

FILSUIVEZ® Prescription Form

Please complete the entire form for each new patient. ALL fields are required. The prescription for FILSUIVEZ 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. **Call 1-833-670-6464 if you have any questions.**

A. Prescriber Information

First Name		Last Name		Specialty	
Address			Phone		Ext.
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		Date of Birth / /		Preferred Contact Language	
Allergies							<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> NKDA		
Concurrent Medications:									
Legal Representative First & Last Name (if applicable)					Relationship		Email		
Cell		Home		Work		Preferred Contact <input type="radio"/> Email <input type="radio"/> Phone <input type="radio"/> OK to leave message			
Legal Representative 2 First & Last Name (if applicable)					Relationship		Email		
Cell		Home		Work		Preferred Contact <input type="radio"/> Email <input type="radio"/> Phone <input type="radio"/> 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	
<input type="radio"/> 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	
<input type="radio"/> 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) _____ m² % BSA affected by open wounds _____

Frequency of wound dressing changes: Up to every _____ days

One tube of FILSUIVEZ covers up to 250 cm² surface area. A tube of FILSUIVEZ is for one-time use and should be discarded once opened.

D. Prescription Information

Medication	Directions	Quantity	Days Supply	Refills
<input type="radio"/> FILSUIVEZ 10% birch triterpenes topical gel	Apply a 1mm layer of FILSUIVEZ 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 FILSUIVEZ to the skin

By submitting this form, I certify that I am the prescribing provider mentioned above; that the person named on this form is my patient; that the information provided herein is, to the best of my knowledge, current, complete, and accurate; that the therapy described above is medically necessary for this patient and the patient's records contain supporting documentation that substantiates the utilization and medical necessity of the therapy; that I have prescribed the therapy to the patient; that the decision to prescribe the therapy was based solely on my independent medical judgment; and that I am authorized under state law to prescribe the therapy. I will be supervising the patient's treatment, and I have reviewed the current prescribing information for the therapy. Further, I certify that I have discussed Chiesi Total Care™ (the "Program") with my patient and that my patient would like to be screened for eligibility for the Program and provided, if applicable, any services under the Program for which my patient is eligible.

I understand that my patient's information provided to Chiesi, its successors, vendors, agents, and representatives (collectively, "Chiesi") is for the use of the Program to verify my patient's insurance coverage; to facilitate the filling of my patient's prescription; to assess my patient's eligibility for the Program and other support programs; and to otherwise administer the Program for the patient.

I certify that I am disclosing the patient's Protected Health Information ("PHI") on this form to the Program for treatment, payment, or healthcare operations purposes, in accordance with the requirements under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, as amended ("HIPAA"). Additionally, I provide my permission to use my personal information for the purposes described above and certify that I have obtained the patient's written authorization in accordance with applicable state and federal law, including HIPAA, to provide the PHI on this form to the Program for such purposes. If my patient is 18 years old or younger, I attest that I have obtained such authorization from the patient's legal guardian. I acknowledge and agree that the Program may reach out to my patient to obtain additional consents or authorizations as deemed appropriate in connection with the Program.

I authorize the Program to conduct a benefits investigation for my patient (and to act on my behalf for the limited purpose of transmitting this prescription to the appropriate pharmacy based on the results of that benefits investigation). If coverage is not available and the patient qualifies for and will receive free product under the Program, I understand that no request for reimbursement for free product or administration of such product may be submitted to any payer,

including Medicare, Medicaid, and any government-funded programs. Receiving free product is not contingent on any purchase obligations, and no free product may be sold, traded, or distributed for sale. I understand that any falsification, omission, or concealment of material fact related to my patient's eligibility for such free product may result in criminal liability.

I consent to Chiesi contacting me by fax, mail, or email to provide additional information about the product(s) marked above or the Program. I understand that the Program may revise, change, or terminate any Program services at any time without notice to me.

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

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

DATE / /