HORIZON
PATIENT SERVICES™

PROCYSBI® (CYSTEAMINE BITARTRATE) DELAYED-RELEASE CAPSULES PRESCRIPTION ENROLLMENT FORM INSTRUCTIONS

The Prescription Enrollment Form is required to initiate treatment with Horizon Pharma's prescription medicine, PROCYSBI.

Instructions:

1. Fill out all patient information, including the most recent results of a white blood cell (WBC) cystine level test, recent history with CYSTAGON® (cysteamine bitartrate) capsules, and use of a gastrostomy tube.
2. Fill out all required prescriber information, including all contact information for the practice or facility.
3. Complete and/or review all required insurance information for the patient and, if possible, attach copies of the patient's insurance cards for primary as well as supplementary insurance.
4. Complete the prescription and clinical information in its entirety; all fields are required. Reference the included select PROCYSBI dosing instructions or the PROCYSBI Prescribing Information for complete dosing information.
5. Review, sign, and date the prescriber certification at the bottom of the Prescription Enrollment Form. In signing, you are indicating to dispense PROCYSBI as written. If a substitution is allowed, it should be noted.
6. Check with your patient to ensure he or she has printed, signed, and dated the required Patient Authorization Form providing HIPAA authorization for Horizon Patient Services and initiation of patient support.
7. Fax pages 1 and 2 of this form, along with both sides of the patient's medical and prescription drug benefit cards, to Horizon Patient Services at 877-773-9411, or email them to HPSPRO@horizonpharma.com. Retain a copy of this form in the patient's records.

Please see Important Safety Information inside and the enclosed PROCYSBI® Full Prescribing Information.

HORIZON PHARMA

HORIZON PATIENT SERVICES™

PROCYSBI® (CYSTEAMINE BITARTRATE) DELAYED-RELEASE CAPSULES PRESCRIPTION ENROLLMENT FORM

Please fax completed form to 877-773-9411, or email it to HPSPRO@horizonpharma.com.

HORIZON PHARMA
Phone: 855-888-4004
Fax: 877-773-9411
PROCYSBI.com

1. PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____

Date of Birth _____ Gender ☐ M ☐ F Height _____ Weight _____

Email _____ Preferred Method of Contact ☐ Home ☐ Mobile ☐ Email ☐ Mail

Currently taking CYSTAGON? ☐ Yes ☐ No

Last CYSTAGON daily dose (mg/day) _____

Currently on dialysis? ☐ Yes ☐ No

Does the patient have a G-tube (feeding tube)? ☐ Yes ☐ No

White blood cell (WBC) test in the last year? ☐ Yes ☐ No

(A bolus [straight] feeding tube 14 French or larger is recommended.)

ALTERNATIVE CONTACT AND/OR CAREGIVER

Best Time to Contact _____

First Name _____ MI _____ Last Name _____

Home Phone _____ Mobile Phone _____

Email _____ Preferred Method of Contact ☐ Home ☐ Mobile ☐ Email ☐ Mail

2. PRESCRIBER INFORMATION

Prescriber First Name _____ MI _____ Last Name _____ Prescriber NPI# _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ Physician Specialty _____

Office Contact Name _____ Email _____ Phone _____

3. INSURANCE INFORMATION — Please attach a copy of both sides of the patient's insurance card(s). ■ No Insurance

PRIMARY INSURANCE

Insurance Carrier _____

Customer Service Phone _____

Subscriber Name _____

Patient's Relationship to Subscriber _____

Subscriber Date of Birth _____

Subscriber ID Number _____

Policy/Employer/Group Number _____

SECONDARY INSURANCE (If any)

Insurance Carrier _____

Customer Service Phone _____

Subscriber Name _____

Patient's Relationship to Subscriber _____

Subscriber Date of Birth _____

Subscriber ID Number _____

Policy/Employer/Group Number _____

Prescription Card? ☐ Yes If Yes, Carrier: _____ Phone: _____

4. PRESCRIPTION AND CLINICAL INFORMATION

Diagnosis (ICD-10-CM Code) ☐ E72.04 ☐ Other _____

Drug Name: PROCYSBI® (cysteamine bitartrate) delayed-release capsules

Directions: _____ mg Prescribed Total Daily Dose _____ Days' Supply _____ Refills

Eg, 600 mg q12h or 500 mg (6 x 75 mg capsules + 2 x 25 mg capsules) q12h.
Dose Titration Eg, 600 mg (8 x 75-mg capsules) q12h; starting at 150 mg (2 x 75-mg capsules) q12h for one week, increase by one 75-mg capsule per dose per week over 6 weeks to reach target dose of 600 mg q12h.

Note: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc.

Is the patient allergic to penicillamine, cysteamine, or any other medication? If yes, please list:

Allergies _____

Prescriber Certification

By signing below, I certify that (a) the above therapy is medically necessary and that I will supervise the patient's treatment accordingly, and (b) I have received the necessary authorizations, including those required by state law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to release the above information and other health and medical information of the patient to Horizon Pharma USA, Inc. and its affiliates and their respective agents and contracted dispensing pharmacies to assist the patient in obtaining coverage for PROCYSBI. I appoint Horizon Pharma USA, Inc. and its affiliates and their respective agents to convey this prescription to the dispensing pharmacy.

By filling out this form, you automatically enroll your patient with cystinosis into the Patient Services Programs, which includes assistance from patient access managers.

☐ Check here if you choose not to enroll this patient in the Patient Services Programs.

X Prescriber Signature _____ Date _____ _____

(Dispense as Written) (Substitution Permitted)

HORIZON PATIENT SERVICES™

PROCYSBI® (CYSTEAMINE BITARTRATE) DELAYED-RELEASE CAPSULES PRESCRIPTION ENROLLMENT FORM

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HORIZON PHARMA
Phone: 855-888-4004
Fax: 877-773-9411
PROCYSBI.com

HIPAA Authorization

I hereby authorize my healthcare providers, my health insurance carriers, and my pharmacies to use and disclose my individually identifiable health information, including my medical records, insurance coverage information, and my name, address and telephone number to Horizon Pharma USA, Inc. and its affiliates and their respective agents and representatives (collectively, "Horizon"), including third parties authorized by Horizon to administer drug support and to dispense drugs (collectively, "Horizon Patient Services") for the following purposes: (1) to establish eligibility for benefits; (2) to communicate with healthcare providers and me about my medical care; (3) to facilitate the provision of products, supplies, or services by a third party including, but not limited to, specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; (5) to enroll me in eligible patient support programs offered by Horizon Patient Services and/or Horizon, including nursing or patient access support services (government-reimbursed programs may not be eligible for all support services offered; please contact Horizon Patient Services for determination); and (6) to send me marketing information related to my treatment or condition (or related products or services in which I might be interested) and to contact me occasionally to obtain my feedback (for market research purposes only) about my treatment, my condition, or my experience with Horizon and/or Horizon Patient Services otherwise as required or permitted by law. I understand the pharmacies may receive a fee from Horizon in exchange for (1) providing me with certain materials and information described above, and (2) using or disclosing certain health information pursuant to this Authorization.

I understand that Horizon, as well as my healthcare providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment, or other care, to sign this Authorization. I understand that I am entitled to a copy of this Authorization. I understand that information disclosed pursuant to this Authorization in some cases may be redisclosed by the recipient and no longer protected by HIPAA or other privacy laws. But Horizon has agreed to use and disclose my information only for purposes of operating the program.

I understand that I may cancel this Authorization at any time by mailing a signed letter requesting such cancellation to Horizon Patient Services, 150 South Saunders Rd, Lake Forest, IL 60045, but that this cancellation will not apply to any information used or disclosed by my healthcare providers and/or health insurance carriers based on this Authorization before they are notified that I have cancelled it. Unless required by state law, this Authorization is valid for whichever is greater: (a) the duration of remaining on this treatment or (b) 10 years from the date signed below.
A photocopy of this Authorization will be treated in the same manner as the original.

Date: _____

Patient's Printed Name: _____

Patient's/Legally Authorized Representative's Signature: _____

Legally Authorized Representative's Printed Name (if required): _____

Patient's/Legally Authorized Representative's Home Address:

Street Address: _____

City: _____ State: _____ Zip Code: _____

Patient's/Legally Authorized Representative's Telephone: _____ ☐ Home ☐ Mobile

Patient's/Legally Authorized Representative's Email Address: _____

Legally Authorized Representative's Relationship to Patient: ☐ Spouse ☐ Parent/Legal Guardian ☐ Representative per Power of Attorney

Is there someone else with whom we may discuss your protected health information? ☐ No ☐ Yes

Name: _____

Name: _____

Relationship to you: _____

HORIZON PHARMA

PROCYSBI DOSING INFORMATION

FOR HEALTHCARE PRESCRIBERS

PROCYSBI® (cysteamine bitartrate) delayed-release capsules

PROCYSBI is available as[1]:	**25 mg: 60 delayed-release capsules/bottle** **75 mg: 250 delayed-release capsules/bottle**

Patients converting to PROCYSBI from immediate-release (IR) cysteamine (CYSTAGON)[1]:

- When switching patients from immediate-release cysteamine bitartrate to PROCYSBI, the starting total daily dose of PROCYSBI is equal to the previous total daily dose of immediate-release cysteamine bitartrate. Divide the total daily dose by 2 and administer every 12 hours.

Patients starting PROCYSBI who are cysteamine naïve[1]:

- Treatment with cysteamine should be started immediately after diagnosis.
- Patients should be started on PROCYSBI at a fraction (1/6 to 1/4) of the maintenance dosage and gradually titrated up to the maintenance dosage over 4 to 6 weeks.
  - Patients 1 year to less than 6 years: Increase the dosage in 10% increments to the maintenance dosage, while monitoring white blood cell (WBC) cystine concentrations. Allow a minimum of 2 weeks between dosage adjustments. If a patient achieves the therapeutic target WBC cystine concentration at a dosage below the recommended weight-based maintenance dosage, then stop dosage escalation and use the dosage as the patient's maintenance dosage.
  - Patients 6 years of age and older: Gradually increase the dosage over 4 to 6 weeks until the maintenance dosage is achieved.
- The maintenance dosage after initial dose escalation is 1.3 g/m^2 of body surface area per day divided into 2 doses given every 12 hours. The table below shows the recommended starting and maintenance dosages of PROCYSBI, converted from body surface area to body weight.

Starting and Maintenance Dosage of PROCYSBI by Body Weight in Cysteamine-Naïve Patients 1 Year of Age and Older (Dosage Rounded Using Available Capsule Strengths)

Weight in kilograms	Starting PROCYSBI Dosage in mg every 12 hours, as a Fraction of the Maintenance Dosage		Maintenance PROCYSBI Dosage in mg every 12 hours*
	1/6 of dosage	1/4 of dosage	
5 or less	25	50	200
6 to 10	50	75	300
11 to 15	75	100	400
16 to 20	100	125	500
21 to 25	100	150	600
26 to 30	125	175	700
31 to 40	125	200	800
41 to 50	150	225	900
51 and greater	175	250	1000

*Higher dosages may be required to achieve target therapeutic WBC cystine concentration.

Monitoring dosage[1]:

- If a patient's precise calculated dosage cannot be obtained, round to the nearest 25 mg. Only use whole capsules.
- After maintenance dosage of PROCYSBI has been achieved, measure the WBC cystine concentration and titrate the PROCYSBI dosage as needed to achieve target WBC cystine concentrations.
- If a dosage adjustment is necessary, increase the dosage by 10%. For patients 1 year to less than 6 years of age, allow a minimum of 2 weeks between dose increments. The maximum dosage of PROCYSBI is 1.95 g/m^2 per day.

If tolerability issues occur with PROCYSBI[1]:

- **If adverse reactions occur, decrease the PROCYSBI dosage and then gradually increase to the maintenance dosage. For cysteamine-naïve patients who have initial intolerance, temporarily discontinue PROCYSBI and then restart at a lower dosage and gradually increase to the maintenance dosage.**

Please see accompanying Full Prescribing Information for complete dosing and administration instructions.

Adherence to cystine-depleting therapy is critical for optimal cystine control.[2,3]

- Patients/caregivers should be urged to take PROCYSBI consistently according to the dosing schedule recommended in the prescribing information.[1]

References: 1. PROCYSBI [package insert]. Lake Forest, IL.: Horizon Pharma USA, Inc; 12/2017. **2.** Gahl WA, Thoene JG, Schneider JA. Cystinosis. *N Engl J Med*. 2002;347(2):111-121. **3.** Brodin-Sartorius A, Tête M-J, Niaudet P, et al. Cysteamine therapy delays the progression of nephropathic cystinosis in late adolescents and adults. *Kidney Int*. 2012;81(2):179-189.

Please see Important Safety Information on next page and the enclosed PROCYSBI Full Prescribing Information.

IMPORTANT SAFETY INFORMATION

PROCYSBI® (cysteamine bitartrate) delayed-release capsules

INDICATIONS AND USAGE: PROCYSBI® (cysteamine bitartrate) delayed-release capsules is a cystine depleting agent indicated for the treatment of nephropathic cystinosis in adult and pediatric patients 1 year of age and older.

CONTRAINDICATIONS:

- Serious hypersensitivity reaction, including anaphylaxis to penicillamine or cysteamine.

WARNINGS AND PRECAUTIONS:

- **Ehlers-Danlos-like Syndrome:** Skin and bone lesions that resemble clinical findings for Ehlers-Danlos-like syndrome have been reported in patients treated with high doses of immediate-release cysteamine bitartrate or other cysteamine salts.
  - o These include molluscoid pseudotumors (purplish hemorrhagic lesions), skin striae, bone lesions (including osteopenia, compression fractures, scoliosis and genu valgum), leg pain, and joint hyperextension.
  - o One patient on immediate-release cysteamine bitartrate with serious skin lesions subsequently died of acute cerebral ischemia with marked vasculopathy.
  - o Monitor patients for development of skin or bone lesions and interrupt PROCYSBI dosing if patients develop these lesions. PROCYSBI may be restarted at a lower dose under close supervision, then slowly increase to the appropriate therapeutic dose.

- **Skin Rash:** Severe skin rashes such as erythema multiforme bullosa or toxic epidermal necrolysis have been reported in patients receiving immediate-release cysteamine bitartrate. If severe skin rashes develop, permanently discontinue use of PROCYSBI.

- **Gastrointestinal Ulcers and Bleeding:** Gastrointestinal (GI) ulceration and bleeding have been reported in patients receiving immediate-release cysteamine bitartrate.
  - o GI tract symptoms including nausea, vomiting, anorexia and abdominal pain, sometimes severe, have been associated with cysteamine. If severe GI tract symptoms develop, consider decreasing the dose of PROCYSBI.

- **Central Nervous System Symptoms:** Central Nervous System (CNS) symptoms such as seizures, lethargy, somnolence, depression, and encephalopathy have been associated with immediate-release cysteamine.
  - o Neurological complications have also been described in some patients with cystinosis who have not been treated with cysteamine.
  - o Carefully evaluate and monitor patients who develop CNS symptoms. Interrupt medication or adjust the dose as necessary for patients with severe symptoms or with symptoms that persist or progress.
  - o Inform patients that PROCYSBI may impair their ability to perform tasks such as driving or operating machinery.

- **Leukopenia and/or Elevated Alkaline Phosphatase Levels:** Cysteamine has been associated with reversible leukopenia and elevated alkaline phosphatase levels. Monitor white blood cell counts and alkaline phosphatase levels. If tests values remain elevated, consider decreasing the dose or discontinuing the drug until values revert to normal.

- **Benign Intracranial Hypertension:** Benign intracranial hypertension (pseudotumor cerebri; PTC) and/or papilledema has been reported in patients receiving immediate- release cysteamine bitartrate treatment.
  - o Monitor patients for signs and symptoms of PTC, including headache, tinnitus, dizziness, nausea, diplopia, blurry vision, loss of vision, pain behind the eye or pain with eye movement. If signs/symptoms persist, interrupt dosing or decrease the dose and refer the patient to an ophthalmologist. If the diagnosis is confirmed, permanently discontinue use of PROCYSBI.

ADVERSE REACTIONS:

The most common adverse reactions (≥5%) in patients treated in clinical trials are vomiting, nausea, gastroenteritis / viral gastroenteritis, abdominal pain, breath odor, diarrhea, skin odor, fatigue, rash, headache, and electrolyte imbalance.

To report SUSPECTED ADVERSE REACTIONS,
contact Horizon Pharma USA, Inc. at 1-855-888-4004 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS:

- Drugs that Increase Gastric pH: Administer PROCYSBI at least 1 hour before or 1 hour after medications containing bicarbonate or carbonate.

- Consumption of alcohol with PROCYSBI may increase the rate of cysteamine release and/or adversely alter the pharmacokinetic properties, as well as the effectiveness and safety of PROCYSBI.

- PROCYSBI can be administered with electrolyte (except bicarbonate) and mineral replacements necessary for management of Fanconi Syndrome as well as vitamin D and thyroid hormone.

USE IN SPECIFIC POPULATIONS

Lactation:

- Breastfeeding is not recommended while taking PROCYSBI.

Please see the enclosed PROCYSBI Full Prescribing Information.

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