

Check for services requested:

- Benefits Verification
- Prior Authorization
- Claims & Appeals Support

- Co-Pay Assistance Program
- Patient Assistance Program (PAP)
- Alternative Coverage (e.g., Independent Foundations and Non Co-Pay Support)

1 PATIENT INFORMATION

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

Patient's Address: _____ City: _____ State: _____ ZIP: _____

Patient's Home Phone #: _____ Cell Phone #: _____ 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 INSURANCE

Check the appropriate box: MEDICARE MEDICAID
 COMMERCIAL/PRIVATE OTHER UNINSURED

Insurance Name: _____

Phone #: _____

Policy ID #: _____ Group #: _____

Policyholder's Name: _____

Policyholder's Date of Birth: / /

Policyholder's Relationship to Patient: _____

SECONDARY INSURANCE

Check the appropriate box: MEDICARE MEDICAID
 COMMERCIAL/PRIVATE OTHER UNINSURED

Insurance Name: _____

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

CPT Code: _____

UDENYCA® (pegfilgrastim-cbqv) Injection (6 mg/0.6 mL prefilled syringe)

Quantity: _____

4 PRESCRIBER INFORMATION

Prescriber's Name: _____ Prescriber's Specialty: _____

Practice/Facility Name: _____

NPI #: _____ DEA #: _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Office Contact's Name: _____ Office Contact's Email: _____

Office Contact's Phone #: _____ Fax #: _____

Tax ID #: _____ Group NPI #: _____ Preferred Method of Contact: Phone Email Fax

5 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 COMPLETE™ 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.

Signature (Required): _____