Coherus Solutions™

UDENYCA® (pegfilgrastim-cbqv)
Patient Assistance Program Enrollment Form

Call 1-844-4-UDENYCA
(1-844-483-3692)
Monday to Friday • 8 AM to 8 PM ET
FAX 1-877-226-6370
www.CoherusSolutions.com

Select services requested:

- ☐ Patient Assistance Program (PAP)
- ☐ Retrospective Patient Assistance
  - Patients who have received UDENYCA® in the past 30 days may be eligible for retrospective patient assistance
  - Medicare patients are not eligible for retrospective patient assistance
- ☐ Temporary PAP (T-PAP)
  - T-PAP may be approved for patients who cannot currently access UDENYCA®:
    - That have applied for Medicaid coverage and are waiting for an approval/denial notice
    - Identified as having active Emergency Medicaid

All fields in orange are required to be completed before form submission.

1 PATIENT INFORMATION

Patient's Name: Sex: ☐ Male ☐ Female DOB: (MM/DD/YYYY) / /

Patient's Address: City: State: ZIP:

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

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.)

PRIMARY MEDICAL INSURANCE (If Applicable)

Check the appropriate box: ☐ MEDICARE ☐ UNDERINSURED* ☐ UNINSURED *Medicare patients with secondary insurance are not eligible for PAP.*

Insurance Name:

Medicare Beneficiary ID# (if applicable):

See documentation requirements below.

Phone #: Policy ID #: Group #:

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

Policyholder's Relationship to Patient:

3 CLINICAL INFORMATION

Primary Diagnosis/ICD-10 Code (REQUIRED): Secondary Diagnosis/ICD-10 Code:

Site of Care: ☐ Freestanding Infusion Center ☐ Hospital Outpatient ☐ Physician Office

4 PRESCRIBER INFORMATION

Prescriber's Name:

Practice/Facility Name: Organization TAX ID#:

Prescriber NPI #: Organization NPI #:

Mailing Address: City: State: ZIP:

Office Contact's Name: Fax #:

Office Contact's Phone #: Email:

Coherus partnered with a new supplier, **TC Script Pharmacy**, to administer and dispense UDENYCA® to patients who qualify for the Coherus Patient Assistance Program (PAP).

TC Script Pharmacy will first reach out to the applicable Healthcare Provider (HCP) office to obtain the concurrent medications consumed or administered to the patient, and any relevant drug-allergy information. If **TC Script Pharmacy** is unsuccessful obtaining the required information from the HCP office, it may need to contact the patient directly before dispensing Coherus PAP drug.

*Underinsured includes patients with health insurance that does not cover UDENYCA® or any pegfilgrastim product (biosimilar or reference product).

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5 TREATMENT PLAN FOR UDENYCA® INJECTION (6MG/0.6 ML PREFILLED SYRINGE)

Prescribing Physician to Complete

Quantity: _____ **Refill(s):** _____ **Frequency of treatments:** _____

Treatment start date: ____/____/____

6 PROVIDER ATTESTATION†

Date: / /

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, reimbursement support as part of the patient's treatment with UDENYCA®. **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 such as a step edit or others deemed as restrictions. For certain products where step edit may not be medically appropriate, and confirmed by the prescribing physician, the Coherus Solutions™ program may consider enrollment following one level of appeal. I can confirm that the patient does not have coverage for UDENYCA® at the date of service or any other pegfilgrastim product (biosimilar or reference product).

Providers requesting more than six (6) PAP fills for the same patient will be required to provide written attestation on business letterhead reaffirming continued PAP necessity (DX, patient therapy log, etc.)

Signature (Required): _____

7 PATIENT FINANCIAL VERIFICATION AUTHORIZATION

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
- ***For traditional Medicare fee-for-service insured patients, an attestation from the HCP is required demonstrating financial hardship due to inability to afford cost share.***

Patient name (required): _____ **Patient date of birth (required):** _____

Patient or patient representative signature: _____

Patient representative name: _____ **Phone:** _____

Relationship to patient: _____

Household size *(number of members including you)* _____ **Household Income** _____

Is it OK to contact patient or patient representative for additional information? ☐ **Yes** ☐ **No**

†To download a Coherus Solutions™ Patient Consent form for the patient to complete, please visit CoherusCsolutions.com and access the Resource tab for Letters and Forms.

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8 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*; or (c) traditional Medicare FFS insured patient(s) that demonstrate financial hardship and cannot afford their cost-sharing obligation as evidenced by a signed attestation from their provider
- Have an adjusted annual household income of ≤ 500% of Federal Poverty Level (FPL)
- Complete and sign consent form and, when applicable, provide income documentation
- Be under the care of a U.S. licensed provider, and receive UDENYCA® 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 or territory
- Diagnosis and dosing are consistent with FDA-approved indication for UDENYCA®
- Not have any other financial support options

9 PATIENT ATTESTATION

I understand that the PAP provides UDENYCA® at no charge and does not include the provider administration fee. I also understand that I am responsible for the administration costs.

I authorize the release of information about me and my medical condition, and I authorize my healthcare provider to release my protected health information and other individually identifiable information, including insurance and financial information, to Coherus BioSciences, Inc., its affiliates, its program administrators, and their respective agents, service providers and field reimbursement professionals (collectively, "Coherus") for the purpose of determining my eligibility for the PAP, and if I am eligible, enrolling me in the PAP, and for managing and administering the PAP program. 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 withdraw/revoke this authorization at any time in the future by contacting my healthcare provider or Coherus Solutions™ at 1-844-483-3692. My refusal or revocation will not affect the commencement or continuation of my treatment by my healthcare provider; however, if I do not sign or revoke this authorization, I will not be eligible to participate in PAP. 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 five (5) years after the date of my signature, unless I revoke it earlier. I understand that I may receive a copy of this authorization.

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 PAP 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. I can confirm that I do not have coverage for UDENYCA® or any other pegfilgrastim product (biosimilar or reference product).

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TC Script Pharmacy will first reach out to your healthcare provider to obtain the concurrent medications consumed or administered to you, and any relevant drug-allergy information. If TC Script Pharmacy is unsuccessful obtaining the required information from your healthcare provider, it may need to contact you directly before dispensing Coherus PAP drug.

Patient Signature _____ Date ____/____/____

* Functionally Underinsured means the patient does not have coverage for UDENYCA® or any other pegfilgrastim product (biosimilar or reference).

Coherus reserves the right to revise or terminate the Coherus Solutions™ program without notice at any time.

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