Coherus Solutions™

UDENYCA® (pegfilgrastim-cbqv)
Patient Consent

Call **1-844-4-UDENYCA** (1-844-483-3692)
Monday through Friday • 8 AM to 8 PM ET
Fax **1-877-226-6370**
www.CoherusSolutions.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 coordinating insurance coverage or otherwise obtain payment for my treatment with the prescribed drug

ii. Coordinating my receipt of the prescribed drug

iii. Determining eligibility and managing the Coherus Solutions™ Patient Assistance Program

iv. Providing me information about the prescribed drug

v. Providing me information on external resources that might be available to me

vi. Assisting me or my provider with co-pay support for the prescribed drug

vii. 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 the Coherus Solutions™ Patient Assistance Program. If I revoke this authorization, my revocation will not affect Protected Heath Information previously disclosed in reliance upon this authorization. I can confirm that I do not have coverage for UDENYCA® or any other pegfilgrastim product (biosimiliar or reference product).

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 the patient): _____

Coherus™ BIOSCIENCES