Purified Cortrophin® Gel
repository corticotropin injection USP 80 U/mL

Cortrophin In Your Corner™

To enroll your patient in the *Cortrophin In Your Corner* program, fax completed form to 1-844-FAX-CIYC (1-844-329-2492) with copies of the front and back of all medical and prescription insurance cards. Questions? Call 1-800-805-5258.

Fax this page

1 Patient Information (Including Patient Authorization of pages 2 and 3)

First Name | M.I. | Last Name | Date of Birth (mm/dd/yyyy) | ☐ M ☐ F Sex | Email (May be emailed for additional authorizations or information regarding this form)

Shipping Address | Apt/Bldg/Fl | City | State | ZIP Code | Phone # | ☐ Permission to Leave Voicemail

Alternative Contact Name | Contact Phone # | Contact Email (May be emailed for additional authorizations or information regarding this form) | Relationship to Patient | Preferred Language of Patient if Other Than English

2 Insurance Information (Please attach copies [front and back] of all medical and prescription insurance cards)

Policyholder: ☐ Self ☐ Other (Please complete policyholder details below) **Policy Type:** ☐ Commercial/Private ☐ Government ☐ Not insured (If uninsured, visit cortrophinhcp.com/support to learn about patient assistance)

Policyholder First Name | Policyholder Last Name | Relationship to Patient

Primary Medical Insurance Name | Insurance Phone # | Subscriber ID # | Group #

Pharmacy Insurance Name | Insurance Phone # | Subscriber ID # | Rx Group # | Rx BIN # | Rx PCN #

Secondary Insurance Name | Insurance Phone # | Subscriber ID # | Group #

3 Prescriber Information (Please include supervising MD or DO, where applicable)

First Name | Last Name | Specialty/Sub-specialty | Phone # | Fax #

Practice Name | Address | City | State | ZIP Code

Prescriber NPI | Group NPI (If applicable) | Prescriber State License # | Tax ID # | Office Contact Name

Office Contact Phone # | Office Contact Email | Preferred Method of Communication: ☐ Phone ☐ Email ☐ No Preference

4 Prescription: Purified Cortrophin Gel (repository corticotropin injection USP)

ICD-10 Diagnosis Code _____ For a list of possible relevant ICD-10 diagnosis codes associated with FDA-approved use, see pages 4 and 6 or full list at cortrophinhcp.com/ICD10.

Please only fill out prescription information for either prefilled syringe or vial.

Purified Cortrophin Gel Single-Dose Prefilled Syringe
For subcutaneous injection only

Please select dose
- ☐ 40 USP units/0.5 mL NDC#62559-861-35
- ☐ 80 USP units/mL NDC#62559-861-11

Frequency
- ☐ 2 times per week
- ☐ 3 times per week
- ☐ Other: _____

Duration: _____

Quantity of prefilled syringes: _____

Refills: _____

☐ **Sharps container**

OR

Purified Cortrophin Gel NDC#62559-860-15
5-mL multiple-dose vial containing 80 USP units/mL
For intramuscular or subcutaneous injection

Route of administration (injection)
☐ Subcutaneous ☐ Intramuscular

Please select dose
☐ 40 units ☐ 80 units ☐ Other: _____

Frequency
☐ 2 times per week ☐ 3 times per week ☐ Other: _____

Duration: _____

Quantity of 5-mL multidose vials: _____

Refills:

Please identify the supplies needed for prescription (for SP dispense only)
Pharmacy to dispense sufficient supplies for therapy

☐ Yes, I would like the pharmacy to dispense sufficient supplies for therapy ☐ No, I would like the pharmacy to dispense the quantity of supplies as written below

Syringe size ☐ 1 mL ☐ 3 mL ☐ Other: _____

Needle size for drawing ☐ 20 G needle, 1" ☐ Other: _____

Needle size for injection ☐ 25 G needle, 5/8" ☐ 25 G needle, 1" ☐ 23 G needle, 1" ☐ 23 G needle, 3/4"

☐ **Sharps container**

Special instructions: Titration or taper dose, if applicable

Allergies ☐ NKDA (no known drug allergies)

☐ Duplicate above orders for Patient Assistance Program (PAP) prescription*
*Indicating a prescription for PAP does not guarantee patient will be eligible for PAP. Terms and conditions will apply.

Patient injection training for administering Cortrophin Gel

☐ By checking here, I request that injection training be arranged for my patient at no cost. I understand that this service is available for multiple in-person or virtual visits and is intended as injection training only.

I verify that the patient and prescriber information on this enrollment form was completed by me or at my direction and that the information contained herein is complete and accurate to the best of my knowledge. I authorize the *Cortrophin In Your Corner* program to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy. By signing below, I agree to the Prescriber Certification and Statement of Medical Necessity on page 2.

_____ _____ OR _____ _____

DISPENSE AS WRITTEN | **DATE** | **SUBSTITUTIONS ALLOWED** | **DATE**

Prescriber signature required for consent and to validate prescriptions. Prescriber attests that this is her/his signature. No stamps allowed.

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Patient Name: _____ **Date of Birth (mm/dd/yyyy):** _____

For Prescriber

Prescriber Certification and Statement of Medical Necessity (Signature on Page 1 Required for Documentation)

I certify that the information contained herein is complete and accurate to the best of my knowledge; the above therapy (the "Product") is medically necessary for this patient and I have made the decision to prescribe the Product; I have received an appropriate written authorization from the patient, in accordance with applicable federal and state privacy law(s), and any other applicable requirements, to release the patient's information to ANI Pharmaceuticals, the *Cortrophin In Your Corner* program (the "Program"), and their agents for purposes of assessing the patient's insurance coverage and participation in the Program and for other purposes outlined in the Patient Authorization for Use and Disclosure of Personal Health Information. I acknowledge that patient's potential participation in the Program is not contingent on or a reward for any past or future requirement to prescribe, purchase, or utilize the Product or any other ANI Pharmaceuticals product. The full value of any Program benefit shall apply to the patient. I have not received and will not receive any price concession or other value from the Program or any other ANI Pharmaceuticals program. If my patient or I decide the patient should discontinue treatment with the Product, neither the patient nor I will incur any financial penalty or consequence from the Program. Any Product provided at no charge to the patient is provided on a complimentary basis, and I will not submit any claims for payment or reimbursement for such Products to any third-party payor, including any federal healthcare program. If I am or become in possession of such Product, I will not resell or attempt to resell the Product. I understand that I must comply with my practicing state's specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. I agree that the Program may contact me about the information in this form as needed to facilitate my patient's enrollment in the Program.

For Patient

Patient Authorization for Use and Disclosure of Protected Health Information (continued on page 3)

I authorize my healthcare providers (including pharmacy providers) and health plans to release, disclose, or re-disclose my protected health information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 ["HIPAA"] and its regulations), including my personal contact and other information on this form, all medical records, financial information, and other information (collectively, "Information") relevant to my enrollment, participation, or receipt of assistance under the *Cortrophin In Your Corner* program (the "Program"), to ANI Pharmaceuticals and its affiliates, and any third parties engaged to assist in administering the Program, in order to: (1) establish my benefit eligibility; (2) communicate with my healthcare providers and health plans about my eligibility for Program support, my benefit and coverage status, and/or my medical care; (3) provide support through the Program, including facilitating the provision of the Cortrophin Gel ("Product") to me, as well as any information or materials related to such support or Product, including marketing, promotional, or educational communications; (4) evaluate the effectiveness of Product support programs; (5) contact me regarding this enrollment form or my use or potential use of the Product and providing me with related patient support communications, including through messages left for me that disclose that I take or may take the Product; (6) facilitate or assist on copayment, coinsurance, and patient assistance program ("PAP") matters, as applicable; and (7) administer, evaluate, and improve the Program, including by analyzing the usage patterns and the effectiveness of ANI Pharmaceuticals products, services, and programs; helping to develop new products, services, and programs; and for other ANI Pharmaceuticals general business and administrative purposes.

I understand that certain entities may receive remuneration for the use or disclosure of my Information and providing support services as authorized above, and that, once my Information has been disclosed under this Authorization, my Information may not be subject to all of the protections and safeguards provided by HIPAA or other federal and state privacy laws. I also understand, however, that the Program plans to use and disclose my Information only for the purposes described above or as required by law.

Patient Name: _____ **Date of Birth (mm/dd/yyyy):** _____

Patient Authorization for Use and Disclosure of Protected Health Information (continued)

I understand that I may refuse to sign this Authorization and that my refusal to sign this Authorization will not affect my right to treatment or payment of benefits for healthcare. I understand that if I refuse to sign, I will not be eligible to receive support through the Program. I may later withdraw this Authorization by sending written notice of my withdrawal from the Program to Serva Health LLC Attn CIYC, 1000 Bishops Gate Blvd, Suite 201, Mount Laurel, NJ, 08054. Withdrawal of this Authorization will end further uses and disclosures of my Information by my healthcare providers and health plans under this Authorization, except to the extent those uses and disclosures have been made in reliance on this Authorization and as permitted by applicable law. I am entitled to receive a copy of this signed Authorization, which expires 5 years after the date it is signed by me unless otherwise specified by state or other applicable law or revoked by me earlier in writing. MARYLAND HEALTHCARE PROVIDERS, under Md. Code HG § 4-303(b)(4) this authorization expires ONE YEAR from the date of signature.

By signing below, I have read and agree to the Patient Authorization for Use and Disclosure of Protected Health Information above and on page 2.

PATIENT NAME OR LEGAL REPRESENTATIVE _____ **SIGNATURE** _____ **DATE** _____

IF LEGAL REPRESENTATIVE, EXPLAIN AUTHORITY TO ACT ON BEHALF OF PATIENT AND RELATIONSHIP* _____

*By signing on behalf of the patient as representative or guardian, I attest that I am legally able to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient may be requested such as power of attorney or legal court order.

☐ **By checking this box, I agree to receive marketing and other communications from ANI Pharmaceuticals regarding Cortrophin Gel, in compliance with the Telephone Consumer Protection Act Consent below. I understand that not checking this box does not impact my enrollment in the *Cortrophin In Your Corner* support program.**

Patient Telephone Consumer Protection Act Consent to Receive Additional Information From ANI Pharmaceuticals or *Cortrophin In Your Corner*

I agree to receive marketing and other communications, including, but not limited to, transactional communications, offers, clinical trial opportunities, and educational materials and information related to my medical condition, treatment, and/or my prescription medication by autodialed SMS text messages and cell or other telephone calls. I understand that opting-in to receive these communications is not required as a condition of purchasing any goods or receiving a copay or other support from the Program. Message and data rates may apply. Message frequency may vary. Reply STOP to cancel and HELP for help. By checking the box to receive communications above, you consent to receive disclosures electronically instead of in paper form. You can withdraw your consent to receive these disclosures at any time without penalty, and you can request a paper copy for no fee by calling us at 1-800-805-5258. You can also call us at that number to update your contact information. To ensure you receive and can retain the necessary disclosures, you must have a device (such as your mobile phone) with internet access, and either a printer or storage space to save the disclosures.

This authorization will remain in effect until I cancel it, which I may do at any time by calling ANI Pharmaceuticals at 1-800-434-1121 or *Cortrophin In Your Corner* at 1-800-805-5258 Monday–Friday, 8 AM–8 PM ET. I may request a copy of this signed authorization.

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Patient Name: _____ **Date of Birth (mm/dd/yyyy):** _____

Possible Relevant ICD-10 Diagnosis Codes

Edematous States

M32.14 Glomerular disease in systemic lupus erythematosus
M32.15 Tubulo-interstitial nephropathy in systemic lupus erythematosus
N04.0 Nephrotic syndrome with minor glomerular abnormality
N04.1 Nephrotic syndrome with focal and segmental glomerular lesions
N04.2 Nephrotic syndrome with diffuse membranous glomerulonephritis
N04.20 Nephrotic syndrome with diffuse membranous glomerulonephritis, unspecified
N04.21 Primary membranous nephropathy with nephrotic syndrome
N04.29 Other nephrotic syndrome with diffuse membranous glomerulonephritis
N04.3 Nephrotic syndrome with diffuse mesangial proliferative glomerulonephritis
N04.B1 Nephrotic syndrome with idiopathic immune complex membranoproliferative glomerulonephritis (IC-MPGN)

Nervous System Disorders

G35.A Relapsing-remitting multiple sclerosis
G35.B0 Primary progressive multiple sclerosis, unspecified
G35.B1 Active primary progressive multiple sclerosis
G35.C0 Secondary progressive multiple sclerosis, unspecified
G35.C1 Active secondary progressive multiple sclerosis
G35.D Multiple sclerosis, unspecified
H46.8 Other optic neuritis

Rheumatic Disorders & Collagen Diseases

M05.79 Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement
M06.9 Rheumatoid arthritis, unspecified
M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
L40.50 Arthropathic psoriasis, unspecified
L40.59 Other psoriatic arthropathy
M32.9 Systemic lupus erythematosus, unspecified
M32.10 Systemic lupus erythematosus, organ or system involvement unspecified
M32.14 Glomerular disease in systemic lupus erythematosus
M33.12 Other dermatomyositis with myopathy
M33.20 Polymyositis, organ involvement unspecified
M33.22 Polymyositis with myopathy

Respiratory Diseases

D86.0 Sarcoidosis of lung
D86.1 Sarcoidosis of lymph nodes
D86.2 Sarcoidosis of lung with sarcoidosis of lymph nodes
D86.3 Sarcoidosis of skin
D86.81 Sarcoid meningitis
D86.82 Multiple cranial nerve palsies in sarcoidosis
D86.83 Sarcoid iridocyclitis
D86.84 Sarcoid pyelonephritis
D86.85 Sarcoid myocarditis
D86.86 Sarcoid arthropathy
D86.87 Sarcoid myositis
D86.89 Sarcoidosis of other sites
D86.9 Sarcoidosis, unspecified

Atopic Dermatitis

L20.0 Besnier's prurigo
L20.81 Atopic neurodermatitis
L20.82 Flexural eczema
L20.83 Infantile (acute) (chronic) eczema
L20.84 Intrinsic (allergic) eczema
L20.89 Other atopic dermatitis
L20.9 Atopic dermatitis, unspecified

Psoriasis

L40.0 Psoriasis vulgaris
L40.8 Other psoriasis
L40.9 Psoriasis, unspecified

(continued on page 6)

Please visit cortrophinhcp.com/ICD10 for a comprehensive list.

Important Safety Information

Contraindications

- Cortrophin Gel is contraindicated for intravenous administration.
- Cortrophin Gel is contraindicated in patients who have any of the following conditions: scleroderma; osteoporosis; systemic fungal infections; ocular herpes simplex; recent surgery; history of or the presence of a peptic ulcer; congestive heart failure; hypertension; primary adrenocortical insufficiency; adrenocortical hyperfunction; or sensitivity to proteins derived from porcine sources.

Warnings and Precautions

- **Infections:** Corticotropin therapy may increase susceptibility to infections and may mask the symptoms of infections.
- **Adrenal insufficiency:** Prolonged corticotropin therapy can increase the potential for adrenal insufficiency after withdrawal of the medication. Adrenal insufficiency may be minimized by gradually reducing the corticotropin dosage. Hormone therapy should be reinstituted if stressful situations arise during discontinuation.
- **Elevated blood pressure, salt and water retention, and hypokalemia:** Corticotropin can cause elevation of blood pressure, salt and water retention, and increased excretion of potassium or calcium.

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Patient Name: _____ **Date of Birth (mm/dd/yyyy):** _____

5 Specialty Pharmacy Prescription Submission

Please select one:

☐ I **HAVE NOT** submitted the prescription to a specialty pharmacy. *Note: A* Cortrophin In Your Corner *case manager will contact you to provide information on all potential specialty pharmacy options.*

☐ I **HAVE** already submitted the patient's prescription **to the following specialty pharmacy:**

Name of specialty pharmacy: _____ Phone: _____ Fax: _____

A complete list of specialty pharmacies where Cortrophin Gel is available can also be found by scanning this QR code or visiting cortrophinhcp.com/specialtypharmacies

Clinical Documentation

NOTE: Many prior authorization processes require a patient's relevant treatment history. Sections 6-10 of the Enrollment Form can be sent to the specialty pharmacy and/or payer as prior authorization or billed claim support.

☐ **Please forward this clinical documentation to payer for review on my behalf.**

☐ **Please request expedited review because patient is currently experiencing an acute flare.**

6 History of Corticosteroid Use (Check all that are applicable)

The following responses were seen during prior corticosteroid use:

- ☐ Patient had inadequate response or the use of corticosteroids failed and Cortrophin Gel is considered another potential treatment option
- ☐ Patient became intolerant to corticosteroids
- ☐ Patient was contraindicated for treatment or had a known corticosteroid intolerance
- ☐ Patient had no IV access
- ☐ Other: _____

If a corticosteroid was previously used, which agent was prescribed?

- ☐ IV or oral methylprednisolone
- ☐ IV or oral dexamethasone
- ☐ Oral prednisone
- ☐ Oral prednisolone
- ☐ Other: _____

7 Recent Relevant Treatment History (Include corticosteroid history)

Medication	Dose	Start Date	Stop Date (if applicable)	Treatment Details/Outcome

Important Safety Information (continued)

Warnings and Precautions (continued)

- **Masking symptoms of other diseases:** Corticotropin may only suppress signs and symptoms of chronic disease without altering the natural course of disease.
- **Psychiatric reactions:** Psychic derangements may appear when corticotropin is used, ranging from euphoria, insomnia, mood swings, personality changes, and depression to psychosis. Existing conditions may be aggravated.

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Patient Name: _____ **Date of Birth (mm/dd/yyyy):** _____

Possible Relevant ICD-10 Diagnosis Codes (continued)

Acute Gouty Arthritis (continued from page 4)

M10.00 Idiopathic gout, unspecified site
M10.011 Idiopathic gout, right shoulder
M10.012 Idiopathic gout, left shoulder
M10.019 Idiopathic gout, unspecified shoulder
M10.021 Idiopathic gout, right elbow
M10.022 Idiopathic gout, left elbow
M10.029 Idiopathic gout, unspecified elbow
M10.031 Idiopathic gout, right wrist
M10.032 Idiopathic gout, left wrist
M10.039 Idiopathic gout, unspecified wrist
M10.041 Idiopathic gout, right hand
M10.042 Idiopathic gout, left hand
M10.049 Idiopathic gout, unspecified hand
M10.051 Idiopathic gout, right hip
M10.052 Idiopathic gout, left hip
M10.059 Idiopathic gout, unspecified hip
M10.061 Idiopathic gout, right knee
M10.062 Idiopathic gout, left knee
M10.069 Idiopathic gout, unspecified knee
M10.071 Idiopathic gout, right ankle and foot
M10.072 Idiopathic gout, left ankle and foot
M10.079 Idiopathic gout, unspecified ankle and foot
M10.08 Idiopathic gout, vertebrae
M10.09 Idiopathic gout, multiple sites
M10.10 Lead-induced gout, unspecified site
M10.111 Lead-induced gout, right shoulder
M10.112 Lead-induced gout, left shoulder
M10.119 Lead-induced gout, unspecified shoulder
M10.121 Lead-induced gout, right elbow
M10.122 Lead-induced gout, left elbow
M10.129 Lead-induced gout, unspecified elbow
M10.131 Lead-induced gout, right wrist
M10.132 Lead-induced gout, left wrist
M10.139 Lead-induced gout, unspecified wrist
M10.141 Lead-induced gout, right hand
M10.142 Lead-induced gout, left hand
M10.149 Lead-induced gout, unspecified hand
M10.151 Lead-induced gout, right hip
M10.152 Lead-induced gout, left hip
M10.159 Lead-induced gout, unspecified hip
M10.161 Lead-induced gout, right knee
M10.162 Lead-induced gout, left knee
M10.169 Lead-induced gout, unspecified knee
M10.171 Lead-induced gout, right ankle and foot
M10.172 Lead-induced gout, left ankle and foot
M10.179 Lead-induced gout, unspecified ankle and foot
M10.18 Lead-induced gout, vertebrae
M10.19 Lead-induced gout, multiple sites
M10.20 Drug-induced gout, unspecified site
M10.211 Drug-induced gout, right shoulder
M10.212 Drug-induced gout, left shoulder
M10.219 Drug-induced gout, unspecified shoulder
M10.221 Drug-induced gout, right elbow
M10.222 Drug-induced gout, left elbow
M10.229 Drug-induced gout, unspecified elbow
M10.231 Drug-induced gout, right wrist
M10.232 Drug-induced gout, left wrist
M10.239 Drug-induced gout, unspecified wrist
M10.241 Drug-induced gout, right hand
M10.242 Drug-induced gout, left hand
M10.249 Drug-induced gout, unspecified hand
M10.251 Drug-induced gout, right hip
M10.252 Drug-induced gout, left hip
M10.259 Drug-induced gout, unspecified hip
M10.261 Drug-induced gout, right knee
M10.262 Drug-induced gout, left knee
M10.269 Drug-induced gout, unspecified knee
M10.271 Drug-induced gout, right ankle and foot
M10.272 Drug-induced gout, left ankle and foot
M10.279 Drug-induced gout, unspecified ankle and foot
M10.28 Drug-induced gout, vertebrae
M10.29 Drug-induced gout, multiple sites
M10.30 Gout due to renal impairment, unspecified site
M10.311 Gout due to renal impairment, right shoulder
M10.312 Gout due to renal impairment, left shoulder
M10.319 Gout due to renal impairment, unspecified shoulder
M10.321 Gout due to renal impairment, right elbow
M10.322 Gout due to renal impairment, left elbow
M10.329 Gout due to renal impairment, unspecified elbow
M10.331 Gout due to renal impairment, right wrist
M10.332 Gout due to renal impairment, left wrist
M10.339 Gout due to renal impairment, unspecified wrist
M10.341 Gout due to renal impairment, right hand
M10.342 Gout due to renal impairment, left hand
M10.349 Gout due to renal impairment, unspecified hand
M10.351 Gout due to renal impairment, right hip
M10.352 Gout due to renal impairment, left hip
M10.359 Gout due to renal impairment, unspecified hip
M10.361 Gout due to renal impairment, right knee
M10.362 Gout due to renal impairment, left knee
M10.369 Gout due to renal impairment, unspecified knee
M10.371 Gout due to renal impairment, right ankle and foot
M10.372 Gout due to renal impairment, left ankle and foot
M10.379 Gout due to renal impairment, unspecified ankle and foot
M10.38 Gout due to renal impairment, vertebrae
M10.39 Gout due to renal impairment, multiple sites
M10.40 Other secondary gout, unspecified site
M10.411 Other secondary gout, right shoulder
M10.412 Other secondary gout, left shoulder
M10.419 Other secondary gout, unspecified shoulder
M10.421 Other secondary gout, right elbow
M10.422 Other secondary gout, left elbow
M10.429 Other secondary gout, unspecified elbow
M10.431 Other secondary gout, right wrist
M10.432 Other secondary gout, left wrist
M10.439 Other secondary gout, unspecified wrist
M10.441 Other secondary gout, right hand
M10.442 Other secondary gout, left hand
M10.449 Other secondary gout, unspecified hand
M10.451 Other secondary gout, right hip
M10.452 Other secondary gout, left hip
M10.459 Other secondary gout, unspecified hip
M10.461 Other secondary gout, right knee
M10.462 Other secondary gout, left knee
M10.469 Other secondary gout, unspecified knee
M10.471 Other secondary gout, right ankle and foot
M10.472 Other secondary gout, left ankle and foot
M10.479 Other secondary gout, unspecified ankle and foot
M10.48 Other secondary gout, vertebrae
M10.49 Other secondary gout, multiple sites
M10.9 Gout, unspecified

For more possible relevant ICD-10 Diagnosis Codes associated with FDA-approved use, visit cortrophinhcp.com/ICD10 for a comprehensive list.

Important Safety Information (continued)

Warnings and Precautions (continued)

- **Ophthalmic reactions:** Prolonged use of corticotropin may produce posterior subcapsular cataracts and glaucoma with possible damage to the optic nerves.
- **Immunogenicity potential:** Prolonged administration of Cortrophin Gel may increase the risk of hypersensitivity reactions. Cases of anaphylaxis have been reported in the postmarketing setting. Neutralizing antibodies with chronic administration may lead to loss of endogenous ACTH and Cortrophin Gel activity.

Patient Name: _____ **Date of Birth (mm/dd/yyyy):** _____

8 FOR EDEMATOUS STATES: Medical Information

Is this for a kidney transplant patient?

☐ Yes ☐ No

Etiology

☐ Focal segmental glomerulosclerosis (FSGS)
☐ Minimal change disease (MCD)
☐ Membranous nephropathy (MN)
☐ IgA nephropathy (IgAN)
☐ Lupus nephritis (LN)

9 FOR ACUTE GOUTY ARTHRITIS: Medical Information

How many acute gout flares has this patient experienced in the past 12 months? _____

Urate-lowering therapies (ULTs)

Is the patient currently on a ULT? If so, which agent was prescribed?

☐ Xanthine oxidase inhibitors (allopurinol or febuxostat)
☐ Uricosuric agent (e.g., probenecid)
☐ Other: _____

If a ULT was previously used, which agent was prescribed?

☐ Xanthine oxidase inhibitors (allopurinol or febuxostat)
☐ Uricosuric agent (e.g., probenecid)
☐ Other: _____

The following responses were seen during ULT use:

☐ Patient currently on ULT
☐ Patient had inadequate response
☐ Patient became intolerant to ULTs
☐ Other: _____

What concurrent medication(s) is the patient taking?

Nonsteroidal anti-inflammatory drugs (NSAIDs)

☐ Indomethacin Dose: _____ Start Date: _____ Stop Date: _____
☐ Other: _____ Dose: _____ Start Date: _____ Stop Date: _____

The following responses were seen during NSAID use:

☐ Patient had inadequate response or the use of NSAIDs failed and Cortrophin Gel is considered another potential treatment option
☐ Patient became intolerant to NSAIDs
☐ Patient was contraindicated for treatment or had a known NSAID intolerance
☐ Other: _____

Colchicine, USP tablets

☐ Colcrys® (colchicine, USP) tablets Dose: _____ Start Date: _____ Stop Date: _____
☐ Other: _____ Dose: _____ Start Date: _____ Stop Date: _____

The following responses were seen during colchicine use:

☐ Patient had inadequate response or the use of colchicine failed and Cortrophin Gel is considered another potential treatment option
☐ Patient became intolerant to colchicine
☐ Patient was contraindicated for treatment or had a known colchicine intolerance
☐ Other: _____

10 FOR RHEUMATIC DISORDERS AND COLLAGEN DISEASES: Medical Information

Indicated Use Based on Diagnosis

If diagnosis is rheumatoid arthritis, including juvenile rheumatoid arthritis, Cortrophin Gel is prescribed as:

☐ Adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation)
☐ Low-dose maintenance therapy (in select cases)

For collagen diseases (systemic lupus erythematosus and systemic dermatomyositis/polymyositis), Cortrophin Gel is prescribed:

☐ During an exacerbation
☐ As maintenance therapy (in select cases)

☐ Other:

Organ Involvement (eg, lungs, bones, skin, etc)

Important Safety Information (continued)

Warnings and Precautions (continued)

- **Vaccination:** Patients should not be vaccinated against smallpox while on corticotropin therapy. Other immunizations should be undertaken with caution due to possible neurologic complications and lack of antibody response.
- **Use in patients with hypothyroidism and cirrhosis:** There is an enhanced effect in patients with hypothyroidism and in those with cirrhosis.

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Patient Name: _____ **Date of Birth (mm/dd/yyyy):** _____

11 Additional Information to Include With Enrollment Form

Please attach all relevant clinical notes (including any allergies and all concurrent medications) and any other information pertinent to your rationale for treatment with Cortrophin Gel, or write that information in the space below.

☐ I am attaching a separate document of relevant clinical notes

☐ I am writing relevant clinical notes in the space provided here

Important Safety Information (continued)

Warnings and Precautions (continued)

- **Use in patients with latent tuberculosis or tuberculin reactivity:** Closely observe for reactivation of the disease.
- **Comorbid diseases:** Corticotropin should be used with caution in patients with diabetes, abscess, pyogenic infections, diverticulitis, renal insufficiency, and myasthenia gravis.
- **Growth and development:** Carefully observe growth and development of infants and children on prolonged corticotropin therapy.
- **Acute gouty arthritis:** Treatment of acute gouty arthritis should be limited to a few days. Conventional concomitant therapy should be administered during corticotropin treatment and for several days after it is stopped.
- **Drug interactions:** Aspirin should be used cautiously with corticotropin in hypoprothrombinemia.
- **Pregnancy:** Since fetal abnormalities have been observed in animals, Cortrophin Gel should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Adverse Reactions

Adverse reactions for Cortrophin Gel include fluid or sodium retention; muscle weakness; osteoporosis; peptic ulcer with possible perforation and hemorrhage; injection site reactions; impaired wound healing; hypertension; convulsions; headache; development of Cushingoid state; suppression of growth in children; anaphylaxis (anaphylactic shock, urticaria, respiratory compromise, edema); and weight gain. These are not all the adverse reactions reported with Cortrophin Gel.

Indications

Cortrophin Gel is a prescription medicine that is injected subcutaneously or intramuscularly. It is indicated for:

- Short-term administration as an adjunctive therapy during an acute episode or exacerbation in rheumatoid arthritis, including juvenile rheumatoid arthritis; psoriatic arthritis; ankylosing spondylitis; and acute gouty arthritis.
- Exacerbations or as maintenance therapy in select cases of systemic lupus erythematosus and systemic dermatomyositis (polymyositis).
- Severe erythema multiforme (Stevens-Johnson syndrome) and severe psoriasis.
- Atopic dermatitis and serum sickness.
- Severe acute and chronic allergic and inflammatory conditions affecting the eye and its adnexa, such as allergic conjunctivitis, keratitis, iritis and iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, and anterior segment inflammation.
- Symptomatic sarcoidosis.
- Inducing a diuresis or remission of proteinuria due to nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus.
- Acute exacerbations of multiple sclerosis.

Please see Indications and Important Safety Information on pages 4-8 and accompanying full Prescribing Information or visit cortrophinhcp.com.

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