Coherus COMPLETE™

The clear choice for patient support

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.CoherusCOMPLETE.com

Check for services requested:

- ☐ Benefits Verification
- ☐ For Electronic Prior Authorization (ePA) Services, go to www.CoherusCOMPLETE.com
- ☐ PA Appeal Support
- ☐ Co-Pay Assistance Program
- ☐ Claim Support and Appeals

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.)

Benefit Verification Preference: ☐ MEDICAL ☐ PHARMACY ☐ BOTH

PLEASE COMPLETE THE INSURANCE SECTION(S) THAT CORRESPOND TO THE PREFERRED BENEFIT VERIFICATION.

PRIMARY MEDICAL INSURANCE

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

Insurance Name:

Medicare Beneficiary ID# (if applicable):

Phone #:

Policy ID #: Group #:

Policyholder's Name:

Policyholder's Date of Birth: / /

Policyholder's Relationship to Patient:

SECONDARY MEDICAL INSURANCE (If Applicable)

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:

PHARMACY BENEFIT PLAN (If Applicable)

Insurance Name:

Phone #:

ID #:

Group #: BIN:

PCN:

Policyholder's Name:

Policyholder's Date of Birth: / /

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)

4 PRESCRIBER INFORMATION

Prescriber's Name:

Practice/Facility Name: Organization Tax ID#:

Individual NPI #: Organization NPI #:

Mailing Address: City: State: ZIP:

Office Contact's Name: Fax #:

Office Contact's Phone #: Email:

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): ______________________________

*To download a Coherus COMPLETE™ Patient Authorization form for the patient to complete, please visit CoherusCOMPLETE.com and access the Resource tab for Letters and Forms.

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