VIATRIS ADVOCATE®

Patient Enrollment Form

Phone: 844.695.2667 • **Fax:** 844.292.8395

Glatiramer Acetate Injection®

PATIENT INFORMATION (Please print)

Name (First, MI, Last, Suffix): _____

Date of Birth: _____ Gender: M ☐ F ☐

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Allergies: _____ Other Medications: _____

Additional opt-in services available:

- ☐ I would like to receive text message injection reminders and I have read and agree to the section below titled "Contact by telephone or text."
- ☐ I would like to receive periodic phone calls from a VIATRIS ADVOCATE® nurse to provide additional therapy support and help answer any therapy-related questions.
- ☐ I would like to receive marketing emails per the attached **Patient Marketing Consent Section C.**

PRESCRIBER INFORMATION

Physician: _____

NP/PA (if prescriber): _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Office Contact: _____ Email: _____

PRESCRIBER SIGNATURE REQUIRED FOR PRESCRIPTION ORDERS:

Statement of Medical Necessity: Primary Diagnosis ICD-10 CM G35 Treatment of Relapsing Forms of Multiple Sclerosis. I authorize VIATRIS ADVOCATE to provide any information on this form to the insurer of the named patient and to forward the above prescription, by fax or by other mode of delivery, to the pharmacy.

Prescriber's Signature:

_____ _____

(Dispense as Written) *(Brand Exchange Permissible)*

_____ _____

(NPI#) *(Date)*

INSURANCE INFORMATION

(Attach a copy of patient's insurance card, front & back)

Insurance information not necessary if Prescriber is ordering device and/or injection training only.

Primary Insurance Name: _____

Medicare: A ☐ B ☐ D ☐ (attach a copy of red, white and blue Medicare card)

Beneficiary/Cardholder Name: _____

Primary Insurance ID#: _____ Group#: _____

Primary Insurance Phone#: _____

Does the patient have a pharmacy benefit card? Yes ☐ No ☐

By signing below, I have read and agree to the attached **Patient Authorization Section A. (Signature required if Prescriber is ordering VIATRIS™ Glatiramer Acetate Injection)**

X _____

Patient/Legal Guardian Signature ***Date (MM/DD/YYYY)***

PRESCRIPTION INFORMATION

(Check the box for prescriptions/orders required: Product, Device and/or Injection Training)

☐ Viatris' Glatiramer Acetate Injection 20 mg/mL pre-filled syringes

- Inject 20 mg SQ once a day
- Dispense: 1 box of 30 syringes (30-day supply)
- May dispense up to a 90-day supply
- Refills: x 1 year

☐ Viatris' Glatiramer Acetate Injection 40 mg/mL pre-filled syringes

- Inject 40 mg SQ 3 times a week
- Dispense: 1 box of 12 syringes (28-day supply)
- May dispense up to a 84-day supply
- Refills: x 1 year

☐ *Whisper*JECT® Autoinjector* device (free of charge)†

- Use as directed
- Dispense: 1 device with instructions for use and travel case
- Refills: None

☐ VIATRIS ADVOCATE to coordinate injection training (injection training to be performed by a Registered Nurse) Please indicate strength for RN (check the box below).

- ☐ Viatris' Glatiramer Acetate Injection 20 mg/mL pre-filled syringes
- ☐ Viatris' Glatiramer Acetate Injection 40 mg/mL pre-filled syringes

Signature stamps not acceptable.
Please attach all prescriptions on Official State Prescription form if mandated by individual state laws.

Please see the next page for Indication and Important Safety Information, and please see accompanying Full Prescribing Information, Patient Information Leaflet and Instructions for Use for GLATIRAMER ACETATE INJECTION 20 mg/mL or GLATIRAMER ACETATE INJECTION 40 mg/mL.

*Whisper*JECT® Autoinjector is available by prescription only. †No party may submit an insurance claim or other claim for payment to any third-party payor (private or government) for this device or training.

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Glatiramer Acetate Injection

A. PATIENT AUTHORIZATION: I authorize my healthcare providers and health insurers to disclose to Viatris Inc. d/b/a VIATRIS ADVOCATE, its affiliates, its program administrator, and their respective agents and service providers (collectively, "VIATRIS ADVOCATE") my protected health information ("PHI"), including information about my insurance, prescriptions, medical condition and health, so that VIATRIS ADVOCATE may use the information to assist me with benefits support in connection with my treatment with Viatris products, communicate with me regarding such treatment and support, to conduct market research and inform me of treatment alternatives. I understand that once disclosed pursuant to this authorization, my PHI may no longer be protected by federal law and could be re-disclosed to others, but I also understand that VIATRIS ADVOCATE intends to safeguard my PHI and to use and disclose it only for the purposes described herein. I understand that I do not need to sign this authorization in order to receive healthcare treatment or insurance benefits, and that I may cancel the authorization at any time by sending a written notice of cancellation by mail to: VIATRIS ADVOCATE Opt-out Administrator, 1000 Mylan Blvd., Canonsburg, PA 15317, or by fax to 1.844.292.8395. If I do not cancel it, the authorization will remain in effect for five years from the date of my signature on the previous page. I understand that I have a right to receive a copy of this authorization when it is signed.

B. CONTACT BY TELEPHONE OR TEXT:

I agree to be contacted by VIATRIS ADVOCATE by mail, email, telephone calls, and text messages at the number(s) and address(es) provided on this Patient Enrollment Form for the purpose of injection reminders and any other purposes described in the preceding Patient Authorization. I confirm that I am the subscriber for the telephone number(s) provided on this Patient Enrollment Form and the authorized user for the email address(es) provided, and I agree to notify VIATRIS ADVOCATE promptly if any of my number(s) or address(es) change in the future. I understand that my wireless service provider's message and data rates may apply.

C. MARKETING CONSENT: I would also like to receive marketing information, offers, and promotions from Viatris Inc. regarding its products, programs, and services. I agree to be contacted by email at the email address provided on this form with such information as well as with inquiries about my opinions regarding such products, programs, and services.
I understand that the personal information I supply to Viatris Inc. will be shared with and among its business partners to provide me with information on
Viatris-specific products, programs and services. I may cancel my participation at any time by calling 1.844.695.2667 or by following the opt-out instructions contained within the emails themselves.

INDICATION: GLATIRAMER ACETATE INJECTION is a prescription medicine used for the treatment of people with relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

IMPORTANT SAFETY INFORMATION: Do not take GLATIRAMER ACETATE INJECTION if you are allergic to glatiramer acetate or mannitol. Serious side effects may happen right after or within minutes after you inject glatiramer acetate injection at any time during your course of treatment. Call your doctor right away if you have any of these immediate post-injection reaction symptoms including: redness to your cheeks or other parts of the body (flushing); chest pain; fast heart beat; anxiety; breathing problems or tightness in your throat; or swelling, rash, hives, or itching. If you have symptoms of an immediate post-injection reaction, do not give yourself more injections until a doctor tells you to.

Chest pain may occur either as part of the immediate post-injection reaction or on its own. This pain usually only lasts a few minutes or can begin around 1 month after you start using glatiramer acetate injection. Call your doctor right away if you experience chest pain.

A permanent indentation under the skin (lipoatrophy and, rarely, death of your skin tissue also referred to as necrosis) at the injection site may occur due to local destruction of fat tissue. In order to reduce your chance of developing these problems, be sure to follow your doctor's instruction on how to use glatiramer acetate injection and be sure to choose a different injection site each time you use glatiramer acetate injection.

Liver problems, including liver failure, can occur with GLATIRAMER ACETATE INJECTION. Call your healthcare provider right away if you have symptoms, such as nausea, loss of appetite, tiredness, dark colored urine and pale stools, yellowing of your skin or the white part of your eye, bleeding more easily than normal, confusion, or sleepiness.

The most common side effects in studies of GLATIRAMER ACETATE INJECTION are redness, pain, swelling, itching, or a lump at the site of injection, rash, shortness of breath, and flushing. These are not all the possible side effects of GLATIRAMER ACETATE INJECTION. For a complete list, ask your doctor or pharmacist. Tell your doctor about any side effects that you have while taking GLATIRAMER ACETATE INJECTION.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit **www.fda.gov/medwatch** or call **1-800-FDA-1088.**

Please see accompanying Full Prescribing Information, Patient Information Leaflet and Instructions for Use for GLATIRAMER ACETATE INJECTION 20 mg/mL or GLATIRAMER ACETATE INJECTION 40 mg/mL.

For more information, visit **glatirameracetate.com.**