Patient Assistance Program
Product Request Form

Coherus Solutions™
Working together to ensure patient access

All fields are required unless otherwise indicated.

Date ____/____/____

PATIENT

First Name _____ Last Name _____ DOB ____/____/____

TREATING PROVIDER

First Name _____ Last Name _____ Title _____

Office Contact _____ Name _____

Phone _____ Email _____ (not required)

Delivery Location _____

PLEASE COMPLETE AND RETURN TODAY TO AVOID PRODUCT SHIPMENT DELAY
FAX Number: 1-877-226-6370

1. Is the patient in need of PAP replenishment? ☐ YES ☐ NO

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

2. Has there been a change in the patient's insurance coverage since the last treatment? ☐ YES ☐ NO

c. If YES, please provide the following information:

Insurance Name: _____

Insurance ID: _____ Insurance Phone: _____

3. When is the patient's next treatment date? ____/____/____

4. Please provide any additional comments below:

_____

_____

_____

_____

If you have any questions, please call Coherus Solutions™ at 1-844-4-UDENYCA (1-844-483-3692), Monday through Friday, 8AM to 8PM ET.

Coherus BIOSCIENCES