

 **briumvi**[™] **patient**
ublituximab-xiiy 150 mg/6 mL injection for IV **support**

FOR HEALTHCARE PROFESSIONALS



Please visit www.briumvipatientsupport.com or call 1-833-BRIUMVI (1-833-274-8684) to learn more and access additional resources.

To learn more about BRIUMVI, visit www.briumvi.com.

Welcome to BRIUMVI Patient Support

BRIUMVI Patient Support offers a flexible program designed to support the treatment journey in a way that works best for patients. Our program focuses on what matters, with key features including:



Flexible Program

Ability to support patients according to your preferences



Easy Enrollment

With our streamlined Start Form and HCP Portal



Case Manager

Who will serve as a patient's single point of contact

Flexible support includes:

Benefits Investigation



BRIUMVI Patient Support offers verification of benefits as well as information about the prior authorization and

appeals process. Let us know what works best for your office in verifying benefits and communicating the results.



Flexible support (cont'd):



BRIUMVI Copay Assistance Program

The BRIUMVI Copay Assistance Program provides financial assistance for eligible commercially insured patients.

- **Product Benefit:** Eligible patients may pay as little as \$0 copay per BRIUMVI treatment up to the annual maximum of \$20,000
- **Administration Benefit:** Eligible patients' out-of-pocket costs may be covered up to \$550 for the initial dose, and then up to \$350 per infusion thereafter
- Enroll your patients in the BRIUMVI Copay Assistance Program by having your patient **check the “BRIUMVI Copay Assistance Program” check box in Section 1 of the Start Form**, or enroll your patients in the BRIUMVI Copay Assistance Program directly at www.briumvicopayportal.com
- Other eligibility requirements apply. Please see full terms and conditions at www.briumvicopayterms.com



Quick Start

Patients experiencing a delay in insurance coverage of greater than 10 business days may be eligible to receive up to their first 2 infusions (day 1 and day 15) at no cost. Additional terms, conditions, and eligibility criteria apply.



Interim Dose

Patients who are currently on BRIUMVI who experience a short-term, temporary insurance issue may be eligible for an interim dose at no cost. Additional terms, conditions, and eligibility criteria apply.



Patient Assistance Program

If eligible, patients may receive BRIUMVI at no charge if the patient is uninsured or underinsured and meets the financial eligibility criteria. Additional terms, conditions, and eligibility criteria apply.*

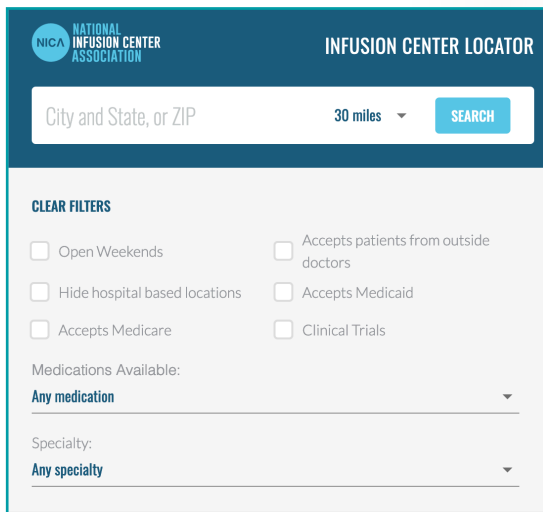
*Financial eligibility criteria is based on fixed annual gross household income/household size, as follows: \$100k/1, \$125k/2, \$150k/3, \$175k/4 (+\$25k for each additional household member).

HCP, healthcare provider.

Flexible support (cont'd):

Infusion Center Locator

BRIUMVI Patient Support has partnered with the National Infusion Center Association (NICA) to provide access to the Infusion Center Locator. BRIUMVI Patient Support can help find a conveniently located infusion site that is in-network for patients.



The screenshot shows the NICA Infusion Center Locator interface. At the top left is the NICA logo. The main heading is "INFUSION CENTER LOCATOR". Below this is a search bar with the placeholder text "City and State, or ZIP", a distance dropdown menu set to "30 miles", and a "SEARCH" button. Underneath the search bar is a "CLEAR FILTERS" section with several checkboxes: "Open Weekends", "Hide hospital based locations", "Accepts Medicare", "Accepts patients from outside doctors", "Accepts Medicaid", and "Clinical Trials". At the bottom of the filters are two dropdown menus: "Medications Available:" with "Any medication" selected, and "Specialty:" with "Any specialty" selected.



All patient and HCP resources can be accessed at www.briumvipatientsupport.com, or you can ask your local BRIUMVI representative for more information.

Patient enrollment

Streamlined Start Form

Patient must complete, sign, and date Section 1

Check box for patient to receive text messages


Patient or HCP completes Section 2

Provider must complete, sign, and date Section 3

Patient signs and dates here

Check box to apply for the Patient Assistance Program

Check box to enroll in the BRIUMVI Copay Assistance Program



START FORM
(Includes all program offerings from page 3)

BRIUMVI Patient Support
PO Box 2355
Morristown, NJ 07962

Phone: 1-833-BRIUMVI
(1-833-274-6684)
Fax: 877-639-2525

Hours of Operation:
Monday-Friday
8 AM to 8 PM EST

1 Patient Information

First Name _____ Last Name _____

Date of Birth (MM/DD/YYYY) _____ Gender _____

Preferred Language: English Spanish Other _____

Address _____

City _____ State _____ ZIP _____

Email Address _____

Mobile Phone # _____
 OK to send text message (Message and data rates may apply)

Additional Phone # _____

Permanent US Resident? Yes No

BRIUMVI Copay Assistance Program

If eligible, I would like to enroll in the BRIUMVI Copay Assistance Program for commercially-insured patients. I have read and agreed to the program terms and conditions (see page 4).

BRIUMVI Patient Assistance Program

BRIUMVI Patient Support provides product to eligible uninsured and underinsured patients at no charge. If you choose to apply for free product, checking the box below will prompt BRIUMVI Patient Support to verify your income.

I have read and agree to the Terms and Conditions and the Fair Credit Reporting Act (FCRA) authorization on page 4.

Household Size (including yourself) _____

2 Patient Insurance

Please check this box if the patient has no insurance

If available, please attach a copy of the front and back of the patient's medical and pharmacy insurance card to this form.

Primary Insurance	Primary Insurance Policy Holder	Primary Insurance Policy ID #	Group #	Primary Insurance Phone #
_____	_____	_____	_____	_____
Secondary Insurance	Secondary Insurance Policy Holder	Secondary Insurance Policy ID #	Group #	Secondary Insurance Phone #
_____	_____	_____	_____	_____

BRIUMVI Patient Assistance Program

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Household Size (including yourself) _____

3 Prescriber Information

Prescriber First Name _____ Prescriber Last Name _____

Phone # _____ Fax # _____ NPI # _____

Address _____ Suite # _____ Tax ID # _____ State License # _____

City _____ State _____ ZIP _____ Office Contact Name _____ Office Contact Phone # _____ Office Contact Email _____

Infusion Options
How do you intend to procure and administer BRIUMVI? (Select only one)

In-Office
Site Name: _____
Address: _____
NPI: _____ Tax ID: _____

Product Procurement:
 Buy & Bill Specialty Pharmacy (SP) Preferred SP: _____

Referral to infusion site: If referral infusion site is known, enter information below:
Site Name: _____
Address: _____ ZIP: _____
Phone: _____ Fax: _____

Check if assistance is needed with locating an infusion site
Who should be contacted? Patient Prescriber

Diagnosis

ICD-10 Code: G35 (M5) Other diagnosis code: _____

BRIUMVI Prescription

NDC: 73150-0150-06: 150 mg vial

Please Select All That Apply

First Infusion Rx: 150 mg (1 vial) IV infusion

Second Infusion Rx: 450 mg (3 vials) IV infusion (2 weeks later)

Subsequent Infusion Rx: 450 mg (3 vials) infusion once every 24 weeks* (quantity sufficient) Refill: _____ times

*Administer the first subsequent infusion 24 weeks after the first infusion

Anticipated Infusion Date: _____ Allergies: _____

Send an electronic prescription if required by state law.

By signing this form, I certify: (a) I am a licensed healthcare provider and have prescribed the TG medicine identified above to the patient identified above based on my independent medical judgment; (b) I received the appropriate patient authorization to release the information above to TG Therapeutics, Inc., and BRIUMVI Patient Support together with their respective third-party service providers, contractors or affiliates, and the dispensing pharmacy for the purpose of assisting the patient with initiating or continuing therapy in accordance with my treatment decisions; (c) I will not attempt to seek reimbursement for free product provided to the patient; (d) I request BRIUMVI Patient Support to convey the prescription described herein to the authorized pharmacy; and (e) if the patient receives copay assistance under the BRIUMVI Copay Assistance Program, I understand that the patient's benefit will be paid directly to me/my office on behalf of my patient if my office is administering the TG medicine and my office will apply any amount received under the BRIUMVI Copay Assistance Program to satisfy the patient's obligation for the TG medicine prescribed.

Prescriber Signature Required (no stamps) _____ Date _____

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Patient enrollment (cont'd)

Begin accessing the Start Form

There are 3 ways to access the Start Form.



The fastest and easiest way to enroll is through the **BRIUMVI HCP Portal**. Visit www.briumvihcpportal.com to enroll your patients.



Download and complete a PDF version at www.briumvipatientsupport.com and fax to 1-877-639-2525.



Ask your local representative for a print version. Complete the form and fax to 1-877-639-2525.

BRIUMVI HCP Portal

Get started with our HCP portal

The BRIUMVI HCP Portal simplifies patient access throughout the treatment journey. Some of the portal's features include:

Streamlined enrollment

Digital Start Form with eSignature



Infusion information

Electronically confirm patient infusion dates



**BRIUMVI
HCP Portal**

Digital communication

Electronic communication between Case Managers and prescribers with dashboard alerts for infusion center updates or when cases require action



Track the status of patient cases

View benefit verifications and status of prior authorizations



What to expect after enrollment

Upon enrollment, your patient will be assigned a Case Manager



The Case Manager will reach out to the patient with a **welcome text message** and a **phone call**



Case Managers can help patients access BRIUMVI and support them throughout their treatment journey



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