

 **briumvi**<sup>®</sup> patient  
ublituximab-xiyy 150 mg/6 mL injection for IV **support**

**FOR HEALTHCARE PROFESSIONALS**



---

Please visit [www.briumvipatientsupport.com](http://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](http://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 most, with key features including:



## Flexible Program

Ability to support patients according to your preferences



## Easy Enrollment

With our streamlined Start Form and eEnroll



## 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.



## Flexible support (cont'd):



### Copay Assistance

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](http://www.briumvicopayportal.com)
- Other eligibility requirements apply. Please see full terms and conditions at [www.briumvicopayterms.com](http://www.briumvicopayterms.com)



### Quick Start

Patients experiencing a delay in insurance coverage 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 cost 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).

# Patient enrollment

---

## There are 3 ways to access the Start Form



Visit [www.briumvipatientsupport.com](http://www.briumvipatientsupport.com) and click **eEnroll** to electronically submit the Start Form.



Download and complete a PDF version at [www.briumvipatientsupport.com](http://www.briumvipatientsupport.com) and fax to **1-877-639-2525**.



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



BRIUMVI Patient Support will contact the patient to obtain their signature through their preferred method if the patient is unavailable to sign in the office.



# Patient enrollment (cont'd)

## Streamlined Start Form

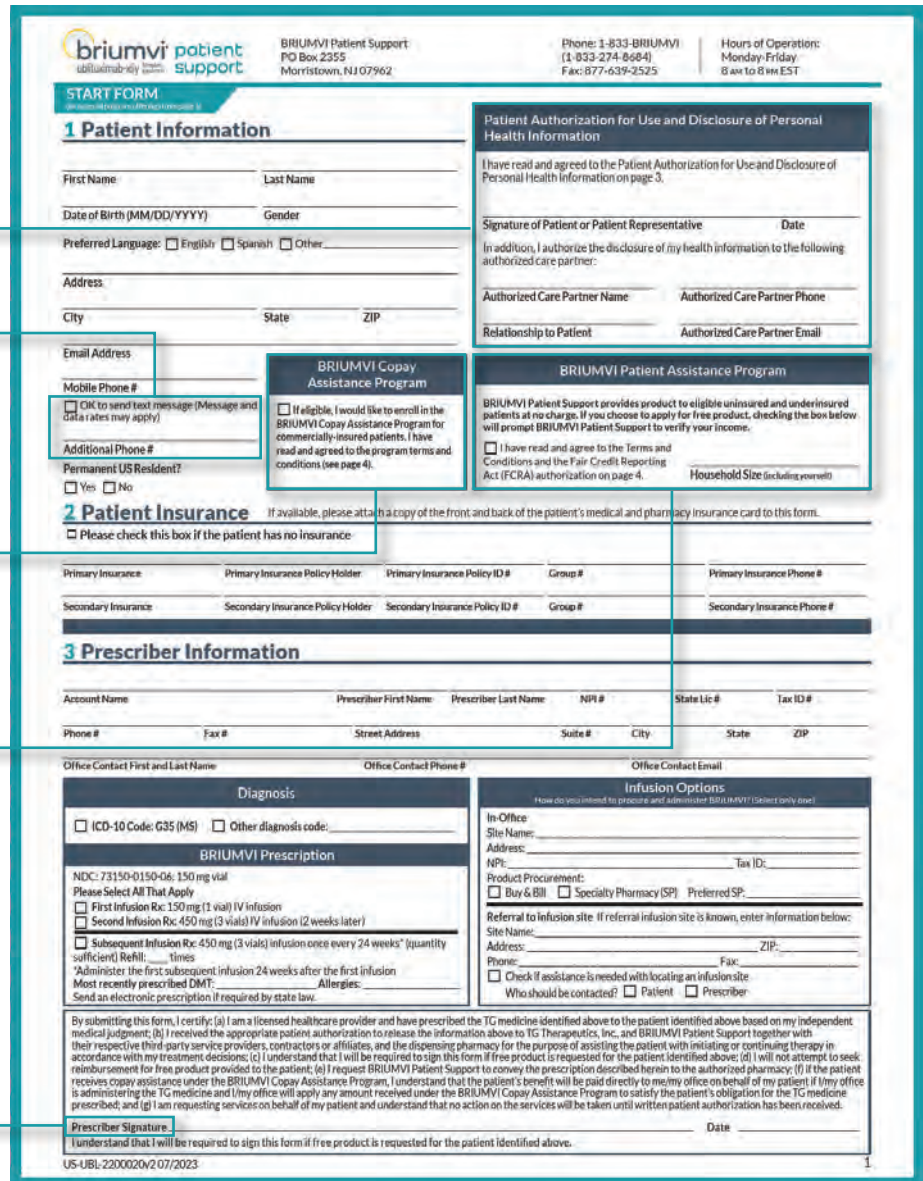
Patient signs and dates here

Check box for patient to receive text messages

Check box to enroll in the BRIUMVI Copay Assistance Program

Check box to apply for the Patient Assistance Program

Prescriber will be required to sign if free product is requested



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

BRIUMVI Patient Support  
 PO Box 2355  
 Morristown, NJ 07962

Phone: 1-833-BRIUMVI  
 (1-833-274-8684)  
 Fax: 877-639-2525

Hours of Operation:  
 Monday-Friday  
 8 am to 8 pm EST

### START FORM

#### 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 # \_\_\_\_\_  
 Click 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**  
 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) \_\_\_\_\_

**Patient Authorization for Use and Disclosure of Personal Health Information**  
 I have read and agreed to the Patient Authorization for Use and Disclosure of Personal Health Information on page 3.  
 Signature of Patient or Patient Representative \_\_\_\_\_ Date \_\_\_\_\_  
 In addition, I authorize the disclosure of my health information to the following authorized care partner:  
 Authorized Care Partner Name \_\_\_\_\_ Authorized Care Partner Phone \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_ Authorized Care Partner Email \_\_\_\_\_

#### 2 Patient Insurance

Please check this box if the patient has no insurance.

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 # \_\_\_\_\_

#### 3 Prescriber Information

Account Name \_\_\_\_\_ Prescriber First Name \_\_\_\_\_ Prescriber Last Name \_\_\_\_\_ NPI # \_\_\_\_\_ State Lic # \_\_\_\_\_ Tax ID # \_\_\_\_\_  
 Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Street Address \_\_\_\_\_ Suite # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Office Contact First and Last Name \_\_\_\_\_ Office Contact Phone # \_\_\_\_\_ Office Contact Email \_\_\_\_\_

**Diagnosis**  
 ICD-10 Code: G35 (MS)  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  
 Most recently prescribed DMT: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 Send an electronic prescription if required by state law.

**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

By submitting 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 understand that I will be required to sign this form if free product is requested for the patient identified above; (d) I will not attempt to seek reimbursement for free product provided to the patient; (e) I request BRIUMVI Patient Support to convey the prescription described herein to the authorized pharmacy; (f) 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 I/my office will apply any amount received under the BRIUMVI Copay Assistance Program to satisfy the patient's obligation for the TG medicine prescribed; and (g) I am requesting services on behalf of my patient and understand that no action on the services will be taken until written patient authorization has been received.

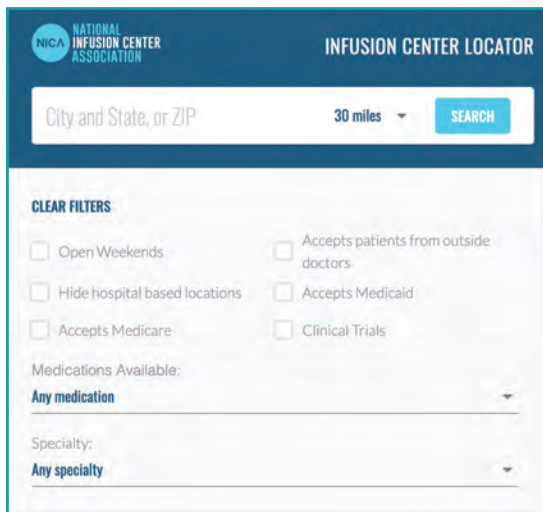
Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_  
 I understand that I will be required to sign this form if free product is requested for the patient identified above.

US-UBL: 2200020v2 07/2023

# Infusion support

## Infusion Center Locator

BRIUMVI Patient Support can help find a conveniently located infusion site that is in-network for patients via the Infusion Center Locator provided by the National Infusion Center Association (NICA).



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". Below the filters are two dropdown menus: "Medications Available:" set to "Any medication" and "Specialty:" set to "Any specialty".



**All patient and HCP resources can be accessed at [www.briumvipatientsupport.com](http://www.briumvipatientsupport.com), or you can ask your local BRIUMVI representative for more information.**

# BRIUMVI Patient Support

---

BRIUMVI Patient Support offers a flexible program to support the treatment journey in a way that works best for your patients.

## What patients can expect after enrollment:

1



### Case Manager Assignment

Once we receive the Start Form from your office, the patient will be assigned a Case Manager who will help them get started on BRIUMVI and assist them throughout their entire treatment journey.

2



### Insurance Coverage Determination

Your patient's Case Manager will **call their insurance company to gather coverage details** for their BRIUMVI treatment. They typically inquire about how your patient's insurance may cover BRIUMVI, specific requirements needed to access BRIUMVI, and potential out-of-pocket cost.

3



### Financial Assistance

Your patient's Case Manager will help them understand if they may be eligible for **financial assistance options**.

4



### Infusion Support

Your patient's Case Manager will continue to reach out prior to each infusion to confirm if there have been any changes and verify insurance coverage for treatment.

---

BRIUMVI Patient Support is available Monday through Friday, 8 am to 8 pm EST.

Patients are encouraged to call **1-833-BRIUMVI (1-833-274-8684)** to reach their dedicated Case Manager if they have any questions or need assistance.

---



**briumvi**<sup>®</sup> patient  
ublituximab-xiiy 150 mg/6 mL injection for IV support

Please visit [www.briumvipatientsupport.com](http://www.briumvipatientsupport.com) or  
call 1-833-BRIUMVI (1-833-274-8684) to learn more and to  
download the patient and HCP office resources outlined in this brochure

To learn more about BRIUMVI, please visit [www.briumvi.com](http://www.briumvi.com).