Helixate FS Trial Product Request Form

The Helixate FS Trial Program is available only to those patients who have not previously enrolled in this program and are not currently on Helixate FS.

Instructions for Patients:

1. Complete the patient information section on the next page and bring it to your healthcare professional.
2. Ask your healthcare professional to complete the prescriber information and prescription information sections of this form.

Important: This form must be filled out completely and signed by your healthcare professional or it will not be processed.

Your free trial product and welcome kit will be sent to you at the address you specify on the request form. Be sure to include your telephone number with your address so shipment arrangements can be confirmed.

Instructions for Prescriber:

1. Complete form and sign authorization.
2. Patients are eligible for up to 6 doses of Helixate FS with a maximum of 20,000 IU.
3. Fax the completed form to 1-888-747-9329 or mail to: The Alliance Pharmacy
   Helixate FS Trial Program
   44 Bond Street
   Westbury, NY 11590

Please complete and fax the form on the next page.

This prescription will be filled and shipped via overnight courier directly to the patient's or physician's address of choice as indicated below:

Please ship to (select one): Patient's address ❑ Physician's address ❑

Patient Information:

First Name: _____ Last Name: _____ DOB: _____

Contact Phone No: _____ Alternate Phone No: _____

E-mail Address: _____ (e-mail is used to inform you of expected arrival date)

Shipping Address (No PO Boxes): _____

City: _____ State: _____ Zip Code: _____

Patient Permission:

Important: Your answers to the following questions do not disqualify you from participation in the Helixate FS free trial program.

1. I authorize an independent, third party to contact me for a follow-up survey about my experience with this program (select one): Yes ❑ No ❑
2. I authorize the administrator of this program to share my information with CSL Behring so I may receive information on product updates and new developments (select one): Yes ❑ No ❑

Prescriber Information:

Physician's Name: _____ Facility Name: _____

State License #: _____

Physician's Address: _____

City: _____ State: _____ Zip Code: _____

Contact name for this product request: _____

Phone: _____ E-mail: _____
(e-mail is used to confirm shipment of product)

Prescription Information:

Patient weight: ____ lb ____ kg Baseline FVIII: _____% Target FVIII activity desired: _____%

Total Helixate FS IU required for 1 dose: _____

Number of doses requested: _____ (Max 6 doses or up to 20,000 IU)

Special Instructions: _____

Authorized refills – 0. This prescription is valid for one time only with no refills.

Physician/Prescriber Authorization: I hereby verify that the above patient has no treatment history with the brand-named product requested. This trial product will not be exported or transferred in exchange for money, other property, or services. No portion of this trial product will be used for reimbursement purposes from Medicaid/Medicare or any other third-party program, which provides cost or charge-based reimbursement to the participating institution, either directly or indirectly.

Physician/Prescriber Signature: _____ Date: _____

NPI #: _____

❑ I would like a CSL Behring representative to contact me.

Helixate FS is manufactured by Bayer HealthCare LLC for CSL Behring LLC.
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Helixate® FS Antihemophilic Factor (Recombinant) Formulated with Sucrose | FactorPLUS™