BIOGEN
BIOSIMILAR SUPPORT SERVICES
FOR PATIENTS

**Questions?**
Contact a Support Coordinator at 1-877-422-8360

**Fax** 1-240-696-8830

# Biogen Biosimilar Support Services Enrollment Form

## INSTRUCTIONS FOR PATIENTS

Biogen Biosimilar Support Services offers eligible patients assistance to get started and stay on treatment. These services may include help understanding out-of-pocket costs and financial assistance for eligible patients.

To speak with a Support Coordinator about the resources that may be available to you, call **1-877-422-8360; Mon-Fri, 8:30 AM – 8 PM EST**.

1. After discussing **Biogen Biosimilar Support Services** with your healthcare provider, read the Patient Consent Information on pages 2 and 3.
2. To get started, fill out the form on page 4. Your healthcare provider will send it to Biogen Biosimilar Support Services, who will help you throughout the process. A Support Coordinator will contact you soon via telephone (1-877-422-8360) if information is needed.

**Biogen takes patient confidentiality very seriously. Signing this consent form will allow Biogen to provide support services that may require use of your personal health information.**

## INSTRUCTIONS FOR HEALTHCARE PROVIDERS

This form provides information to **Biogen Biosimilar Support Services** to contact your patients to provide support services. Please complete this form and return via fax to our toll-free fax number: 1-240-696-8830.

1. To get started, have your patient read the Patient Consent Information on pages 2 and 3. If you collectively determine a need for **Biogen Biosimilar Support Services**, have them fill out and sign the patient section of the form on page 4.
2. Complete the Healthcare Provider portion on pages 5-7. Copy both sides of the patient's medical insurance card and pharmacy benefit card.
3. Fax the completed form and copies of the insurance cards to 1-240-696-8830. Then give your patient the Instructions for Patients and Patient Consent Information pages. A **Biogen Biosimilar Support Services Support Coordinator** will contact your patient, if information is needed, to help them throughout the process.

As an alternative to this enrollment form, visit **BiogenBiosimilarSupportServices.com** to enroll your patients online

Visit **ByoovizHCP.com/Support** to learn more about Biogen Biosimilar Support Services

Biogen

BYO-US-0202v7 08/23
225 Binney Street, Cambridge, MA 02142

# PATIENT CONSENT INFORMATION

**Please read the following. If you agree, complete, sign, and date the corresponding section on page 4.**

## I. Authorization to Share Health Information

I understand that I have certain rights related to the collection, use, and disclosure of my medical and health information. This information is called "protected health information" (PHI) and includes demographic information (such as sex, race, date of birth, etc.), the results of physical examinations, clinical tests, blood tests, X-rays, and other diagnostic medical procedures that may be included in my medical records. Biogen will not use my PHI without my consent.

By signing this Authorization, I authorize my healthcare provider, my health insurance company, and my pharmacy providers ("Healthcare Entities") to disclose to Biogen, and companies working with Biogen (collectively, "Biogen"), health information relating to my medical condition, treatment, and insurance coverage for Biogen to (i) provide me with support services (and related information and materials) related to any of Biogen's products, including but not limited to, online support, financial assistance services, compliance and persistency and other therapy support services, (ii) conduct data analysis, market research and other necessary internal business activities, and (iii) provide me with information about Biogen's products, services, and programs for educational or other purposes. I understand that once I sign this Authorization, and my medical and health information is disclosed to Biogen by the Healthcare Entities, the Health Insurance Portability and Accountability Act (HIPAA) will no longer protect my information because Biogen is not covered by HIPAA. However, Biogen agrees to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. I understand that my pharmacy provider may receive remuneration from Biogen in exchange for the health information and/or for any therapy support services provided to me.

I understand that I may refuse to sign this Authorization. I further understand that my treatment (including with a Biogen product), payment for treatment, insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization; but if I do not sign it or later cancel it, I will not be able to receive Biogen's therapy support services.

I may cancel this Authorization at any time by mailing a letter to: Biogen, ATTN: Patient Services, 5000 Davis Drive, PO Box 13919, Research Triangle Park, NC, 27709 or emailing **privacy@biogen.com**. Canceling this Authorization will end my consent to further disclosure of my health information to Biogen by my Healthcare Entities after they are notified of my cancellation, but will not affect previous disclosures by them pursuant to this Authorization. Canceling this authorization will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance.

This Authorization expires ten (10) years, or such shorter timeframe required by applicable law, from the day I sign it as indicated by the date next to my signature unless otherwise canceled earlier as set forth above.

**Please sign in the space provided in Section A on page 4 to authorize your consent.**

## II. Patient Services Authorization

By checking the "Agree to terms" box and signing this authorization, I authorize Biogen, and companies working with Biogen, to provide me with support services related to any of Biogen's products, including but not limited to: online support, financial assistance services, compliance and persistency and other therapy support services, as well as any information or materials related to such services. I understand and agree that personnel including but not limited to nurses, providing such support services on behalf of Biogen are not employed by my healthcare professional. I authorize Biogen, and companies working with Biogen, to contact me to provide such services and information by mail, email, fax, telephone call, text message (including calls and text messages made with an automatic telephone dialing system or a prerecorded voice), chat and push notifications and other forms of electronic messaging.

I also authorize Biogen, and companies working with Biogen, to use and disclose my medical and health information in connection with providing the services, including but not limited to, disclosing my information to vendors, processors, and service providers for business purposes associated with providing the services, sharing such information with my healthcare provider, insurance provider, or pharmacy, or disclosing my information where required by applicable laws or regulations. I also authorize the disclosure of my health information to specific individuals that I have designated.

**Please sign in the space in Section B on page 4 to authorize your consent.**

# PATIENT CONSENT INFORMATION

## III. Marketing Authorization

By checking the box for this authorization, I authorize Biogen, and companies working with Biogen, to contact me by mail, email, fax, telephone call, and text message for marketing purposes or otherwise provide me with information about Biogen's products, services, and programs or other topics of interest, conduct market research or otherwise ask me about my experience with or thoughts about such topics.

I understand that Biogen may use auto-dialers, prerecorded messages and artificial voice messages to contact me at the telephone number I have provided on this form and that my mobile provider may charge me to receive these messages. I understand and agree that any information that I provide may be used by Biogen for marketing purposes, including targeted online marketing, as well as to help develop new products, services, and programs. I understand that Biogen will not sell or transfer my personal information to any unrelated third party for marketing purposes without my express permission. I understand that my consent to receive marketing communications is not required as a condition of purchasing or receiving any goods or services from Biogen. I understand that I may revoke this authorization and choose not to receive services or information from Biogen by mailing a letter to the address above or sending an email with the subject "Unsubscribe" to **privacy@biogen.com**.

**Please check the box in Section C on page 4 to authorize your consent.**

---

Residents of certain US States (including but not limited to California) may have additional rights regarding the collection, use, maintenance, disclosure, and deletion of your personal information. To understand or exercise those rights California residents please visit **https://www.biogen.com/privacy-center/california-policy.html**. For more information, visit **https://www.biogen.com/privacy-center.html**.

I understand that I have the right to receive a copy of the terms and conditions of my agreement with Biogen, and that I may request that copy at the time of signing or at a later date by contacting Biogen at: Biogen, ATTN: Patient Services, 5000 Davis Drive, PO Box 13919, Research Triangle Park, NC, 27709 or emailing **privacy@biogen.com**.

BIOGEN
BIOSIMILAR SUPPORT SERVICES
FOR PATIENTS

**Questions?**
Contact a Support Coordinator at 1-877-422-8360

**Fax** 1-240-696-8830

**PLEASE ENSURE PAGES 4-7 ARE COMPLETED**

# THE FOLLOWING SECTION SHOULD BE FILLED OUT BY THE PATIENT

*denotes a required field

## A I. Authorization to Share Health Information

I have read and understand the *Authorization to Share Health Information* and agree to the terms.

Signature of Patient or Patient's Legal Representative* Date*

If signed by Legal Representative, by my signature above, I represent and warrant that I have current legal authority to execute on behalf of the patient.

Please Explain Authority to Act on Behalf of the Patient

## B II. Patient Services Authorization

I have read and understand the *Patient Services Authorization* and agree to the terms.

Signature of Patient or Patient's Legal Representative* Date*

If signed by Legal Representative, by my signature above I represent and warrant that I have current legal authority to execute on behalf of the patient.

**Authorizing a Caregiver (optional)**

By providing caregiver information below, I authorize the disclosure of my health information to the following designated individual (optional).

☐ I also authorize this individual to take action on my behalf for the purposes of assessing my eligibility and enrolling me in Biogen services. I attest that the individual designated below has my permission and the knowledge and ability to accurately provide information about my insurance plans as well as provide details regarding my financial status.

If you authorize a caregiver above, please fill out the fields below:

Caregiver First Name | Caregiver Last Name | Relationship

Address

City | State | ZIP Code

Caregiver Email | Caregiver Phone

By providing the caregiver information above, I confirm that I have received permission from the designated individual listed above to share their contact information with Biogen.

## C III. MARKETING AUTHORIZATION

I also consent to receive autodialed and prerecorded marketing calls and text messages from Biogen, and companies working with Biogen, at the telephone number(s) that I provide. I understand that my consent is not required as a condition of purchasing or receiving any goods or services from Biogen.

☐ I have read and understand "Marketing Authorization" and hereby agree to receive information from Biogen (optional).

## PATIENT INFORMATION

First Name* | M.I. | Last Name*

Date of Birth (MM/DD/YYYY)*

Gender* (Check one) ☐ M ☐ F

Email

Phone Number

Address Type (Check one) ☐ Mailing ☐ Home ☐ Work ☐ Other

Address Line 1 (address/street)*

Address Line 2 (apt/suite #)

City* | State* | ZIP Code*

Biogen

BYO-US-0202v7 08/23
225 Binney Street, Cambridge, MA 02142

BIOGEN
BIOSIMILAR SUPPORT SERVICES
FOR PATIENTS

**Questions?**
Contact a Support Coordinator at 1-877-422-8360

**Fax** 1-240-696-8830

**PLEASE ENSURE PAGES 4-7 ARE COMPLETED**

# THE FOLLOWING SECTION SHOULD BE FILLED OUT BY A HEALTHCARE PROVIDER

## SUPPORT REQUESTED (check all that apply)

- ☐ Medical Benefits Verification
- ☐ Pharmacy Benefits Verification
- ☐ Appeals Support
- ☐ Authorization Assistance (Medical Benefit)
- ☐ Prior Authorization Assistance (Pharmacy Benefit)
- ☐ Claims Support
- ☐ Financial Assistance

## HEALTHCARE PROVIDER

First Name* | Last Name*

NPI* | Tax ID*

DEA Number* | Provider State License Number*

Licensing State* (only if state license # provided) | HIN

## ADMINISTRATION SITE

Name*

Tax ID* | NPI*

Address Line 1 (address/street)*

Address Line 2 (suite #/floor)

City* | State* | ZIP Code*

Office Contact First Name | Office Contact Last Name

Office Contact Phone Number* | Office Contact Email*

Fax number*

☐ Check here if HCP practice address is the same as the administration site.

Procurement Method (Check one)

☐ Specialty Pharmacy ☐ Buy and Bill

## PATIENT PRIMARY MEDICAL INSURANCE

Insurance Name* | Plan Name*

Policy Number* | Group Number

Plan Type (Check one)*

☐ Commercial/ Private ☐ Medicare ☐ TRICARE® ☐ VA/Military

☐ Managed Medicaid ☐ Traditional Medicaid ☐ Other

Phone Number*

Cardholder Relationship to Subscriber (Check one)

☐ Dependent ☐ Self ☐ Spouse

Subscriber Name* | Cardholder DOB (MM/DD/YYYY)*

## PRIMARY MEDICAL PHARMACY INSURANCE

Pharmacy Insurance Name*

Pharmacy Insurance Cardholder Identification*

Pharmacy Insurance Group Number

Benefit Identification Number (BIN)

Processor Control Number (PCN)

Phone Number*

**anti-VEGF Therapy History (Check one)**

☐ New to aVEGF ☐ Switching from another aVEGF Therapy

Therapy Switching From

Biogen

BYO-US-0202v7 08/23
225 Binney Street, Cambridge, MA 02142

**PLEASE ENSURE PAGES 4-7 ARE COMPLETED**

## PATIENT SECONDARY MEDICAL INSURANCE

Medical Insurance Name*

Plan Name*

Medical Insurance Policy Number*

Medical Insurance Group Number

Medical Insurance Plan Type (Check one)

☐ Commercial/ Private ☐ Medicare ☐ TRICARE® ☐ VA/Military

☐ Managed Medicaid ☐ Traditional Medicaid ☐ Other

Medical Insurance Phone Number

Cardholder Relationship to Subscriber (Check one)

☐ Dependent ☐ Self ☐ Spouse

Subscriber Name*

Cardholder DOB (MM/DD/YYYY)*

Pharmacy Insurance Name*

Pharmacy Insurance Cardholder Member ID*

Pharmacy Insurance Group Number

Benefit Identification Number (BIN)

Processor Control Number (PCN)

Phone Number*

## THE FOLLOWING SECTION SHOULD BE FILLED OUT BY A HEALTHCARE PROVIDER

*denotes a required field

## DRUG INFORMATION

Drug Name:* ☐ BYOOVIZ™ (ranibizumab-nuna)

HCPCS II Code:* ☐ Q5124 “Injection, ranibizumab-nuna, biosimilar, (BYOOVIZ), 0.1 mg”

NDC Code:* ☐ 64406-0019-01

## CLINICAL INFORMATION

Primary Indication (Check one)

☐ Neovascular (Wet) Age-Related Macular Degeneration (AMD)

☐ Macular Edema Following Retinal Vein Occlusion (RVO)

☐ Myopic Choroidal Neovascularization (mCNV)

**Primary Diagnosis Code* (Check one)**

**Neovascular (Wet) Age-Related Macular Degeneration (AMD)**

| **Exudative age-related macular degeneration** | Right eye | Left eye | Bilateral | Unspecified eye |
|---|---|---|---|---|
| Stage Unspecified | ☐ H35.3210 | ☐ H35.3220 | ☐ H35.3230 | ☐ H35.3290 |
| With active choroidal neovascularization | ☐ H35.3211 | ☐ H35.3221 | ☐ H35.3231 | ☐ H35.3291 |
| With inactive choroidal neovascularization | ☐ H35.3212 | ☐ H35.3222 | ☐ H35.3232 | ☐ H35.3292 |
| With inactive scar | ☐ H35.3213 | ☐ H35.3223 | ☐ H35.3233 | ☐ H35.3293 |

**Macular Edema Following Retinal Vein Occlusion (RVO)**

| **Central retinal vein occlusion** | Right eye | Left eye | Bilateral | Unspecified eye |
|---|---|---|---|---|
| With macular edema | ☐ H34.8110 | ☐ H34.8120 | ☐ H34.8130 | ☐ H34.8190 |
| **Tributary (branch) retinal vein occlusion** | Right eye | Left eye | Bilateral | Unspecified eye |
| With macular edema | ☐ H34.8310 | ☐ H34.8320 | ☐ H34.8330 | ☐ H34.8390 |

**Myopic Choroidal Neovascularization (mCNV)**

| **Degenerative myopia** | Right eye | Left eye | Bilateral | Unspecified eye |
|---|---|---|---|---|
| With choroidal neovascularization | ☐ H44.2A1 | ☐ H44.2A2 | ☐ H44.2A3 | ☐ H44.2A9 |

## HCP ATTESTATION

My signature certifies the following: (i) that the person named on this Enrollment Form is my patient, (ii) that I have obtained his/her written authorization and certification under Section 2.3 of this form, (iii) that to the best of my knowledge the information, if applicable, under Section 6.2 of this form is accurate and complete, (iv) that I will retain in my files the complete patient-executed Enrollment Form, and (v) that upon request, I will promptly provide a copy of this patient-executed Enrollment Form on file to **Biogen Biosimilar Support Services**.

My signature below certifies that the person named on this form is my patient, the information provided on this application, to the best of my knowledge, is complete and accurate, and that **BYOOVIZ** received in response to this application is only for the use of **BYOOVIZ** for the patient named on this form. With regard to any patient eligible for patient assistance through the **Biogen Biosimilar Support Services** program, I acknowledge that this medication will not be offered for sale, trade, or barter and **EITHER** no claim for reimbursement of either **BYOOVIZ** or related medical procedures and services will be submitted to Medicare, Medicaid, or any third-party payer **OR** I will provide appropriate denial and appeals documentation to support requests for patients who are deemed uninsured after a claim was submitted. I consent to **Biogen Inc.** and its affiliates, representatives, agents, and contractors contacting me by fax, phone, mail, or email to confirm receipt of **BYOOVIZ** or provide additional information about **BYOOVIZ** or the **Biogen Biosimilar Support Services** program and that **Biogen Inc.** may revise, change, or terminate any program services at any time without notice to me. I authorize **Biogen Inc.** and its representatives and contractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient, and I appoint the **Biogen Biosimilar Support Services** program solely to convey the prescription herein on my behalf to the pharmacy chosen by or for the above-named patient.

| | |
|---|---|
| Provider Signature* | Date* |