BRIUMVI Patient Support
www.briumvipatientsupport.com
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 ET

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

START FORM (includes all program offerings from page 3)

☐ BRIUMVI Clinical Trial
Clinical Trial # _____

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

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 2.

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 _____

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 3).

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 PAP Terms and Conditions and the Fair Credit Reporting Act (FCRA) authorization on page 3.

Household Size (including yourself) _____

2 PATIENT INSURANCE

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

☐ **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

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

DIAGNOSIS

☐ ICD-10 Code: G35.A Relapsing-Remitting Multiple Sclerosis
☐ ICD-10 Code: G35.C0 Secondary Progressive Multiple Sclerosis, Unspecified
☐ ICD-10 Code: G35.C1 Active Secondary Progressive Multiple Sclerosis
☐ ICD-10 Code: G35.D Multiple Sclerosis, Unspecified
☐ ICD-10 Code: G37.9 Demyelinating Disease of Central Nervous System, Unspecified
☐ Other Diagnosis Code: _____

BRIUMVI PRESCRIPTION

NDC: 73150-0150-06: 150 mg vial
Please Select All That Apply

☐ **First Infusion:** 150 mg intravenous infusion
☐ **Second Infusion:** 450 mg intravenous infusion two weeks after the first infusion

☐ **Subsequent Infusion:** 450 mg intravenous infusion 24 weeks after the first infusion and every 24 weeks thereafter Refill: _____ times

Prior DMT & last dose date: _____ 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 ☐ Referral to infusion site

Infusion Site Name: _____

Address: _____

Phone: _____ Fax: _____

NPI: _____ Tax ID: _____

Billing NPI (if different from Site NPI): _____

Product Procurement:

☐ Buy & Bill ☐ Specialty Pharmacy (SP) Preferred SP: _____

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

By signing below, 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, infusion provider and distributor 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 seek reimbursement from any third-party payer, including, but not limited to Medicare and Medicaid, for any free product provided to the patient, nor will I charge the patient for any free product (e) I request BRIUMVI Patient Support to convey the prescription described herein to the authorized pharmacy, infusion provider and distributor; (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 I/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 _____

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Please read the following carefully, then sign and date where indicated on page 1.

By providing my signature on page 1 of this form, I authorize my physician, other healthcare providers, pharmacies and my health plan, and their service providers (collectively, my "Providers") to disclose my personal health information relating to my insurance benefits, medical condition, treatment and prescription details (my "PHI") to TG Therapeutics, Inc., its affiliates, service providers and other vendors (collectively "TG Therapeutics"), so TG Therapeutics may provide me with support services (the "Services") under the BRIUMVI Patient Support (the "Program"), as described below. Such PHI may also include my name, birth date, postal address, telephone number, email address, and information about my financial status.

The Services under the Program may include (i) helping to coordinate insurance coverage for, access to, and receipt of the TG Therapeutics medicine my physician has prescribed, (ii) determining my eligibility for enrollment into financial assistance services, including copay assistance, (iii) assisting with identification of an infusion site, (iv) conducting quality assurance and other internal business activities to evaluate and improve the Program and Services, and (v) contacting me by mail, telephone, email, or, if I check the relevant box on page 1 of this form, by text messages*, to provide me with information about the Program, the Services, and TG Therapeutics medicines, as well as other information and alerts that TG Therapeutics believes may be of interest to me (some of which may be considered marketing), and to ask my opinion about my participation in the Program or about my experience on a TG Therapeutics medicine, and for market research purposes.

If I have identified an authorized care partner on the Patient Start Form (see Section 1), I hereby give my permission for TG Therapeutics to use my PHI to contact my Authorized Care Partner for such purposes. I (and, if applicable, my care partner) can opt out of the use of my PHI to make such contacts at any time by notifying TG Therapeutics at 1-833-BRIUMVI (1-833-274-8684) 8:00 AM to 8:00 PM ET Monday through Friday. I (and, if applicable, my care partner) can opt out of text messages by texting "STOP" to the phone number from which I received a text message.

I also authorize TG Therapeutics, in delivering the Services, to share my PHI with my Providers and my health insurance plan(s). My Providers may receive payment for making disclosures of my PHI to TG Therapeutics in connection with providing certain Program Services, such as medication support. Once my PHI has been disclosed to TG Therapeutics, federal and state privacy laws, including the Health Insurance Portability and Accountability Act ("HIPAA"), may no longer protect the PHI from further disclosure.

I do not have to sign this Authorization to obtain my medication or insurance coverage, but I understand that if I do not sign it, I will not be able to participate in the Program.

This Authorization will remain in effect for five (5) years from the date I signed it, unless I withdraw it or if a shorter time is required by law. I may withdraw at any time by sending a written notice to BRIUMVI Patient Support, PO Box 2355, Morristown, NJ 07962 or contacting TG Therapeutics at 1-833-BRIUMVI (1-833-274-8684). If I withdraw this Authorization, that will invalidate further reliance on the Authorization to make uses and disclosures of my PHI, but it will not invalidate uses and disclosures made prior to TG Therapeutics' receipt of my notice of withdrawal. Withdrawal of this Authorization would mean that I could no longer participate in the Program and TG Therapeutics would no longer be able to provide me with the Services.

*Wireless carriers may charge for text messages from TG Therapeutics.

BRIUMVI PATIENT ASSISTANCE PROGRAM TERMS & CONDITIONS

Please read the following carefully, then check the box where indicated on page 1.

I understand that I have the option to consent to having TG Therapeutics perform an electronic verification of my financial information to verify my eligibility and process my application for the BRIUMVI Patient Assistance Program ("PAP"). I am providing "written instructions" under the Fair Credit Reporting Act ("FCRA") authorizing TG Therapeutics to obtain information from my credit profile, solely for the purpose of determining financial qualifications for PAP. This authorization allows TG Therapeutics to perform this process as needed for the duration of my participation in PAP. The financial and health plan information I have provided is complete and accurate to the best of my knowledge. I understand that the BRIUMVI Patient Assistance Program includes eligibility criteria, including demonstration of financial need, and that TG Therapeutics will make an assessment about whether I meet that criteria. I may not meet the eligibility criteria and therefore may not qualify for PAP. I may be asked to provide proof of income. Patients with insurance plans that participate in or are involved in any way with an alternative funding program requiring or encouraging patients to apply to a manufacturer's patient assistance program, including the BRIUMVI PAP, or otherwise pursue specialty drug prescription coverage through an alternative funding vendor as a condition, requirement, or prerequisite for coverage of BRIUMVI, or that otherwise denies, delays, modifies, restricts, or withholds any insurance benefits contingent upon application to, or denial of eligibility for, specialty drug prescription coverage through the alternate funding vendor are not eligible for the BRIUMVI PAP. If I receive free product through PAP, I will not submit, or cause to be submitted, any claims for payment or reimbursement from any third-party payer, including any federal healthcare program such as Medicare or Medicaid, or any private or other insurance plan, or from any other person or entity for such free product. I will not seek to have the cost of any product provided under the PAP counted toward my Medicare Part D true out-of-pocket costs (TrOOP). I agree to notify TG Therapeutics promptly if: (1) I obtain coverage for products provided under PAP through another source (federal, state, or private health plan), (2) I no longer meet the income criteria for PAP, or (3) I find any errors in this enrollment form. If required by my health plan, I will notify the health plan of any free product I receive through PAP. I must reapply for PAP annually. TG Therapeutics has the right at any time, and without notice, to modify or discontinue free product that it may be providing under PAP. Additional terms and conditions may apply.

BRIUMVI COPAY ASSISTANCE PROGRAM TERMS & CONDITIONS

Please read the following carefully, then check the box where indicated on page 1.

I agree to my enrollment in the BRIUMVI Copay Assistance Program ("Program") if confirmed as eligible. I understand that any assistance with my applicable cost-sharing or copayment for BRIUMVI or administration costs associated with BRIUMVI will be made in accordance with the Program terms and conditions available at www.briumvicopayterms.com, which include, but are not limited to:

- The Program is available only to eligible, commercially-insured patients with coverage for BRIUMVI
- Patients who reside in Massachusetts and Rhode Island are not eligible for copay assistance for BRIUMVI administration costs
- The Program assistance is exclusively for the benefit of the enrolled patient
- I must be 18 years of age or older
- The Program is not available if I am enrolled in: Medicare, Medicaid, TRICARE, any other state or federally funded healthcare program, or any prescription drug plan that prohibits the use of manufacturer copay support
- The Program includes an annual cap for the cost savings provided under the Program. When the cap is reached, I will be responsible for all out-of-pocket costs associated with BRIUMVI
- This Program is not valid where prohibited by law
- I must not to seek reimbursement for all or any part of the cost savings I receive through the Program
- Information about my cost savings under this Program will be sent to my physician, designated site of care, or designated specialty pharmacy
- TG Therapeutics has the right at any time and without notice to modify or discontinue the Program

Please read the complete terms and conditions available at www.briumvicopayterms.com.