

## INSTRUCTIONS FOR HEALTHCARE PROFESSIONALS



Complete all required fields with an asterisk



Have your patient complete and sign the Patient Information section (page 1) after reading the Patient Authorization in Section 6 (page 3)



Sign the Prescriber Certification in Section 5 (page 2)



Fax this completed form (pages 1-3) to 855-299-8746 or email it to [info@AnzupgoLetsGo.com](mailto:info@AnzupgoLetsGo.com)

Alternatively, complete and submit the digital enrollment form directly at [Anzupgohcp.com/access-and-resources/access](https://Anzupgohcp.com/access-and-resources/access)

## \*Required

## SECTION 1: Patient Information (to be completed by patient)

**Note: Patients enrolling in the ANZUPGO® Let's GO™ Support Program must be at least 18 years of age.**

Patient name\*: \_\_\_\_\_ Date of birth\*: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender\*: ☐ M ☐ F ☐ Non-binary  
FIRST MI LAST MM DD YYYY

Address\*: \_\_\_\_\_ City\*: \_\_\_\_\_ State\*: \_\_\_\_\_ ZIP\*: \_\_\_\_\_

Primary phone\*: \_\_\_\_\_ Alternate phone\*: \_\_\_\_\_ OK to leave a detailed message? ☐ Yes ☐ No

Preferred contact method: ☐ Text ☐ Call ☐ Email Preferred time of day to contact: ☐ Morning ☐ Afternoon ☐ Evening

Email\*: \_\_\_\_\_ Primary language: \_\_\_\_\_

Legal representative name (if applicable): \_\_\_\_\_ FIRST LAST

Legal representative phone number: \_\_\_\_\_ Legal representative email: \_\_\_\_\_

- ☐ **Must check box if applying for Patient Assistance Program (PAP)** – I agree this is written authorization for LEO Pharma and its vendors under the Fair Credit Reporting Act (FCRA), to obtain information from my credit profile or other information, solely for the purpose of determining financial qualifications for PAP administered by LEO Pharma. I understand that I must affirmatively agree to these terms to proceed with the financial screening process, which is a condition of participation in PAP.
- ☐ **(Optional) I am 18 years of age or older and want to receive helpful tips and resources** about LEO Pharma Inc. and its products and services, including research opportunities, promotional materials about products, disease education, or other savings programs. By checking the box, I agree to be contacted by LEO Pharma Inc. and its service providers to receive marketing communications, including by email, SMS, call, or text message. I understand that I may opt out at any time by calling 1-855-ANZUPGO (269-8746) or by contacting us following the instructions in How to Contact Us in the LEO Pharma Privacy Policy at [Leo-pharma.us/privacy-policy](https://Leo-pharma.us/privacy-policy). Consent is not a condition of receipt of goods or services. Message frequency may vary. Text HELP for info. Text STOP to cancel. Message and data rates may apply.

For details about how we collect and use personal information, including individual privacy rights, please see LEO Pharma privacy policy, located at [Leo-pharma.us/privacy-policy](https://Leo-pharma.us/privacy-policy).

**Patient Authorization:** I certify that I have read the Patient Authorization in Section 6 (page 3), and I authorize the disclosure of my information to LEO Pharma as described.

SIGN  
HERE\*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient/legal representative signature MM DD YYYY

\_\_\_\_\_  
Relationship to patient (if applicable)

SIGN  
HERE\*

**Program Terms and Conditions:** By signing below, I agree to the ANZUPGO Let's GO Support Program Terms and Conditions located at [Anzupgo.com/full-terms-conditions](https://Anzupgo.com/full-terms-conditions).

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient/legal representative signature MM DD YYYY

\_\_\_\_\_  
Relationship to patient (if applicable)



Click or scan  
the QR code for Program  
Terms and Conditions.

[Anzupgo.com/full-terms-conditions](https://Anzupgo.com/full-terms-conditions)

For more information about the  
ANZUPGO Let's GO Support Program,  
call **1-855-ANZUPGO (269-8746)**,  
Monday-Friday, 8 AM-8 PM ET.

## SECTION 2: Insurance Information

**NOTE: You may attach a copy of both sides of the patient's insurance card(s) instead of, or in addition to, the below:**

Coverage: ☐ Medicare ☐ Medicaid ☐ Commercial/Private ☐ Other ☐ Uninsured

Primary prescription insurance\*: \_\_\_\_\_ Group number\*: \_\_\_\_\_

Phone number\*: \_\_\_\_\_ Policy ID\*: \_\_\_\_\_ PCN\*: \_\_\_\_\_ BIN\*: \_\_\_\_\_

Policyholder name\*: \_\_\_\_\_ Policyholder date of birth\*: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

Policyholder relationship to patient\*: \_\_\_\_\_

Secondary prescription insurance? ☐ Yes ☐ No

\*Required

### SECTION 3: Clinical Information

Clinical notes attached? ☐ Yes ☐ No

Date of diagnosis:  /  /   
MM DD YYYY

**NOTE: The coding information provided below is for informational purposes only, is subject to change, and may not apply to all patients or all health plans. The healthcare professional is responsible for selecting the appropriate ICD-10-CM code(s).**

ICD-10-CM code(s) (See below for example codes.):\*

Allergic contact dermatitis:  
L23.0-L23.7, L23.81, L23.89

Atopic dermatitis:  
L20.89, L20.9

Irritant contact dermatitis: L24.0-L24.7, L24.81,  
L24.89, L24.A1, L24.A2, L24.A9, L24.B1-L24.B3

Other and unspecified dermatitis:  
L30.1, L30.8, L30.9

Prior therapies (include start and stop dates)\*:

Current therapies:

Medication allergies: ☐ No known allergies

☐ Check here if patient has initiated ANZUPGO® therapy with samples

Date samples started:  /  /   
MM DD YYYY

### SECTION 4: Prescriber Information

Prescriber name\*:  NPI number\*:  State license number: 

Office name\*:  Office phone\*:  Office fax: 

Address\*:  City\*:  State\*:  ZIP\*: 

Office contact name:  Office contact email: 

### SECTION 5: ANZUPGO® (delgocitinib) Prescription Information

#### Enhanced services pharmacies

Click or scan the QR code for the most current and complete list.

[AnzupgoHCP.com/access-and-resources/resources](https://AnzupgoHCP.com/access-and-resources/resources)


**Upon your patient's coverage determination, your patient's prescription will be directed to your preferred enhanced services pharmacy.**

Preferred enhanced services pharmacy name: 
☐ No preference

**NOTE: Complete ANZUPGO® enhanced services pharmacy prescription AND ANZUPGO® Bridge Program prescription (if applicable) and sign the Prescriber Certification below.**

|          | Medication and Prescription Type                                          | Dosage Form and Strength | Quantity                       | Refills                         | Dosage Instructions                                                                                             |
|----------|---------------------------------------------------------------------------|--------------------------|--------------------------------|---------------------------------|-----------------------------------------------------------------------------------------------------------------|
| PHARMACY | <input type="checkbox"/> ANZUPGO® enhanced services pharmacy prescription | 30 g tube Cream, 2%      | <input type="text"/> (specify) | <input type="text"/> (specify)  | Apply a thin layer of ANZUPGO® twice daily to clean and dry skin of the affected areas on the hands and wrists. |
| BRIDGE   | <input type="checkbox"/> ANZUPGO® Bridge Program prescription†            | 30 g tube Cream, 2%      | <input type="text"/> 1         | <input type="text"/> (specify)† | Apply a thin layer of ANZUPGO® twice daily to clean and dry skin of the affected areas on the hands and wrists. |

†I approve the dispense of a limited supply of ANZUPGO® for my patient if they experience a qualified lapse in insurance coverage, in accordance with the Terms, Conditions, and Eligibility Rules found at [Anzupgo.com/full-terms-conditions](https://Anzupgo.com/full-terms-conditions).

**ATTENTION PRESCRIBERS: Please follow your state's prescribing guidelines for electronic prescribing (if applicable).**

#### Prescriber certification

By signing and dating below, I certify this therapy is medically necessary and this information is complete and accurate to the best of my knowledge. I certify that I am the prescriber who has prescribed ANZUPGO® to the identified patient above for an FDA-approved indication. For the purposes of transmitting this prescription, I authorize LEO Pharma, its affiliates, business partners, agents and service providers, including patient support program service providers (collectively, "LEO Pharma") to forward for these limited purposes this prescription electronically, by facsimile, or by mail to the appropriate dispensing pharmacies. I authorize for my commercially insured patients one or more months of temporary shipments of ANZUPGO® during a benefits determination delay or during the appeal process after an initial coverage delay for ANZUPGO® for the above identified patient. I agree to assist in efforts to secure access to ANZUPGO® for my commercially insured patient. I will not attempt to seek reimbursement for any free product provided under the ANZUPGO® Let's GO™ Support Program and no medication may be returned for credit. I certify that any medication received will be used only for the patient named on this form and will not be offered for sale, trade, or barter. I acknowledge that this program is exclusively for the purposes of patient care and not for remuneration of any sort. I further understand that any free product provided is not contingent on any purchase obligations. I understand that LEO Pharma may revise, change, or terminate the Program at any time without notice. I certify that I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to LEO Pharma and its affiliates, business partners, and agents for purposes relating to LEO Pharma patient support programs, including assisting the patient with benefits verification, prior authorization/appeals assistance, financial assistance resources and information, such as copay support or free drug programs, for which the patient may be eligible, and other support for ANZUPGO®.

#### PRESCRIBER SIGNATURE\*

SIGN HERE

Date\*:  /  /   
MM DD YYYY

OR

SIGN HERE

Date\*:  /  /   
MM DD YYYY

Prescriber signature (No Stamps)\* - DISPENSE AS WRITTEN/BRAND MEDICALLY NECESSARY/DO NOT SUBSTITUTE/NO SUBSTITUTION/DAW/MAY NOT SUBSTITUTE

Prescriber signature (No Stamps)\* - MAY SUBSTITUTE/PRODUCT SELECTION PERMITTED/SUBSTITUTION PERMISSIBLE

## SECTION 6: Patient Authorization

**Please read the following carefully, then sign and date where indicated in Section 1 on page 1.**

I hereby authorize my healthcare providers, pharmacies, and health insurers, and their service providers (collectively, "Authorized Parties") to use, release, share, or disclose information relating to my insurance benefits, medical condition, treatment, and prescription details related to my therapy ("Personal Information") to LEO Pharma, its affiliates, business partners, agents, and service providers, including patient support program service providers (collectively, "LEO Pharma"), in order to receive or be eligible to receive the following LEO Pharma services (the "Services"):

- Assistance coordinating insurance coverage for, access to, or receipt of my prescription medication from LEO Pharma
- Communications through phone, text, or email about possible access, savings and support services, including, for example, LEO Pharma patient support programs, and, if I am enrolled, assistance administering my participation in those programs
- Communications through phone, text, or email about my prescription medication from LEO Pharma and treatment, including, for example, reminders, health and lifestyle tips, product, and program-related information. Communications may be customized based on Personal Information obtained from my Authorized Parties
- Participation in quality assurance activities such as surveys and feedback related to the Services or my treatment

In delivering the Services, LEO Pharma may release or disclose my Personal Information (including the personal health information set forth therein) to my Authorized Parties and certain financial assistance programs that may assist with my prescription medication payments. I understand and acknowledge LEO Pharma and Authorized Parties may combine my records and information with information and data collected from other sources and use that aggregated information to administer the Services listed above. I understand and acknowledge LEO Pharma may be required to share my records and information with law enforcement authorities or other government officials, or when required by law, statute, regulation, or a judicial or administrative order.

Once I authorize the release of my records and information, I understand and acknowledge it may be re-disclosed by the recipient, and it may no longer be protected by federal or state health privacy laws or other applicable data protection laws or regulations.

I understand that this Authorization is voluntary and that I do not have to sign it in order to get treatment or payment of eligibility in or enrollment benefits from my insurers.

I understand that I can revoke this Authorization at any time by calling 1-855-ANZUPGO (269-8746) or by emailing [info@AnzupgoLetsGo.com](mailto:info@AnzupgoLetsGo.com) or writing to:



**ANZUPGO® Let's GO™**  
PO Box 1587  
Jeffersonville, IN 47131

OR



**LEO Pharma Support Services**  
7 Giralda Farms  
Madison, NJ 07940

This Authorization will expire 5 years after I sign it, or earlier if required by law, unless I revoke it sooner. If the Authorization expires or is revoked, I understand and acknowledge that I may no longer qualify for Services from LEO Pharma, but it will not impact my treatment or my insurance benefits from Authorized Parties. I also understand and acknowledge that if an Authorized Party is disclosing my records and personal health information to LEO Pharma on an authorized, ongoing basis, my revocation of this Authorization will be effective with respect to that Authorized Party as soon as that Authorized Party receives notice of my revocation and such revocation will not affect prior uses or disclosures of my records and personal health information. I understand that I will be able to keep a copy of this Authorization and may, at any time, request a copy of this Authorization. My information may be de-identified and aggregated by LEO Pharma. I understand that my information will be used by LEO Pharma in accordance with the LEO Pharma privacy policy, located at [Leo-pharma.us/privacy-policy](http://Leo-pharma.us/privacy-policy).

**Please see full Prescribing Information and Medication Guide.**

