Coherus COMPLETE™
The clear choice for patient support

Print Form Save Form

Patient Assistance Program 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:

☐ Patient Assistance Program (PAP)

☐ Retro PAP
- For patients who have received UDENYCA® (pegfilgrastim-cbqv) in the past 6 months
- Medicare patients are not eligible for RetroPAP

☐ Temporary PAP (T-PAP)
- T-PAP may be approved for patients who cannot currently access UDENYCA®:
  - That have applied for Medicaid coverage and are waiting for an approval/denial notice
  - Identified as having active Emergency Medicaid

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.)

PRIMARY MEDICAL INSURANCE (If Applicable)

Check the appropriate box: ☐ MEDICARE ☐ UNDERINSURED* ☐ UNINSURED *Medicare patients with secondary insurance are not eligible for PAP.*

Insurance Name:

Medicare Beneficiary ID# (if applicable):

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:

4 PRESCRIBER INFORMATION

Prescriber's Name:

Practice/Facility Name: Organization TAX ID#:

Prescriber NPI #: Organization NPI #:

Mailing Address: City: State: ZIP:

Office Contact's Name: Fax #:

Office Contact's Phone #: Email:

5 Rx FOR UDENYCA® INJECTION (6MG/0.6 ML PREFILLED SYRINGE)

Prescribing Physician to Complete

Quantity: _____ Refill(s): _____ Frequency of treatments: _____

Treatment start date: _____ Anticipated refill 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): _____

6 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): _____

*Underinsured includes patients with health insurance that does not cover UDENYCA®.

†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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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 form and sign prescription
- Patient must complete and sign the consent and, when applicable, provide income documentation

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.

I authorize the release of information about me and my medical condition, and I authorize my healthcare provider to release my protected health information and other individually identifiable information, including insurance and financial information, to Coherus BioSciences, Inc., its affiliates, its program administrators, and their respective agents, service providers and field reimbursement professionals (collectively, "Coherus") for the purpose of determining my eligibility for the PAP, and if I am eligible, enrolling me in the PAP, and for managing and administering the PAP program. I understand that once my protected health information is disclosed as permitted by this authorization, it may be redisclosed by Coherus and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal privacy laws. I understand that I may refuse to sign this authorization. I may also withdraw/revoke this authorization at any time in the future by contacting my healthcare provider or Coherus COMPLETE™ at 1-844-483-3692. My refusal or revocation will not affect the commencement or continuation of my treatment by my healthcare provider; however, if I do not sign or revoke this authorization, I will not be eligible to participate in the PAP. If I revoke this authorization, my revocation will not affect protected health information previously disclosed in reliance upon this authorization. I understand and agree that this authorization will remain valid for five (5) years after the date of my signature, unless i revoke it earlier. I understand that I may receive a copy of this authorization.

By applying for the PAP, I understand and agree that (i) there is no charge to participate and my participation is not contingent upon any requirement to purchase or use any Coherus product; (ii) completing and signing the PAP application and this authorization does not guarantee my eligibility; (iii) the PAP may change or end at any time; (iv) PAP medication received will not count toward my true-out-of-pocket costs under Medicare Part D; and (v) I will not seek to be reimbursed or receive credit from any insurance provider, including Medicare Part D plans, for any PAP medication received.

Patient Signature _____ Date _____

APPLICANT FINANCIAL VERIFICATION AUTHORIZATION

I understand that by checking the "I Agree" box immediately following this notice, I am providing "written instructions" to Coherus BioSciences, Inc. and/or its agents and contractors under applicable federal and/or state law authorizing them to perform electronic income verification by obtaining information from my personal credit profile or other information from Experian Health. I authorize Coherus and/or their agents and contractors to obtain such information solely to validate my income for the purposes of determining my eligibility for patient assistance.

☐ **I AGREE to the terms above for electronic income verification using Experian Health.**

☐ **I DO NOT AGREE with the terms above and do not wish to have my income verified by Experian Health. I understand that I will be asked to provide supporting documentation to authenticate my income and eligibility.**

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**

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