



von Willebrand  
Factor/Coagulation  
Factor VIII Complex  
(Human)



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 wilate® for up to 3 doses not to exceed 5,000 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 wilate® von Willebrand Factor/Coagulation Factor VIII Complex (Human) for the patient indicated below; and
- A fully completed wilate 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:

**wilate®** von Willebrand Factor/Coagulation Factor VIII Complex (Human)

Available Vial Sizes (500 IU, 1000 IU)

Patient Weight  KG \_\_\_\_\_  LB \_\_\_\_\_

Dose IU/kg \_\_\_\_\_ Total IU's Required for one dose of wilate® \_\_\_\_\_

**Additional Prescriber Instructions:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



von Willebrand  
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### PROGRAM REQUIREMENTS:

The Octapharma wilate 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 wilate Free Trial offer. The wilate 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 wilate and does not require any additional prescription(s) or refills to be filled. Product dispensed pursuant to the terms of the wilate 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 wilate Free Trial program is valid for wilate only – No substitutions permitted. The wilate 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 wilate Free Trial Program. In submitting this form, I request that wilate 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:** \_\_\_\_\_

### PATIENT CONSENT AND HIPAA AUTHORIZATION:

Covance, Inc. is operating the Octapharma wilate 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 wilate<sup>®</sup> von Willebrand Factor/Coagulation Factor VIII Complex (Human) prescription, via mail, fax or other mode of delivery, to the specialty pharmacy designated by Covance, Inc in order to facilitate dispensing of wilate 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 wilate Free Trial Program. **Register at [www.factorway.com](http://www.factorway.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**