LOQTORZI® (toripalimab-tpzi)injection

LOQTORZI Solutions™ Enrollment Form

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

HCP attestation (Section 5) required to complete enrollment
*Denotes **REQUIRED** Information

Check for services requested:*

- ☐ Benefits Verification
- ☐ Co-Pay Savings Program
- ☐ Patient Assistance Program (PAP)†‡
- ☐ Support for Claims, Prior Authorizations and Appeals

1 PATIENT INFORMATION (PATIENT CONSENT AND SIGNATURE REQUIRED FOR PAP, SEE PAGE 5)

Patient's Name:*

Gender at birth:* ☐ Male ☐ Female DOB:* (MM/DD/YYYY) / /

Patient's Address:*

City:* State:* ZIP:*

Patient's Phone #:* ☐ Home ☐ Cell Email:

Alternate contact name: Phone #:

OK to leave a message ☐ Yes ☐ No Best time to call ☐ Morning ☐ Afternoon ☐ Evening

2 INSURANCE INFORMATION

(Please attach a copy of both sides of the patient's insurance card(s). If not available, please complete the information below.)

Is the patient insured?* ☐ Yes ☐ No

Insurance Type:* ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other

If the patient is uninsured, please complete pages 3-5 to enroll in the Patient Assistance Program.

Benefit Verification Preference:* ☐ MEDICAL ☐ PHARMACY ☐ BOTH

PLEASE COMPLETE THE INSURANCE SECTION(S) THAT CORRESPOND TO THE PREFERRED BENEFIT VERIFICATION.

	PRIMARY MEDICAL INSURANCE*	SECONDARY MEDICAL INSURANCE (if applicable)
Insurance Name*		
Phone Number*		
Policy ID Number*		
Group Number*		
Policy Holder's Name*		
Policy Holder's Date-of-birth*	/ /	/ /
Policy Holder's Relationship to Patient*		
Medicare Beneficiary ID Number *(if applicable)*		

PHARMACY BENEFIT PLAN (If Applicable)

Insurance Name: Phone Number:

ID Number: Group Number: BIN: PCN:

Policyholder's Name: Policyholder's Date of Birth: / /

†**Temporary Patient Assistance Program (TPAP):** If a patient does not currently have coverage for the product and has an application for Medicaid pending, the patient may be eligible to enroll into TPAP and receive LOQTORZI cost-free on a **temporary basis up to 90 days**.

‡**Retrospective Patient Assistance:** Patients may be eligible if they have received LOQTORZI in the past 30 days and meet all other eligibility requirements. Medicare patients are not eligible for retrospective patient assistance.

Please see **page 2** for **HCP Attestation** and **Required Signature**

LOQTORZI® (toripalimab-tpzi)injection

LOQTORZI Solutions™ Enrollment Form

Call 1-844-483-3692
Monday–Friday 8 AM to 8 PM ET
FAX 1-877-226-6370

*Denotes **REQUIRED** Information

Patient Name: _____

3 CLINICAL INFORMATION

Drug Name: LOQTORZI

Primary Diagnosis/ICD-10 Code:*

Secondary Diagnosis

Site of Care:* ☐ Freestanding Infusion Center ☐ Physician Office ☐ Hospital Outpatient Clinic ☐ Hospital Inpatient ☐ Home ☐ Other

Anticipated Start Date: / /

4 PRESCRIBER INFORMATION*

Prescriber's Name:*

Practice/Facility Name:*

Organization Tax ID Number:* Organization NPI Number:*

Individual NPI Number:* Provider PTAN:*

Mailing Address:* City:* State:* ZIP:*

Office Contact's Name:* Fax Number:*

Office Contact's Phone Number:* Email:*

5 HEALTHCARE PROFESSIONAL ATTESTATION*

I, _____ (Print Name) attest that, where required by applicable law, regulation, or other applicable authority, I have obtained patient consent, permission and/ or a HIPAA authorization ("Legal Permission") permitting me to use and disclose my patients' 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 providing patient support programs, co-pay assistance, and/or patient assistance or reimbursement support as part of the patient's treatment with LOQTORZI. I maintain records of such Legal Permission consistent with applicable law. I further certify that (a) any reimbursement investigation support provided to patients through Coherus Solutions™ is not made in exchange, directly or indirectly, for my recommendation, prescription, or use of the above therapy or any other product or service for or from anyone, and (b) my decision to prescribe the above therapy was based solely on my determination of medical necessity. For insured patients, I understand that the Coherus Solutions™ program does not provide free drug in the instance of an administrative error or a coverage restriction. In addition, I attest that LOQTORZI is being prescribed consistent with the approved prescribing information or I believe it is medically necessary based on the patient's diagnosis.

Healthcare Professional Signature (Required)**:*** _____ **Date:*** / /

Please see **pages 3-5** for additional **information required** for the **Patient Assistance Program**

LOQTORZI® (toripalimab-tpzi)injection

LOQTORZI Solutions™ Enrollment Form

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

‡Denotes **REQUIRED** Information to enroll in the PAP Program

Patient Name: _____

To enroll in the Patient Assistance Program, completion of Sections 6 - 9 is required

6 PRESCRIPTION: (ONLY REQUIRED FOR PAP ENROLLMENT)
MUST BE COMPLETED BY A LICENSED PRESCRIBER

Patient Name: _____

Patient Weight: _____kg

Medication Name: LOQTORZI

Strength: 240 mg/6 mL (40 mg/mL) vial

Dose:
- ☐ 240 mg IV every 3 weeks — Quantity: _____ (vials) Refills: _____
- ☐ 3 mg/kg IV every 2 weeks, Dose:_____mg — Quantity: _____ (vials) Refills: _____
- ☐ Other: _____, Dose:_____mg — Quantity: _____ (vials) Refills: _____

All prescriptions must accurately reflect the dose, number of vials, and refills needed for the appropriate patient dosage. Refills must be requested by calling LOQTORZI Solutions. It is the prescriber responsibility to update any prescription needs, including the dose and quantity of vials based on patient weight adjustments, if applicable. Please allow 5-7 business days for processing PAP refills. All PAP refill requests must be requested prospectively prior to treating the patient.

PRESCRIBER: PLEASE SIGN AND DATE

Prescriber's Signature‡ _____ **Date:‡** / /

Dispense as Written OR Substitutions Allowed

Signature by other office personnel and stamp or graphic/images not allowed.

SHIP TO: *(If the shipping address is different than the address on page 2, please include the appropriate address.)*

Practice/Facility Name: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

7 PATIENT ASSISTANCE PROGRAM: Eligibility Criteria

Under this program, Coherus BioSciences, Inc. agrees to ship product to the provider for patients who qualify for the Patient Assistance Program (PAP). The terms and conditions below must be met in order for a patient to be enrolled in the program:

- Be either: (a) uninsured; (b) functionally underinsured†
- Have an adjusted annual household income of ⩽ 500% of Federal Poverty Level (FPL)
- Complete and sign consent form and either provide income documentation or consent for Coherus to run a credit check
- Be under the care of a U.S. licensed provider, and receive LOQTORZI in an established practice located in the U.S. incident to the prescribing physician's professional services in the outpatient setting
- Be a U.S. resident of any U.S. state
- Diagnosis and dosing are consistent with FDA-approved indication for LOQTORZI, or provider believes LOQTORZI is medically necessary based on the patient's diagnosis
- Not have any other financial support options

†To be considered underinsured, the patient has insurance but no coverage for LOQTORZI.

LOQTORZI Solutions™ Enrollment Form

‡Denotes **REQUIRED** Information to enroll in the PAP Program

Patient Name: _____

To enroll in the Patient Assistance Program, completion of Sections 6 - 9 is required

8 PATIENT FINANCIAL VERIFICATION AUTHORIZATION (ONLY required for PAP enrollment)‡

Household size (number of members including you):‡ **Household Income:**‡

I understand that by checking the "I Agree" box immediately following this notice, I am providing "written instructions" to Coherus BioSciences, Inc. and/or its agents and contractors under applicable federal and/or state law authorizing them to perform electronic income verification by obtaining information from my personal credit profile or other information from Experian Health. I authorize Coherus and/or their agents and contractors to obtain such information solely to validate my income for the purposes of determining my eligibility for patient assistance. As a soft credit check, it will not impact my credit score.

- ☐ **I AGREE to the terms above for electronic income verification using Experian Health.**
- ☐ **I DO NOT AGREE with the terms above and do not wish to have my income verified by using Experian Health. I understand that I will be asked to provide supporting documentation to authenticate my income and eligibility.**

If additional income documentation is required, the following documents are acceptable for income verification:

- Social Security/Disability benefit statement, monthly check, or 1099
- Previous year tax return or W-2 statement
- Unemployment or disability determination letter

9 PATIENT CONSENT (Patient consent required for PAP enrollment and otherwise if requested by provider)

I authorize my physician(s) and their staff and my health insurance plan to disclose my personal information, which may include 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:

- Verifying or coordinating insurance coverage or otherwise obtain payment for my treatment with the prescribed drug
- Coordinating my receipt of the prescribed drug
- Determining eligibility and managing the Coherus Solutions™ Patient Assistance Program
- Providing me information about the prescribed drug
- Providing me information on external resources that might be available to me
- Assisting me or my provider with co-pay support for the prescribed drug
- Assisting 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 redisclosed 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 Coherus Solutions™ Patient Access and Support Programs including the Patient Assistance Program (if applicable). If I revoke this authorization, my revocation will not affect Protected Heath 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.

Please see next page for PATIENT SIGNATURE

LOQTORZI® (toripalimab-tpzi)injection

LOQTORZI Solutions™ Enrollment Form

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

†Patient consent may be required if requested by provider

‡Denotes **REQUIRED** Information to enroll in the PAP Program

Patient Name: _____

To enroll in the Patient Assistance Program, completion of Sections 6 - 9 is required

9 PATIENT CONSENT (continued)

I understand that if I receive free medication through the Patient Assistance Program, the PAP provides LOQTORZI at no charge and does not include the provider administration fee. I also understand that I am responsible for the administration costs. By applying for PAP, I understand and agree that (i) there is no charge to participate and my participation is not contingent upon any requirement to purchase any Coherus product; (ii) completing and signing the application and this authorization does not guarantee my eligibility; (iii) PAP may change or end at any time; (iv) PAP medication received will not count toward my true out-of-pocket costs under Medicare Part D; and (v) I will not seek to be reimbursed or receive credit from any insurance provider, including Medicare Part D plans, for any PAP medication received. In applying for the patient assistance program, I can confirm that I do not have coverage for LOQTORZI.

I certify that the personal information that I provide to Coherus Solutions™ is true and complete. I understand that if I am not being enrolled in the Patient Assistance Program then the income verification will not apply. I agree that, at any time during my participation in Coherus Solutions™ Support Programs, additional documentation to verify my personal information may be requested, if there is missing information or I do not respond to requests for additional documents, my participation may be delayed, or I may no longer be able to participate.

If I qualify for, and receive, co-pay assistance or free medication assistance through the PAP, I agree to comply with Coherus' program rules and I will not get reimbursed for the assistance I receive from anyone else, including from an insurance program, another charity, or from a health savings, flexible spending, or other health reimbursement account. I understand that the Coherus Solutions™ programs may be discontinued or the rules for participation may change at any time, without notice.

COHERUS PATIENT CONSENT & PRIVACY NOTICE (Required)†‡

☐ I consent to the collection, use, and disclosure of my personal health data by Coherus BioSciences, Inc. as described in the COHERUS PATIENT CONSENT section above. My consent is required to process personal data under certain privacy laws, and I have the right to withdraw my consent by calling Coherus Solutions™ at 1-844-483-3692 or by writing to PO Box 7613, Overland Park, Kansas, 66207.

PATIENT TEXT MESSAGE (Optional Consent)

☐ Coherus may use automatic dialing machines or artificial or prerecorded messages to contact me and may leave a voicemail or SMS/text message. Coherus may send automated and recurring text messages from Coherus Solutions™ or Coherus BioSciences, Inc., including service updates, marketing messages, refill reminders, and other notifications (standard text messaging rates may apply). SMS/text messages from Coherus Solutions™ will be sent to the mobile phone number provided. Reply HELP for help or STOP to cancel. I understand that I am not required to provide this consent as a condition of purchasing any goods or services.

MARKETING (Optional Consent)

☐ I consent to the collection, use, and disclosure of my health-related personal data to receive communications from Coherus Solutions™ or Coherus BioSciences, Inc., regarding its products, programs, services, scientific research and other research opportunities. My consent is required to process personal data under certain privacy laws, and I have the right to withdraw my consent by calling Coherus Solutions™ at 1-844-483-3692 or by writing to PO Box 7613, Overland Park, Kansas, 66207.

SIGNATURE REQUIRED FOR PAP ENROLLMENT

Signature:†‡ _____ **Date:†‡** / /

Patient or Patient Representative Name:†‡ _____ **Relationship to Patient:†‡** _____

Coherus Solutions™
Working together to ensure patient access