NUWIQ®
Antihemophilic Factor
(Recombinant)

octapharma
For the safe and optimal use of human proteins

FREE TRIAL REQUEST FORM

PRESCRIBER INSTRUCTIONS:

Please review and fill out this form in its entirety. This free trial may be redeemed for a one-time trial supply of NUWIQ® for up to 6 doses not to exceed 20,000 IU's as prescribed for your patient. The trial supply will be shipped to the patient at the address provided on this form.

If you have questions, please contact the Factor My Way Support Center at 1-855-498-4260. Hours of operation are Monday - Friday from 8:30am - 5:00pm EDT

In order for the free trial request to be fulfilled you must fax the following to Covance at 1-800-554-6744

- A valid prescription for NUWIQ®, Antihemophilic Factor (Recombinant) for the patient indicated below; and
- A fully completed NUWIQ Free Trial Request Form with both physician and patient/guardian signatures

PRESCRIBER INFORMATION:

Prescriber Name _____
Facility Name _____
Prescriber Address _____
City _____ State _____ ZIP _____
State License _____
Phone _____
Fax # _____
NPI # _____
Office Contact Name _____
Email (used to confirm shipment of product) _____

PATIENT INFORMATION:

Name_____
Contact Phone_____
Patient Address _____
City _____ State _____ ZIP _____
Date of Birth _____
Email _____
Language preference: ☐English ☐Spanish ☐Other _____
Current Therapy _____

PRESCRIPTION INFORMATION:

NUWIQ® Antihemophilic Factor (Recombinant)

Available Vial Sizes (250 IU, 500 IU, 1000 IU, 2000 IU, 2500 IU, 3000 IU, or 4000 IU)

Patient Weight ☐ KG _____ ☐ LB _____

Dose IU/kg _____ Total IU's Required for one dose of NUWIQ® _____

Additional Prescriber Instructions: _____
_____

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PROGRAM REQUIREMENTS:

The Octapharma NUWIQ Free Trial program is for a maximum of one trial shipment per patient's lifetime. It is illegal for any person to sell, purchase, or trade; or to offer to sell, purchase, or trade or to counterfeit a NUWIQ Free Trial offer. The NUWIQ Free Trial program is valid only for product to be dispensed by a pharmacy designated by Covance up to the limits above. Program eligibility does not require any future purchases or orders for NUWIQ® and does not require any additional prescription(s) or refills to be filled. Product dispensed pursuant to the terms of the NUWIQ Free Trial program shall not be billed to any patient or third-party payer, public (e.g. Medicaid, Medicare or any other similar federal or state healthcare program) or private. Offer good only in the United States and cannot be combined with any other free trial, coupon, rebate or similar offer. Octapharma reserves the right to rescind, revoke or amend this program without notice. The NUWIQ Free Trial program is valid for NUWIQ® only – No substitutions permitted. The NUWIQ Free Trial program is good for one fill only and refills will not be authorized. Void where prohibited by law. This is not insurance.

TO BE COMPLETED BY LICENSED PRESCRIBER:

I have read and agree to the terms and conditions of the NUWIQ Free Trial Program. In submitting this form, I request that NUWIQ Free Trial product be shipped to my office, and I agree that I will not seek payment from any person or entity for such product. I attest that I have obtained the patient's affirmative authorization to release the above information as may be necessary to Octapharma. If patient is younger than 18 years, I attest that I have obtained authorization from the patient's legal guardian.

Prescriber Signature: _____ **Date:** _____

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 delay.

PATIENT CONSENT AND HIPAA AUTHORIZATION:

Covance, Inc. is operating the Octapharma NUWIQ Free Trial Program and providing services on behalf of Octapharma, in accordance with all applicable HIPAA requirements. I authorize Covance, Inc. to contact my healthcare provider, in order to release and disclose to such parties all relevant medical records, insurance and third-party payor information, and to send my NUWIQ® Antihemophilic Factor (Recombinant) prescription, via mail, fax or other mode of delivery, to the specialty pharmacy designated by Covance, Inc in order to facilitate dispensing of NUWIQ® to me. I also authorize my health-care provider to release and disclose to Covance, Inc. such health information as is necessary to fulfill the above listed purposes. I understand that once information is disclosed it may no longer be protected by federal health information privacy laws and it is possible it may be re-disclosed.

☐ I understand that I need to enroll into the Factor My Way program to be eligible for the NUWIQ Free Trial Program.
Register at www.factormyway.com or by calling the Factor My Way Support Center at 1-855-498-4260

Patient Name: _____

Patient Signature: _____

Parent/Guardian (If patient is under 18 years of age): _____

Date: _____

Please fax this 2-page enrollment form when completed to Covance at 1-800-554-6744