CIMERLI™
(ranibizumab-eqrn) injection

Patient Consent

Call 1-844-483-3692
Monday to Friday | 8 AM to 8 PM ET
FAX 1-877-226-6370
www.CIMERLISolutions.com

I authorize _____ and his/her staff (my "Prescriber") to disclose my health, demographic, and other individually identifiable information, including insurance and financial information to Coherus BioSciences, Inc., its affiliates, its program administrator, and their respective agents, service providers and field reimbursement professionals for the purpose of:

i. Verifying or coordinate insurance coverage of otherwise obtain payment for me treatment with the prescribed drug
ii. Coordinate my receipt of the prescribed drug
iii. Determine eligibility and manage the Patient Assistance Program
iv. Provide me information about the prescribed drug
v. Provide me information on external resources that might be available to me
vi. Assist me or my provider with co-pay support for the prescribed drug
vii. Assist me or my provider with insurance coverage and reimbursement support services, including benefits verification checks, prior authorizations, claim reviews and denials, or searching for alternative funding from charitable foundations

I understand that Coherus will disclose my health information to my pharmacies, health insurer(s), healthcare providers, caregivers, and other third parties for the purposes described above, and Coherus may contact me directly.

I understand that once my Protected Health Information is disclosed as permitted by this authorization it may be re disclosed by Coherus and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal privacy laws. I understand that I may refuse to sign this authorization. I may also revoke (withdraw) this authorization at any time in the future by contacting my Prescriber. My refusal or future revocation will not affect the commencement or continuation of my treatment by my Prescriber, however, if I do not sign or I revoke this authorization, I will no longer be eligible to participate in the Patient Assistance Program. If I revoke this authorization, my revocation will not affect Protected Health Information previously disclosed in reliance upon this authorization.

I understand and agree that this authorization will remain valid for 5 years after the date of my signature, unless I revoke it earlier. I understand that I may receive a copy of this authorization.

Signature _____ Date _____

Relationship to patient (if not patient) _____

CIMERLI Solutions™ is part of the Coherus Solutions™ family of programs.

Coherus Solutions™