

Hulio360[™] Enrollment and Prescription Form

Designed Around You

Patients can be enrolled into the HULIO360 Program two ways:

1. Fax – Complete this Enrollment and Prescription Form in its entirety and fax it to 866-335-7539.
2. E-Prescription – Send an electronic prescription for HULIO® (adalimumab-fkjp) through your EHR directly to The Lash Group (1800 Innovation Pt, Fort Mill, SC 29715; NCPDP: 4237942). Please make sure your patient's cell phone number* is on file in your EHR so it is included with the e-prescription. HULIO360 will text and call your patient as part of the enrollment process for this prescription.

By submitting this form or e-prescribing HULIO to The Lash Group, you are requesting support services on behalf of the patient named below. Services include but are not limited to: benefits verification, prior authorization assistance, assistance with appeals, copay assistance, alternate funding options, prescription triage, nursing services, injection training, Welcome Kit with Travel Bag, and Sharps container.

1. PATIENT INFORMATION

First Name	Middle Initial	Last Name	
_____	_____	_____	
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Date Of Birth (MM/DD/YYYY)	_____		
Address 1	_____		
Address 2	City	State	Zip
_____	_____	_____	_____
Home Phone Number*	Mobile Phone Number*	Email Address	
_____	_____	_____	

*By providing the patient's phone number, you represent that your patient is aware of the disclosure and has given consent to be contacted by Biocon Biologics Inc. regarding this prescription, as well as the pharmacy fulfilling the prescription.

2. INSURANCE INFORMATION *Fax both sides of your patient's medical and prescription benefit insurance card.* Patient has no insurance

Beneficiary Name:	First Name	Middle Initial	Last Name	
_____	_____	_____	_____	
Medical Insurance:	Provider	Policy Number	Group Number	Phone Number
_____	_____	_____	_____	_____
Pharmacy Insurance:	Provider	Member ID	PCN (If Applicable)	
_____	_____	_____	_____	
	Group ID	BIN (If Applicable)		
	_____	_____		

3. PRESCRIPTION INFORMATION *Check the box for prescription required.*

- | | | |
|---|---|---|
| <input type="checkbox"/> HULIO Pen (adalimumab-fkjp) injection 40mg/0.8mL | <input type="checkbox"/> HULIO PFS (adalimumab-fkjp) injection 20mg/0.4mL | <input type="checkbox"/> HULIO PFS (adalimumab-fkjp) injection 40mg/0.8mL |
| <input type="checkbox"/> Adalimumab-fkjp Pen injection 40mg/0.8mL | <input type="checkbox"/> Adalimumab-fkjp PFS injection 20mg/0.4mL | <input type="checkbox"/> Adalimumab-fkjp PFS injection 40mg/0.8mL |

Starting therapy (if applicable):

Direction	Quantity
_____	_____
No Refills	_____
Quantity of Boxes (2 doses per box)	Refills
_____	_____
Primary ICD-10 Code (Required)	_____

Ongoing therapy:

Inject _____ mg subcutaneously every _____ days	
Direction	

Quantity of Boxes (2 doses per box)	Refills
_____	_____
Secondary ICD-10 Code (Optional)	_____

Patient's preferred specialty pharmacy	Phone Number	<input type="checkbox"/> Check if sent to specialty pharmacy
_____	_____	

Note: Payer-mandated pharmacies may take first precedence, followed by preferred by specialty pharmacy.

4. PRESCRIBER INFORMATION

First Name	Last Name	Facility Name	
_____	_____	_____	
Address	City	State	Zip
_____	_____	_____	_____
Phone Number	Fax Number	NPI Number (required)	Office Contact Name
_____	_____	_____	_____
Prescriber's Signature: (Required)	Supervising Physician's Signature: (Where Required)	Date	
_____	_____	_____	

By completing and transmitting this form, I am certifying that I have received from my patient and have on file the patient's HIPAA consent and all other necessary permissions from my patient authorizing the release of the patient's identification and insurance information, including the information I have provided above, to Biocon Biologics Inc., its affiliates, its program administrator, and their respective agents and service providers (collectively, "HULIO360") for them to use in providing the patient with benefit verification and patient support services as described herein.

In the absence of ERx, if required by applicable state law, please attach copy of prescription on official state prescription form. (Ex. Official NY State Prescription ONYSRx)

HULIO is a registered trademark and HULIO360 is a trademark of Fujifilm Kyowa Kirin Biologics Co., Ltd., licensed use by Biosimilar Collaborations Ireland Limited, a Biocon Biologics.

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