Chiesi TOTAL care℠

Getting Started Guide

To get a patient started on FILSUVEZ® topical gel, follow 2 steps outlined in this guide

Visit chiesitotalcare.com or call 1-833-670-6464 We're ready to help!

Indication and Important Safety Information

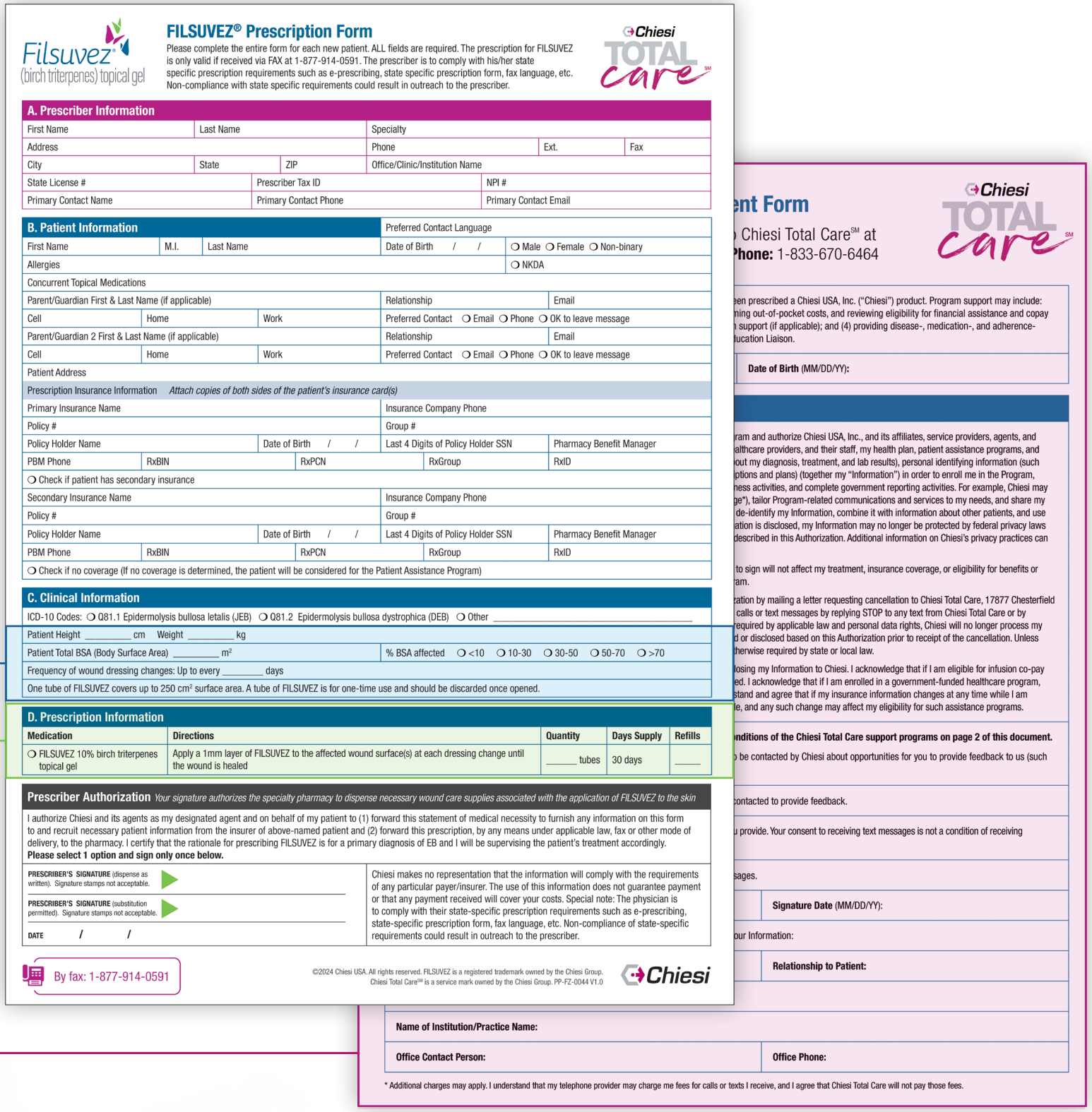
Indication
FILSUVEZ is indicated for the treatment of wounds associated with dystrophic and junctional epidermolysis bullosa (EB) in adult and pediatric patients 6 months of age and older.

Warnings & Precautions
Local hypersensitivity and skin reactions have been reported in patients treated with FILSUVEZ, including urticaria and dermatitis. If signs or symptoms of hypersensitivity occur, discontinue use immediately and initiate appropriate therapy.

Please see accompanying full Prescribing Information for FILSUVEZ topical gel.

Filsuvez® (birch triterpenes) topical gel

Step 1: Fill out the Prescription and Patient Consent Forms



Filsuvez® (birch triterpenes) topical gel

FILSUVEZ® Prescription Form

Please complete the entire form for each new patient. ALL fields are required. The prescription for FILSUVEZ is only valid if received via FAX at 1-877-914-0591. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Chiesi TOTAL care℠

A. Prescriber Information

First Name	Last Name		Specialty		
Address			Phone	Ext.	Fax
City	State	ZIP	Office/Clinic/Institution Name		
State License #	Prescriber Tax ID		NPI #		
Primary Contact Name	Primary Contact Phone		Primary Contact Email		

B. Patient Information

First Name	M.I.	Last Name	Preferred Contact Language		
			Date of Birth / /	❍ Male ❍ Female ❍ Non-binary	
Allergies				❍ NKDA	
Concurrent Topical Medications					
Parent/Guardian First & Last Name (if applicable)			Relationship	Email	
Cell	Home	Work	Preferred Contact ❍ Email ❍ Phone ❍ OK to leave message		
Parent/Guardian 2 First & Last Name (if applicable)			Relationship	Email	
Cell	Home	Work	Preferred Contact ❍ Email ❍ Phone ❍ OK to leave message		
Patient Address					
Prescription Insurance Information *Attach copies of both sides of the patient's insurance card(s)*					
Primary Insurance Name			Insurance Company Phone		
Policy #			Group #		
Policy Holder Name		Date of Birth / /	Last 4 Digits of Policy Holder SSN	Pharmacy Benefit Manager	
PBM Phone	RxBIN	RxPCN	RxGroup	RxID	
❍ Check if patient has secondary insurance					
Secondary Insurance Name			Insurance Company Phone		
Policy #			Group #		
Policy Holder Name		Date of Birth / /	Last 4 Digits of Policy Holder SSN	Pharmacy Benefit Manager	
PBM Phone	RxBIN	RxPCN	RxGroup	RxID	
❍ Check if no coverage (If no coverage is determined, the patient will be considered for the Patient Assistance Program)					

C. Clinical Information

ICD-10 Codes: ❍ Q81.1 Epidermolysis bullosa letalis (JEB) ❍ Q81.2 Epidermolysis bullosa dystrophica (DEB) ❍ Other _____

Patient Height _____ cm Weight _____ kg	
Patient Total BSA (Body Surface Area) _____ m^2	% BSA affected ❍ <10 ❍ 10-30 ❍ 30-50 ❍ 50-70 ❍ >70
Frequency of wound dressing changes: Up to every _____ days	
One tube of FILSUVEZ covers up to 250 cm^2 surface area. A tube of FILSUVEZ is for one-time use and should be discarded once opened.	

D. Prescription Information

Medication	Directions	Quantity	Days Supply	Refills
❍ FILSUVEZ 10% birch triterpenes topical gel	Apply a 1mm layer of FILSUVEZ to the affected wound surface(s) at each dressing change until the wound is healed	_____ tubes	30 days	_____

Prescriber Authorization *Your signature authorizes the specialty pharmacy to dispense necessary wound care supplies associated with the application of FILSUVEZ to the skin*

I authorize Chiesi and its agents as my designated agent and on behalf of my patient to (1) forward this statement of medical necessity to furnish any information on this form to and recruit necessary patient information from the insurer of above-named patient and (2) forward this prescription, by any means under applicable law, fax or other mode of delivery, to the pharmacy. I certify that the rationale for prescribing FILSUVEZ is for a primary diagnosis of EB and I will be supervising the patient's treatment accordingly.
Please select 1 option and sign only once below.

PRESCRIBER'S SIGNATURE (dispense as written). Signature stamps not acceptable.

PRESCRIBER'S SIGNATURE (substitution permitted). Signature stamps not acceptable.

DATE / /

Chiesi makes no representation that the information will comply with the requirements of any particular payer/insurer. The use of this information does not guarantee payment or that any payment received will cover your costs. Special note: The physician is to comply with their state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance of state-specific requirements could result in outreach to the prescriber.

By fax: 1-877-914-0591

Chiesi

A

B

C

ent Form

Chiesi Total Care℠ at
Phone: 1-833-670-6464

Chiesi TOTAL care℠

een prescribed a Chiesi USA, Inc. ("Chiesi") product. Program support may include: ning out-of-pocket costs, and reviewing eligibility for financial assistance and copay n support (if applicable); and (4) providing disease-, medication-, and adherence- ducation Liaison.

Date of Birth (MM/DD/YY):

ram and authorize Chiesi USA, Inc., and its affiliates, service providers, agents, and althcare providers, and their staff, my health plan, patient assistance programs, and out my diagnosis, treatment, and lab results), personal identifying information (such ptions and plans) (together my "Information") in order to enroll me in the Program, ness activities, and complete government reporting activities. For example, Chiesi may ge*), tailor Program-related communications and services to my needs, and share my de-identify my Information, combine it with information about other patients, and use ation is disclosed, my Information may no longer be protected by federal privacy laws described in this Authorization. Additional information on Chiesi's privacy practices can

to sign will not affect my treatment, insurance coverage, or eligibility for benefits or am.

zation by mailing a letter requesting cancellation to Chiesi Total Care, 17877 Chesterfield calls or text messages by replying STOP to any text from Chiesi Total Care or by required by applicable law and personal data rights, Chiesi will no longer process my d or disclosed based on this Authorization prior to receipt of the cancellation. Unless herwise required by state or local law.

losing my Information to Chiesi. I acknowledge that if I am eligible for infusion co-pay ed. I acknowledge that if I am enrolled in a government-funded healthcare program, stand and agree that if my insurance information changes at any time while I am le, and any such change may affect my eligibility for such assistance programs.

nditions of the Chiesi Total Care support programs on page 2 of this document.

be contacted by Chiesi about opportunities for you to provide feedback to us (such

contacted to provide feedback.

u provide. Your consent to receiving text messages is not a condition of receiving

sages.

Signature Date (MM/DD/YY):

our Information:

Relationship to Patient:

Name of Institution/Practice Name:

Office Contact Person: **Office Phone:**

* Additional charges may apply. I understand that my telephone provider may charge me fees for calls or texts I receive, and I agree that Chiesi Total Care will not pay those fees.

Indication and Important Safety Information

Adverse Reactions

The most commonly reported adverse reaction in clinical trials was pruritus and pain at the wound application site (7.3%).

Please see accompanying full Prescribing Information for FILSUVEZ topical gel.

Specify clinical information related to patient body surface area

A

Patient Total BSA (Body Surface Area) _____ m^2

% BSA affected ☐ <10 ☐ 10-30 ☐ 30-50 ☐ 50-70 ☐ >70

Frequency of wound dressing changes: Up to every _____ days

One tube of FILSUVEZ covers up to 250 cm^2 surface area.
A tube of FILSUVEZ is for one-time use and should be discarded once opened.

Specify prescription information

B

Use the specified clinical information from the section above to calculate the quantity of tubes required.

Medication	Directions	Quantity	Days Supply	Refills
❍ FILSUVEZ 10% birch triterpenes topical gel	Apply a 1mm layer of FILSUVEZ to the affected wound surface(s) at each dressing change until the wound is healed	_____ tubes	30 days	_____

Ask each patient to sign the Patient Consent Form

C

Please ask each patient to sign the Patient Consent Form before they leave the office and fax it along with the Enrollment Form for each patient.

Participation in the Chiesi Total Care program is optional.

Step 2: Once you have completed the form:

1. **Attach copies of patient insurance and prescription cards – front and back.**
2. **First prescription for the patient:**
   THE FIRST COPY OF THE FORM MUST BE FAXED FOR EACH PATIENT. Fax completed form to Chiesi Total Care℠ at **1-877-914-0591. PLEASE COMPLETE ONE FORM PER PATIENT.**
3. **Subsequent prescriptions:**
   After the initial script is filled, future prescriptions can be made via telephone or e-script. If you wish to send additional forms via e-script please search for “PANTHERx" in your EMR/HMR’s e-prescribing software.

The fillable pdf can be downloaded and saved for future use.
Scan the QR code to download a copy.

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Adverse Reactions

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Patient Counseling Information

Please refer to Prescribing Information for administration instructions.

To report SUSPECTED ADVERSE REACTIONS, contact Chiesi USA Inc. at 1-888-661-9260 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Please see accompanying full Prescribing Information for FILSUVEZ topical gel.

For more information, visit FILSUVEZ.com/HCP

References: 1. FILSUVEZ® (birch triterpenes) Prescribing Information. Amryt, December, 2023

Chiesi Total Care℠ Program offered through PANTHERx Rare Pharmacy.

PP-FZ-0028 V2.0 2024

Chiesi
global rare diseases