accord Cares™ | CAMCEVI® (leuprolide) 42 mg injection emulsion

AccordCares™ Prescription and Enrollment Form

To get started, please complete and fax this form to 1-855-558-6304, or you may complete and electronically sign at www.accordcaresportal.com. For assistance, please call AccordCares™ at 1-866-258-7151.

SELECT ALL REQUESTED SERVICES:

☐ Benefits Verification
(Complete sections 1,2,3)

☐ Co-Pay Program
(Complete sections 1,2,3 - patient signature **not** required)

☐ Prior Authorization Support and/or Appeal Support
(Complete sections 1,2,3)

☐ Patient Assistance Program (PAP) (For Uninsured Patients)
(Complete sections 1,2,3,5 - patient signature required)

SECTION 1: PATIENT INFORMATION *INDICATES A REQUIRED FIELD

SEX* ☐ M ☐ F

* PATIENT NAME (FIRST, MI, LAST)

* STREET ADDRESS | * CITY | * STATE | * ZIP

☐ OKAY TO LEAVE MESSAGE

* DATE OF BIRTH (MM/DD/YY) | * PRIMARY PHONE | ALTERNATE PHONE

LANGUAGE PREFERENCE | CAREGIVER NAME | RELATIONSHIP TO PATIENT | CAREGIVER PHONE

SECTION 2: INSURANCE INFORMATION PLEASE INCLUDE A COPY OF EACH INSURANCE CARD *INDICATES A REQUIRED FIELD

☐ PATIENT HAS NO INSURANCE (SKIP TO SECTION 3 BELOW)

	PRIMARY INSURANCE	SECONDARY INSURANCE	PRESCRIPTION INSURANCE
* INSURANCE / PAYER NAME			
INSURANCE PLAN NAME			
* POLICYHOLDER NAME			
* POLICYHOLDER DOB			
* RELATIONSHIP TO POLICYHOLDER			
* POLICY ID NUMBER			
GROUP NUMBER			
INSURANCE PHONE NUMBER			
RX BIN / PCN	Not Applicable	Not Applicable	

Product (all references to the Product in this form shall mean the product selected below):

☐ CAMCEVI: PRE-FILLED SYRINGE CONTAINING 42 MG OF CAMCEVI (LEUPROLIDE INJECTABLE EMULSION): Inject 42mg subcutaneously once every 6 months.

*PRIMARY DIAGNOSIS CODE:	SECONDARY DIAGNOSIS CODE:

SECTION 3: PRESCRIBER CERTIFICATION TO BE COMPLETED BY HEALTHCARE PROVIDER **INDICATES A REQUIRED FIELD*

By signing below, I represent and warrant the following:

- I am authorized pursuant to the laws of my state of license to prescribe the Product.
- I, or others in my healthcare provider practice group, ("my Practice") have obtained written authorization from the patient named in this Enrollment Form that (1) complies with the requirements of the HIPAA Privacy Rule, 45 C.F.R. § 164.508; (2) authorizes me and the Practice, as well as the patient's health insurance plan(s), to disclose the patient's personal health information ("PHI"), including information relating to the patient's medical condition and prescription medications and the information disclosed in this Enrollment Form to AccordCares™, the AccordCares Patient Assistance Program ("PAP") and the AccordCares Co-Pay Program (collectively, "the Programs"); and (3) authorizes the Programs (together with their respective administrators, contractors, or other affiliates) to use and disclose the PHI for purposes of benefits investigation and reimbursement support.
- I have read and agree to the Terms and Conditions of the AccordCares Co-Pay Program (below). I certify that, to the best of my knowledge, the patient meets the criteria set forth in the Terms and Conditions. Further, I certify that I, or a provider in my practice, have determined that the prescribed product is medically appropriate of the patient and I, or a provider in my practice, will supervise the patient's treatment
- I certify that I/my office will not (1) charge the patient any fee to complete this form (2) advertise or otherwise use the Programs as a means of promoting my services or the Product; and (3) will not consider the fact that the patient may receive a benefit from the Programs when determining the amount of any charge(s) to the patient.
- I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient.
- If the patient receives free product through the AccordCares Patient Assistance Program, neither I nor my Practice will seek reimbursement for such product administered to the patient from any source.
- Neither I nor my Practice will receive any reimbursement from AccordCares, whether for administration fees or otherwise.
- If required, I understand that I am/my office is responsible for reporting receipt of AccordCares Co-Pay Program benefits to any insurer, health plan, or other third party that pays for or reimburses any part of the medication cost paid for by the AccordCares Co-Pay Program.
- I hereby certify that, for any insured patient seeking co-pay assistance under the AccordCares Co-Pay Program, in the absence of financial support from such program, any applicable copay, coinsurance, or other out-of-pocket cost for the Product will be collected from the patient upon treatment.
- I understand that I may be asked to sign a new Prescriber Certification if the Terms and Conditions of the AccordCares Co-Pay Program for the Product change.
- I understand that information concerning Program participants may be summarized for statistical or other purposes and provided to AccordCares and/or the Programs only for use in an aggregated, de-identified format.
- I and my Practice grant the Programs the right to conduct periodic audits of my Practice's records to verify the information provided herein, excluding patient-identifiable data (unless the auditor enters into an appropriate agreement with my Practice to protect an individual's medical privacy).
- I consent to receive communications related to the Programs by phone, email, and fax.
- I understand that AccordCares, its affiliates and vendors reserve the right to modify or discontinue this program at this facility/practice or terminate assistance at any time and without notice.
- I certify that the information provided above is true and correct and that the Product is being prescribed for the patient listed above.

* PRINT NAME OF HEALTHCARE PROVIDER | * HEALTHCARE PROVIDER SIGNATURE | * SIGNATURE DATE (MM/DD/YY)

* PRACTICE / INSTITUTION NAME

* STREET ADDRESS | * CITY | * STATE | * ZIP

* OFFICE PHONE | * OFFICE FAX | * OFFICE CONTACT

* OFFICE CONTACT PHONE NUMBER | * GROUP TAX ID | * NPI NUMBER | * STATE LICENSE NUMBER

SECTION 4: COPAY ASSISTANCE

AccordCares™ Co-Pay Assistance Program Terms and Conditions: The AccordCares Co-Pay Program can be used to reduce the amount of an eligible patient's out-of-pocket expenses for the Product. With this program, eligible patients may pay as little as $0 co-pay per the Product treatment, subject to a maximum benefit of $10,000 per calendar year for out-of-pocket expenses for the Product including co-pays or coinsurances.

Patient must comply with the terms and conditions below:

- Patient must have private insurance with coverage of the Product.
- This program is not valid for patients who are enrolled in a state or federally funded insurance program, including but not limited to Medicare, Medicaid, TRICARE, Veterans Affairs health care, a state prescription drug assistance program, or the Government Health Insurance Plan available in Puerto Rico (formerly known as "La Reforma de Salud").
- Program offer is not valid for cash-paying patients and the patients are responsible for any out-of-pocket costs for the Product that exceed the annual maximum.
- The program does not cover or provide support for supplies, procedures, or any physician-related service associated with the Product.
- This offer is not valid when the entire cost of a patient's prescription drug is eligible to be reimbursed by patient's private insurance plans or other private health or pharmacy benefit programs.
- The patient must deduct the value of this assistance from any reimbursement request submitted to patient's private insurance plan, either directly by you or on your behalf.
- If required, the patient is responsible for reporting use of the program to any private insurer, health plan, or other third party who pays for or reimburses any part of the prescription filled using the program.
- The patient should not use the program if their insurer or health plan prohibits use of manufacturer co-pay assistance programs.
- The patient or patient's legally authorized representative must be 18 years of age or older to be eligible for this Co-Pay Assistance Program.

- This program is not considered health insurance. This program is not valid where prohibited by law. This program cannot be combined with any other savings, free trial or similar offer for the specified prescription. Valid prescription is required.
- Accord Biopharma reserves the right to rescind, revoke or amend this program without notice. This offer is not conditioned on any past, present, or future purchase, including refills. The program terms and offer will expire at the end of each calendar year.

SECTION 5: PATIENT ASSISTANCE PROGRAM

TO BE COMPLETED BY THE PATIENT OR THEIR AUTHORIZED REPRESENTATIVE (SECTION 5 IS ONLY REQUIRED IF REQUESTING PATIENT ASSISTANCE)

AccordCares™ Patient Assistance Program and Fair Credit Reporting Act (FCRA) Authorization:

By signing below, the patient acknowledges that they will comply with the terms and conditions below:

- The AccordCares Patient Assistance Program is available to patients that do not have insurance, or their medicine is not covered by insurance.
- The patient will notify AccordCares promptly if patient's insurance situation changes.
- The patient understands that patient must meet certain income and other eligibility requirements. Some patients with Medicare Prescription Drug Coverage (Part D) who cannot afford their medicines and who meet certain financial criteria may also be eligible for assistance.
- AccordCares may ask for proof of income at any time for the purpose of audit/verification. Also Accord BioPharma may verify patient's eligibility for the AccordCares Program, and the patient understands that such verification may include contacting patient or patient's healthcare provider for additional information and/or reviewing additional financial, insurance, and medical information. If requested, the patient agrees to provide proof of income within 30 days of the request. Continuation in the program is conditioned upon timely verification of income.
- The patient authorizes Accord Biopharma to use patient's demographic information to access reports on patient's individual credit history from consumer reporting agencies for the purposes of determining patient's income eligibility. The patient understands that, upon request, Accord Biopharma will tell patient whether an individual consumer report was requested and the name and address of the agency that furnished it. The patient further understands and authorizes Accord Biopharma to use any consumer reports about patient and information collected from patient, along with other information they obtain from public and other sources, to estimate patient's income in conjunction with the AccordCares Patient Assistance Program eligibility determination process.
- The patient certifies that the financial information patient has set forth below, including the number of people in patient's household and patient's household income, are true and accurate to the best of patient's knowledge.
- The patient certifies that patient will not seek reimbursement or credit for this prescription requested under the AccordCares Patient Assistance Program from any insurer, health plan, or government program, and if patient is a member of a Medicare Part D plan, patient will not seek to have this prescription, or any cost associated with it, counted as part of patient's out-of-pocket cost for prescription drugs.
- The patient understands that any drugs provided under the AccordCares Patient Assistance Program shall not be sold, traded, bartered, or transferred.
- The patient understands that any program assistance provided by AccordCares will terminate if the program becomes aware of any fraud or if this medication is no longer prescribed for the patient.
- The patient certifies that patient cannot afford this medication.
- Patient certifies that patient is a permanent resident of the U.S. or U.S. Territory (including Guam, Puerto Rico, and the Virgin Islands), lives in the United States, or a U.S. Territory, and is being treated by a U.S. licensed doctor.
- The patient understands that completing this application does not ensure that patient will qualify for this program.
- Accord BioPharma reserves the right to rescind, revoke, or amend this program without notice.

Uninsured patients who are prescribed the Product may be eligible for the AccordCares Patient Assistance Program. To help determine if you/the patient qualifies, please fill in the information below (Patient Financial information is only required if requesting Patient Assistance):

Annual Pretax Household Income: $_____ Number Living in the Household (including members under 18) _____

WHICH BEST DESRIBES YOU? ☐ **I AM A PATIENT** ☐ **I AM A LEGALLY AUTHORIZED REPRESENTATIVE**

* **PRINT NAME OF PATIENT**

* **PRINT NAME OF LEGALLY AUTHORIZED REPRESENTATIVE** * **LEGALLY AUTHORIZED REPRESENTATIVE'S RELATIONSHIP TO PATIENT**

* **SIGNATURE OF PATIENT (OR PATIENT'S AUTHORIZED REPRESENTATIVE)** * **DATE (MM/DD/YYYY)**

☐ *(optional)* I have read and agree to the Terms and Conditions for participation in the AccordCares™ Patient Assistance Program and provide my authorization for the Fair Credit Reporting Act Authorization on Page 3.