility

Acthar Gel Commercial Co-pay Program Terms and Conditions:

*Terms and Conditions apply. This benefit covers Acthar® Gel (repository corticotropin injection). The program provides up to $15,000 per calendar year toward the patient's Acthar Gel prescription costs. Eligibility: Available to patients with commercial prescription insurance coverage for Acthar Gel. Co-pay assistance program is not available to patients receiving any form of prescription coverage under any federal, state, or government-funded insurance program or where prohibited by law. Such programs include Medicare (including Medicare Part D and Medicare Advantage), Medigap, Medicaid, TRICARE, Department of Defense, or Veterans Affairs programs. If at any time a patient begins receiving prescription drug coverage under any such federal, state, or government-funded healthcare program, patient will no longer be able to use the Acthar Gel Copay Card and patient must call Acthar Patient Support at 1-888-435-2284 to stop participation. The value of this program is exclusively for the benefit of patients and is intended to be credited towards patient out-of-pocket obligations and maximums, including applicable co-payments, coinsurance, and deductibles. Patients are responsible for any out-of-pocket costs above and beyond the program's annual maximum benefit. The offer does not constitute prescription drug coverage and is not intended to substitute health insurance. Patients who are members of insurance plans that adjust their patients' out of pocket co-pay or co-insurance responsibilities for certain prescription drugs based upon the patient's enrollment in manufacturer sponsored co-pay assistance for such drugs (often termed "accumulator" or "maximizer" programs) may be restricted from the Acthar Gel Copay Card program. Patients may not seek reimbursement for value received from the Acthar Gel Copay program from any third-party payers. Restrictions, including monthly maximums, may apply. Other Terms and Conditions apply. Offer subject to change or discontinuance without notice.

SELECT IMPORTANT SAFETY INFORMATION

Pregnancy

- Acthar may cause fetal harm when administered to a pregnant woman

Please see additional Important Safety Information throughout and full Prescribing Information.

Acthar® Gel Commercial Starter Program

For eligible patients† who are awaiting insurance approval for Acthar Gel, jump-start their treatment on Acthar for free while they await the outcome of their reimbursement process.

See if your patients are eligible for this program

To be eligible for the commercial starter program, patients must have:

1. A valid prescription for an on-label indication
2. **Not** used Acthar Gel any time in the past 36 months
3. Commercial or private insurance

Help your appropriate patients get Acthar Gel

Patients who have commercial or private insurance can get Acthar Gel promptly. McKesson Specialty Pharmacy will arrange delivery of Acthar Gel directly with the approved patient, 1 vial at a time, as long as it is prescribed to them or until their reimbursement process is completed.

Continue your patient's treatment when the reimbursement process is completed

- If coverage is approved, the patient will receive Acthar Gel vials through their own Specialty Pharmacy with coverage by their insurance provider
- If coverage is denied, the patient will then be screened for eligibility to the Acthar Patient Assistance Program
- When the reimbursement process is completed, the patient will no longer receive Acthar Gel vials under this program

See full program Terms and Conditions below.

Complete the Acthar Gel Commercial Starter Program enrollment in section 5 of the Referral Form and make sure you have appropriate signatures before submitting the form to the Acthar Patient Services HUB.

†Acthar Gel Commercial Starter Program Terms and Conditions:

Eligible patients for this Program must meet the following criteria: have a valid prescription for selected on-label indication in the therapeutic area of rheumatology, pulmonology, ophthalmology, or nephrology, have not used Acthar Gel (currently or in the past 36 months), have verified commercial or private insurance, and are not participating in Medicare, Medicaid, or any government-funded healthcare plan. This Program is valid for one vial of Acthar Gel at a time as needed; however, the patient will no longer receive Acthar Gel under this Program when the patient receives insurance approval or a final denial of coverage. The patient agrees not to seek reimbursement from any third-party payer for all or any part of Acthar Gel dispensed pursuant to this Program. This Program is void where prohibited by law. Mallinckrodt reserves the right to rescind, revoke, or amend this Program at any time without notice. By participating in this Program, the patient agrees to these terms and conditions.

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IMPORTANT SAFETY INFORMATION

Contraindications

Acthar is contraindicated:

- For intravenous administration
- In infants under 2 years of age who have suspected congenital infections
- With concomitant administration of live or live attenuated vaccines in patients receiving immunosuppressive doses of Acthar
- 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 origin

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-adrenal (HPA) axis 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 axis 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. Monitor blood pressure and sodium and potassium levels
- 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 gastrointestinal (GI) bleeding and gastric ulcer. There is also an increased risk for perforation in patients with certain GI disorders. Monitor for signs of perforation and bleeding
- Acthar may be associated with central nervous system effects ranging from euphoria, insomnia, irritability, mood swings, personality changes, and severe depression to 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. Cases of anaphylaxis have been reported in the postmarketing setting. Neutralizing antibodies with chronic administration may lead to loss of endogenous ACTH and Acthar activity
- There may be 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 in patients on long-term therapy

Adverse Reactions

- Commonly reported postmarketing adverse reactions for Acthar include injection site reaction, asthenic conditions (including fatigue, malaise, asthenia, and lethargy), fluid retention (including peripheral swelling), insomnia, headache, and blood glucose increased
- The most common adverse reactions for the treatment of infantile spasms (IS) are increased risk of infections, convulsions, hypertension, irritability, and pyrexia. Some patients with IS progress to other forms of seizures; IS sometimes masks these seizures, which may become visible once the clinical spasms from IS resolve

Pregnancy

- Acthar may cause fetal harm when administered to a pregnant woman

Please see full Prescribing Information for additional Important Safety Information.

References: 1. Acthar Gel (repository corticotropin injection) [prescribing information]. Bedminster, NJ: Mallinckrodt ARD LLC. **2.** Fleischmann R, Furst DE, Connolly-Strong E, Liu J, Zhu J, Brasington R. Repository corticotropin injection for active rheumatoid arthritis despite aggressive treatment: a randomized controlled withdrawal trial. *Rheumatol Ther*. 2020;7(2):327-344. **3.** Aggarwal R, Marder G, Koontz DC, Nandkumar P, Qi Z, Oddis CV. Efficacy and safety of adrenocorticotropic hormone gel in refractory dermatomyositis and polymyositis. *Ann Rheum Dis*. 2018;77(5):720-727. **4.** Baughman RP, Barney JB, O'Hare L, Lower EE. A retrospective pilot study examining the use of Acthar gel in sarcoidosis patients. *Respir Med*. 2016;110:66-72. **5.** Hladunewich MA, Cattran D, Beck LH, et al. A pilot study to determine the dose and effectiveness of adrenocorticotrophic hormone (Acthar® Gel) in nephrotic syndrome due to idiopathic membranous nephropathy. *Nephrol Dial Transplant*. 2014;29(8):1570-1577. **6.** Bomback AS, Canetta PA, Beck LH Jr, Ayalon R, Radhakrishnan J, Appel GB. Treatment of resistant glomerular diseases with adrenocorticotropic hormone gel: a prospective trial. *Am J Nephrol*. 2012;36(1):58-67. **7.** Madan A, Mijovic-Das S, Stankovic A, Teehan G, Milward AS, Khastgir A. Acthar gel in the treatment of nephrotic syndrome: a multicenter retrospective case series. *BMC Nephrol*. 2016;17:37. **8.** Tumlin J, Galphin C, Santos R, Rovin B. *Kidney Int Rep*. 2017;2(5):924-932. **9.** Bomback AS, Tumlin JA, Baranski J, et al. Treatment of nephrotic syndrome with adrenocorticotropic hormone (ACTH) gel. *Drug Des Devel Ther*. 2011;5:147-153. **10.** Filippone EJ, Dopson SJ, Rivers DM, et al. Adrenocorticotropic hormone analog use for podocytopathies. *Int Med Case Rep J*. 2016;9:125-133. **11.** Hogan J, Bomback AS, Mehta K, et al. Treatment of idiopathic FSGS with adrenocorticotropic hormone gel. *Clin J Am Soc Nephrol*. 2013;8(12):2072-2081. **12.** Wirta D, McLaurin E, Ousler G, Liu J, Kacmaz RO, Grieco J. Repository corticotropin injection (Acthar® Gel) for refractory severe noninfectious keratitis: efficacy and safety from a phase 4, multicenter, open-label study. *Ophthalmol Ther*. 2021;10(4):1077-1092.

Questions?

Acthar Patient Support has answers!

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ACTHAR® PATIENT SUPPORT FOR YOUR PATIENTS AND PRACTICE STARTS HERE

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