Virtual Debit Card
Fax Coversheet

Coherus COMPLETE™
The clear choice for patient support

To: Coherus COMPLETE™ Co-Pay Assistance Program	Fax To: 1-888-481-0544
Pages (including cover):	Requested Payment Type: ☒ Virtual Debit Card
Date:	
From:	Primary Phone:
Patient Name:	Patient Date of Birth:

This coversheet is only required when requesting reimbursement with a Virtual Debit Card.

Please include your patient's Explanation of Benefits (EOB) and FAX to Coherus COMPLETE™ Co-Pay Assistance Program. Please ensure the claim documentation clearly states the CPT/Q-Code, NDC, and/or Drug Name as well as the patient's remaining out-of-pocket expense for UDENYCA® (pegfilgrastim-cbqv).

Once claim is approved, a Virtual Debit Card will be issued by fax.

To continue to be eligible, your patient must be using private or commercial insurance to cover a portion of their medication costs for UDENYCA®. This program is not available to individuals who use any state or federally-funded healthcare program to cover a portion of medication costs, such as Medicare, Medicaid, TRICARE, Department of Defense, or Veterans Administration. The provider needs to confirm with the patient they will not seek reimbursement from any other programs.

If you have any questions about the Coherus COMPLETE™ Co-Pay Assistance Program, please call 1-844-4-UDENYCA (1-844-483-3692) or visit www.CoherusCOMPLETE.com.

Sincerely,

The Coherus COMPLETE™ Co-Pay Assistance Program Manager

0220-COH-P413