Ryplazim®
plasminogen, human-tvmh

PATIENT ENROLLMENT FORM

Ryplazim® Support Services
Phone: 888-274-5275
Fax: 408-419-1768

PATIENT INFORMATION (required)

Patient name:

Date of birth: Sex: ☐ M ☐ F

Address:

City: State: Zip code:

Phone: Email:

Preferred method of contact: ☐ Phone ☐ Email

Best time to contact: ☐ Morning (8 AM—10 AM ET) ☐ Day (10 AM—5 PM ET) ☐ Evening (5 PM—8 PM ET)

If the patient is under 18

Primary contact/caregiver name:

Relationship to patient:

Phone:

Email:

INSURANCE INFORMATION (required)
Attach a copy of the front and back of all applicable insurance cards, if available

☐ Patient does not currently have insurance. ☐ Copy of the patient's insurance card(s) are attached.

Please complete the required information below only if not attaching a copy of the patient's insurance card(s) to this form.

Primary insurance type: ☐ Private/commercial ☐ Medicaid – State ☐ Other

Primary insurance name:

Beneficiary/cardholder name:

Cardholder relationship to patient:

Policy ID #

Benefit investigation or verification requested: ☐ Yes ☐ No

Prior authorization required: ☐ Yes ☐ No

Co-pay assistance eligibility? ☐ Yes ☐ No

KEDRION BIOPHARMA

Ryplazim® plasminogen, human-tvmh

PATIENT ENROLLMENT FORM

Ryplazim® Support Services
Phone: 888-274-5275
Fax: 408-419-1768

Patient Name: _____

CLINICAL INFORMATION (required)

The healthcare provider is responsible for sending the prescription to one of the specialty pharmacies listed at the top of the page.
Providers must submit a Statement of Medical Necessity along with any prescription orders that document the diagnosis and explanation of the disease.

☐ Check here if office visit notes are attached/included

Diagnosis (ICD-10)

E88.02 Plasminogen deficiency type 1: ☐ Yes ☐ No ☐ Unsure

H10.22 Pseudomembranous conjunctivitis: ☐ Yes ☐ No ☐ Unsure

H10.51 Ligneous conjunctivitis: ☐ Yes ☐ No ☐ Unsure

Other diagnosis and/or important clinical information? Please describe:

Has the patient ever been treated with RYPLAZIM?: ☐ Yes ☐ No ☐ Unsure

If yes, date of last treatment: If yes, next dose due:

What other treatments has the patient received? Please list:

Patient height (cm): Patient weight (kg):

Date height and weight were recorded:

SPECIALTY PHARMACY INFORMATION

Preferred pharmacy (please select one): ☐ NuFactor ☐ TAP ☐ MedMonk ☐ Northridge Pharmacy Specialty & Infusion

Pharmacy contact information:

NuFactor	**TAP**	**CVS**	**MedMonk**	**Northridge Pharmacy Specialty & Infusion**
P: 800-323-6832	P: 866-767-4883	P: 866-792-2731	P:	f: 818-882-8929
F: 1-855-270-7347	F: 1-516-876-0200	F: 800-323-2445	F:	

RYPLAZIM® PRESCRIBING INFORMATION

Prescribed dose of RYPLAZIM: _____mg/kg

Dispense quantity and refills: _____vial(s) with_____refill(s)

Infusion frequency: _____mg/kg ☐ Q2D ☐ Q3D ☐ Q4D ☐ Other_____

Per the RYPLAZIM label, recommended dose is 6.6 mg/kg of body weight infused every 2 to 4 days.

Route of intravenous administration

☐ Peripheral ☐ Other (please describe):

Start date:

KEDRION BIOPHARMA

OTHER DRUG ORDERS (dispense quantity sufficient for month supply unless otherwise noted)

- ☐ Decline
- ☐ Sterile water for injection 20 mL vial (or other available size): Use as directed to reconstitute Ryplazim. Dispense 1 month supply. Refill for same period as Ryplazim.
- ☐ Sodium chloride 0.9% 10 mL PFS: Use as directed to prime filter, confirm IV patency, and flush IV access post infusion. Refill for same period as Ryplazim.
- ☐ Lidocaine/prilocaine 2.5%/2.5% cream 30 gm (or other available size): Apply topically 60 min. pre-needle insertion prn discomfort. Dispense 1 month supply. Refill for same period as Ryplazim.
- ☐ Implanted port adult/pedi > 15 kg:

  1) Sodium chloride 0.9% 10 mL PFS: 5 to 10 ml pre/post use & 10 to 20ml post-blood draw
  2) Heparin 100 units/ml syr: 5 ml post last NS & daily if accessed; monthly if de-accessed.

OTHER ORDERS (dispense sufficient quantity)

- ☐ Ancillary supplies as necessary to administer Ryplazim and other medications, including equipment, devices and disposables.

THERAPY INITIATION AND SITE OF CARE

- ☐ Nursing needed: Nurse to administer medications per physician orders. If IV route: nurse to obtain IV access via placement of peripheral IV catheter or butterfly needle and instruct patient or caregiver on IV access. If peripheral IV, may leave in place up to 5 days as long
- ☐ Nursing needed: Instruct patient or caregiver to self-administer therapy

Number of skilled nursing visits to support at-home RYPLAZIM® infusion:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Unlimited

Specialty pharmacy to coordinate nursing? ☐ Yes ☐ No

Site of care

☐ Physician office ☐ Infusion clinic ☐ Outpatient hospital ☐ Home infusion ☐ Other:_____

Therapy initiation plan for RYPLAZIM® infusions

- ☐ Patient/caregiver received in-office training, will self-administer first dose at home
- ☐ First dose will be administered clinical setting, followed by in-home skilled nursing support for _____ doses
- ☐ First dose will be administered clinical setting, patient/caregiver will be trained on self-administration and subsequent doses will be self-administered at home

PRESCRIBER AUTHORIZATION (required)

- ☐ Dispense As Written / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute

  Prescriber's Signature: Date:

- ☐ May Substitute / Product Selection Permitted / Substitution Permissible

  Prescriber's Signature: Date:

- ☐ CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution"

ATTN: New York and Iowa providers, please submit electronic prescription

AUTHORIZING HEALTHCARE PROVIDER INFORMATION (required)

First name: Last name:

Address:

City: State: Zip code:

Practice phone: Practice fax:

Practice contact first and last name:

Practice contact phone: Practice contact email:

INFUSING OFFICE INFORMATION

☐ Same as provider (If different from provider, please complete)

Practice or facility name:

Contact first and last name:

Phone: Fax: Email:

PHYSICIAN AUTHORIZATION (required)

I certify that RYPLAZIM® is medically necessary for this patient. I will be supervising the patient's treatment accordingly. Non-approval of RYPLAZIM® may result in further deterioration of the patient's health and/or hospitalization. By signing below, I certify that I have received the necessary authorization from the patient to release the medical and/or patient information referenced on this form relating to the above-referenced patient to Kedrion Biopharma and its contracted agent or contractors working solely on behalf of the patient for the purpose of seeking reimbursement through RYPLAZIM Cares, verifying insurance coverage and/or the evaluation of the patient's eligibility for alternate sources of funding, patient support services, including materials fulfillment, and product fulfillment via specialty pharmacies.

Physician signature: Date:

Physician NPI #

Patient Name: _____

STATEMENT OF MEDICAL NECESSITY

For the treatment of plasminogen deficiency type 1 (hypoplasminogenemia)

Physician office address

_____

Date: _____

To: _____
(Insurer)

Re: _____
(Patient name)

I am writing on behalf of my patient, _____ (patient name) who is an _____ (age, sex) to document medical necessity of RYPLAZIM® [plasminogen, human-tvmh] for the treatment of plasminogen deficiency type 1 (hypoplasminogenemia). This letter provides information about the patient's medical history and diagnosis and a statement summarizing my treatment rationale.

Plasminogen deficiency, or hypoplasminogenemia, is a quantitative protein deficiency with decreased plasminogen activity and antigen characterized by the accumulation of extravascular fibrin-rich lesions on mucosal surfaces. Depending on the site and extent of lesions, hypoplasminogenemia may be life-threatening or associated with poor quality of life or disability.

Plasminogen deficiency is a systemic disorder. Lesions may develop on mucosa throughout the body including the eyes, ears, nose, oral cavity, airways, urinary and genital tracts, gastrointestinal (GI) system, skin, and central nervous system (CNS). Symptoms relate to the extent, size, lesion duration, and organ affected.

- Eye lesions may be associated with photophobia, pain, corneal abrasions, and vision loss.
- CNS lesions may result in obstructive hydrocephalus, recurrent shunt obstruction, and Dandy-Walker malformation. Tracheobronchial lesions may result in respiratory compromise or obstruction.
- Gingival lesions with resultant loss of bone and dentition.
- Middle ear lesions can cause hearing impairment or loss.
- Vocal cord lesions with hoarseness or loss of voice.
- Female genital tract lesions may cause painful menses and infertility.
- Urinary tract lesions can result in renal obstruction.
- GI lesions may cause ulcers and what appears to be an inflammatory bowel disease.
- Wounds may be associated with poor healing.

Lesions can develop at any age and be present for variable intervals. Historically, clinicians have tried many treatments, including surgical removal. Although surgical removal maybe helpful initially, it typically leads to accelerated lesion regrowth and is not recommended without adequate replacement of the plasminogen level.

For further information on this disorder, please see the following references:

1. Shapiro AD, Nakar C, Parker JM, Thibaudeau K, Crea R, Sandset PM. Plasminogen, human-tvmh for the treatment of children and adults with plasminogen deficiency type 1. *Haemophilia.* 2023;29(6):1556-1564. doi:10.1111/hae.14849
2. Mehta R, Shapiro AD. Plasminogen deficiency. *Haemophilia.* 2008;14(6):1261-1268. doi:10.1111/j.1365-2516.2008.01825.x

Patient Name: _____

In June 2021, the FDA approved the first and only specific treatment for plasminogen deficiency: a human plasminogen concentrate. RYPLAZIM® (plasminogen, human-tvmh) is a plasma-derived human plasminogen indicated for the treatment of patients with plasminogen deficiency type 1 (hypoplasminogenemia). Treatment with RYPLAZIM increases the plasma level of plasminogen—enabling a temporary correction of the plasminogen antigen level and reduction or resolution of the lesions. The regimens used in the pivotal study targeted a minimal increased trough activity above baseline levels.

The recommended dosage of RYPLAZIM is 6.6 mg/kg body weight administered intravenously every 2 to 4 days; however, other treatment regimens such as daily infusion may be required based upon the severity of the symptoms or need for intervention. In the pivotal clinical trial, all patients reached the primary endpoint overall rate of clinical success. Overall rate of clinical success is defined as 50% of patients with visible or other measurable non-visible lesions achieving at least 50% improvement in lesion number/size, or functionality impact from baseline. In addition, 78% of all external lesions at baseline and 75% of all internal lesions at baseline were resolved by the end of week 48. No patient developed recurrent or new external or internal lesions.

Duration: RYPLAZIM is temporarily replacing plasminogen. The therapeutic goal is to increase the trough plasminogen activity by an absolute 10% above baseline. Initial treatment regimens are usually initiated at three-day intervals; however, the health care provider must consider individualized needs as previously stated based upon the site of lesions and clinical status of the patient. The duration of treatment is determined by the health care provider and may be life-long.

Patients who participated in the clinical trial were continued in a compassionate use program and have continued to benefit from the RYPLAZIM treatment. To prevent recurrence of disease manifestations and their associated sequelae, it is required that _____ continue treatment with RYPLAZIM.
(patient name)

In summary, RYPLAZIM is medically necessary for this patient's medical condition.
Please contact me if any additional information is required to ensure the prompt approval of RYPLAZIM.

Sincerely,

_____
(Physician signature)

_____
(Date)

_____
(Please print physician name)

Patient Name: _____

Treatment Rationale | Date of confirmed diagnosis:

A diagnosis of plasminogen deficiency type 1 was confirmed by (check all that apply):

Confirmatory test	Method	Description
☐	Blood testing, laboratory	To determine plasminogen activity and antigen level

Value: _____ Date: _____

Normal reference range for laboratory & sample:_____

☐ Full results report attached

Optional test(s)	Method	Description
☐	Genetic testing	To detect alterations in the *PLG* gene
☐	Biopsy	To determine if the removed lesion demonstrates a buildup of fibrin-rich deposits when viewed under a microscope

_____ has developed lesions in the following areas:

(patient name)

☐ Eye(s). Please describe: _____

☐ Ear(s). Please describe: _____

☐ Oral cavity. Please describe: _____

☐ Central nervous system. Please describe: _____

☐ Respiratory tract. Please describe: _____

☐ Female genital tract. Please describe: _____

☐ Gastrointestinal tract. Please describe: _____

☐ Gastrointestinal tract. Please describe: _____

☐ Skin. Please describe: _____

☐ Other. Please describe: _____

If the patient developed eye lesions:

Have they been surgically removed? ☐ Yes ☐ No

If surgically removed, what was the date of the last removal?

When did lesions return? After _____ weeks After _____ months

What other treatments were attempted?

What were the dates of treatment?

How long after treatment did lesions return? After _____ weeks After _____ months

Patient Name: _____

Patient's diagnosis	ICD-10	Description
☐	E88.02	Plasminogen deficiency
☐	H10.51	Ligneous conjunctivitis
☐	H10.511	Ligneous conjunctivitis, right eye
☐	H10.512	Ligneous conjunctivitis, left eye
☐	H10.513	Ligneous conjunctivitis, bilateral
☐	H10.519	Ligneous conjunctivitis, unspecified eye
Associated findings		
☐	G91.4	Hydrocephalus
☐	H67	Otitis media
☐	J99	Respiratory disorder related to plasminogen deficiency

Patient's history and diagnosis:
Include information here regarding the patient's condition, history related to their condition, and specific diagnosis. Please indicate if any other pertinent documentation is attached.