

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): _____

Patient Assistance Program

Under this program, Coherus BioSciences agrees to ship product to the provider for patients who qualify for the Patient Assistance Program (PAP). The terms and conditions below must be met in order for a patient to be enrolled in the program.

- Patient must meet the eligibility criteria.
- Provider must complete enrollment process, including the PAP enrollment form.
- Patient must provide consent to disclose personal information to Coherus COMPLETE™ to perform a soft credit check and, when applicable, provide income documentation for the purposes of the PAP.

I understand that the PAP provides UDENYCA® (pegfilgrastim-cbqv) at no charge and does not include the provider administration fee. I also understand that I am responsible for the administration costs.

By signing this form, I attest that I am a U.S. resident. (US Residency means currently residing in the USA with the intent to reside there indefinitely).

Income Verification

Coherus COMPLETE™ and its authorized third-party agents will use my date of birth or Social Security number and/or additional demographic information as needed to access my credit information derived from public and other sources to estimate my income in conjunction with the eligibility determination process. The free product financial approval tool (via soft credit inquiry) will not impact my credit score.

Opt-out for the free product financial approval tool (soft credit inquiry): Please do not access my credit information to estimate my income via soft credit inquiry.

I will instead provide one of the following income documents along with this Coherus COMPLETE™ Enrollment Form:

- Copy of W-2 or most recently filed US Income Tax Return (IRS Form 1040, 1040A, 1040EZ, 1040NR, or 1040PR), **or**
- Copy of most recent pay stub **plus** most recently filed US Income Tax Return, **or**
- Copy of transcript received through submission of IRS 4506-T (request for transcript form is not accepted), **or**
- Copy of most recent Social Security/disability monthly check, Award Letter, Benefit Statement or 1099, **or**
- Copy of Unemployment Determination letter

Prescribing Physician to Complete

Rx for UDENYCA® (pegfilgrastim-cbqv) injection (6mg/0.6 mL prefilled syringe)

Quantity: _____ Refill(s): _____ Sig instructions: _____

Treatment start date: ___/___/___ Anticipated refill date: ___/___/___

For patients who are being considered for retrospective PAP, please include the date of service on which

UDENYCA® was administered (date of service): ___/___/___

If available, please include administration log # _____

Patient name (required): _____ Patient date of birth (required): _____

Patient or patient representative signature: _____

Patient representative name: _____ Phone: _____

Relationship to patient: _____

Is it OK to contact patient or patient representative for additional information? Yes No