Coherus COMPLETE™
The clear choice for patient support

Product Replacement Program

Call **1-844-4-UDENYCA (1-844-483-3692)**
Monday through Friday • 8 AM to 8 PM ET
Fax **1-877-226-6370**
www.CoherusCOMPLETE.com

Product Request Form

The Coherus COMPLETE™ Product Replacement program allows physician offices or hospital outpatient departments to receive UDENYCA® (pegfilgrastim-cbqv) replacement product if all eligibility criteria is met. (See Coherus COMPLETE™ Product Replacement Program Terms and Conditions).

Please complete this form and submit all required documentation to Coherus COMPLETE™ via **Fax at 1-877-226-6370**

Date: _____ *Date of service:* _____ *Date of denial:* _____

If applicable:

Date of 1st appeal: _____ *Date of 2nd appeal:* _____

_____ _____ _____
Patient first name *Patient last name* *Patient date of birth*

_____ _____ _____
Provider first name *Provider last name* *Provider title*

_____
Treatment facility name

Product-Specific Benefit Verification

For a patient to qualify for the Product Replacement Program, a product-specific benefit verification demonstrating active coverage must have been completed and documented prior to treatment with UDENYCA® (pegfilgrastim-cbqv).
Please complete the following:

The product-specific benefit verification was completed by

☐ Provider/provider office ☐ Coherus COMPLETE™ Date benefit verification completed _____

If the provider/provider office conducted the product-specific benefit verification, please submit proof of verification:

Payer reference number: _____ or customer service agent name, date and time of call _____

Additionally, if available, or if payer reference number is not available, please submit medical record notes that document the product-specific benefit verification with this request form.

Was a prior authorization (PA) required or a Predetermination recommended?

☐ Yes ☐ No Date PA submitted _____

If a PA was required or predetermination was recommended, please submit the PA or predetermination approval documentation with this request form.

All appeals must be completed within the timely filing limit. If appeals were conducted by the provider office, please provide the following documentation with this request form:

- Initial denied claim (EOB)
- Documentation of TWO levels of appeals and denials

If only one level of appeals has been completed, please contact Coherus COMPLETE™ to assist with the second appeal.

By signing below, I attest that I have the patient's HIPAA consent on file authorizing release of the patient's protected health information and insurance information to Coherus BioSciences, Inc., its business partners, and field reimbursement professionals*. In addition, I attest that a product-verification was completed, all payer coverage requirements were followed for UDENYCA® prior to administration, and that UDENYCA® was used for the FDA approved indication as part of the patient's treatment with UDENYCA®. I attest that I will not receive payment for UDENYCA® and that I do not belong to a physician practice that receives an all-inclusive patient for patients covered under this insurance plan. I understand the program only provides a replacement product and does not cover any costs related to the office visit or administration of the product. Coherus BioSciences may modify or discontinue this program without notice at any time for any reason.

Office Contact (Name)_____ Date:_____

Office Contact Signature_____

*If you do not have patient consent, please utilize patient consent form at www.CoherusCOMPLETE.com.

Coherus BIOSCIENCES