Patient Assistance Program Product Request Form

All fields are required unless otherwise indicated.

Date ____/____/____

PATIENT

First Name ____________________ Last Name ____________________ DOB ____/____/____

TREATING PROVIDER

First Name ____________________ Last Name ____________________ Title ____________________

Office Contact ____________________ Name ____________________

Phone ____________________ Email ____________________ (not required)

PLEASE COMPLETE AND RETURN TODAY TO AVOID PRODUCT SHIPMENT DELAY
FAX Number: 1-877-226-6370

1. Is the patient in need of PAP replenishment? ☐ YES ☐ NO

a. Providers requesting more than six (6) PAP fills for the same patient will be required to provide written attestation reaffirming continued PAP necessity (DX, patient therapy log, hardship, etc.)

2. Has there been a change in the patient's insurance coverage since the last treatment? ☐ YES ☐ NO

c. If YES, please provide the following information:

Insurance Name: ____________________

Insurance ID: ____________________ Insurance Phone: ____________________

3. When is the patient's next treatment date? ____/____/____

4. Please provide any additional comments below:

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If you have any questions, please call Coherus COMPLETE™ at 1-844-4-UDENYCA (1-844-483-3692), Monday through Friday, 8AM to 8PM ET.

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