Coherus Solutions™

UDENYCA® (pegfilgrastim-cbqv)
Product Replacement Program

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

Product Request Form

The Coherus Solutions™ Product Replacement program allows physician offices or hospital outpatient departments to receive UDENYCA® (pegfilgrastim-cbqv) replacement product if all eligibility criteria is met.
(See Coherus Solutions™ Product Replacement Program Terms and Conditions).

Please complete this form and submit all required documentation to Coherus Solutions™ via **Fax at 1-877-226-6370**

Date: _____ *Date of service:* _____ *Date of denial:* _____

If applicable:

Date of 1st appeal: _____ *Date of 2nd appeal:* _____

_____	_____	_____
Patient first name	*Patient last name*	*Patient date of birth*
_____	_____	_____
Provider first name	*Provider last name*	*Provider title*

_____
Treatment facility name *Contact phone number*

_____
Delivery location

Product-Specific Benefit Verification

For a patient to qualify for the Product Replacement Program, a product-specific benefit verification demonstrating active coverage must have been completed and documented prior to treatment with UDENYCA®.

Please complete the following:

The product-specific benefit verification was completed by

☐ Provider/provider office ☐ Coherus Solutions™ Date benefit verification completed _____

If a Benefit Verification was not completed by the HUB, a legible co-pay of the Summary of Benefits obtained by the office, prior to injection, must be submitted.

Was a prior authorization (PA) required or a Predetermination recommended?

☐ Yes ☐ No Date PA submitted _____

If a PA was required or predetermination was recommended, please submit the PA or predetermination approval documentation with this request form.

All appeals must be completed within the timely filing limit. If appeals were conducted by the provider office, please provide the following documentation with this request form:

- Initial denied claim (EOB)
- Documentation of TWO levels of appeals and denials
- A copy of the charge sheet or claim form (CMS 1500 or UBO4) must be submitted to confirm that therapy was used for an on-label indication

If only one level of appeals has been completed, please contact Coherus Solutions™ to assist with the second appeal.

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To be completed by office

By signing below, I 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 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® (pegfilgrastim-cbqv). 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. In addition, I attest that a benefits-verification was completed, all payer coverage requirements were followed prior to administration, and that the product was prescribed for a medically appropriate use as determined by the specific payer's policies and coverage guidelines. I also attest that I did not or will not receive payment for the product in which I am requesting a replacement nor do I belong to a physician practice that receives an all-inclusive payment for patients covered under the insurance plan. I understand the program only provides a replacement product and does not cover any costs related to the office visit or administration of the product. I understand and agree, Coherus BioSciences, Inc. may modify or discontinue its Product Replacement Program without notice at any time for any reason.

I attest that I will not receive payment for UDENYCA® and that I do not belong to a physician practice that receives an all-inclusive payment for patients covered under this insurance plan. **I acknowledge that this product replacement will be returned if payment is recognized at any time in the future.**

Office Contact (Name)_____ Date:_____

Office Contact Signature_____

*If you do not have patient consent, please utilize patient consent form at www.CoherusSolutions.com

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To be completed by Field Reimbursement Manager (FRM)

I, _____(FRM), hereby attest that I:

(1) performed a thorough review of necessary documentation pertaining to the included claim(s)

(2) certify that to the best of my ability, this PRP request complies with SOP-001977

(3) believe that based upon this review, alternative steps the provider would take, beyond those outlined in section 4.2 of SOP-001977, do not seem to be warranted.

Field Reimbursement Manager Signature_____ Date: _____

Coherus BIOSCIENCES