Heron Connect Insurance Verification and Program Enrollment Form

This form should be used to enroll patients receiving CINVANTI® (aprepitant) injectable emulsion and/or SUSTOL® (granisetron) extended-release injection into Heron Connect for insurance verification, copay assistance, and patient assistance. To enroll a patient, please complete and submit the enrollment form by faxing it to 1-844-504-8652. Heron Connect can be reached at 1-844-437-6611 to answer general questions, 8 AM to 8 PM ET, Monday through Friday, or visit HeronConnect.com.

HERON CONNECT®

CINVANTI® (aprepitant) injectable emulsion | sustol® (granisetron) extended-release injection

PRODUCT SELECTION (REQUIRED) ❍ CINVANTI ❍ SUSTOL ❍ Both CINVANTI & SUSTOL

HERON CONNECT offers claims tracking to monitor the status of your SUSTOL and CINVANTI claims. This service confirms that claims are being processed appropriately by the payer. Would you like to enroll in this service? **Yes** ❍ **No** ❍

1 PRESCRIBING PHYSICIAN INFORMATION AND PHYSICIAN ENROLLMENT CERTIFICATION (REQUIRED)

Physician's Name: _____ Address: _____

Practice/Facility Name: _____ City: _____ State: _____ ZIP: _____

Physician's Specialty: _____ Telephone: ( ) _____

Physician's State License #: _____ Fax: ( ) _____

Physician's Tax ID #: _____ Email: _____

Prescriber's National Provider Identifier (NPI) #: _____ Site's National Provider Identifier (NPI) #: _____

Site Contact: _____ Telephone: ( ) _____ Email: _____

2 PATIENT INFORMATION AND INSURANCE INFORMATION (REQUIRED)

Patient's Name: _____ Preferred Phone: ( ) _____

Address: _____ Email: _____

City: _____ State: _____ ZIP: _____ Date of Birth: _____

Gender: ❍ Male ❍ Female

Attach a copy of the insurance card (front AND back) OR complete insurance information below:

Primary Insurance: _____ **Secondary Insurance:** _____

Primary Insured's Name: _____ Secondary Insured's Name: _____

Employer: _____ Employer: _____

Phone: _____ Phone: _____

Policy #: _____ Policy #: _____

Group #: _____ Group #: _____

Health Plan Name: _____ Health Plan Name: _____

3 PATIENT TREATMENT INFORMATION

Patient's Primary Diagnosis (ICD-10): _____ Patient's Secondary Diagnosis (ICD-10): _____

Administered With (include all chemotherapy agents): _____

Therapy Provided in: ❍ Doctor's Office ❍ Hospital ❍ Outpatient Facility – Treatment Start Date: _____

Previous Therapy/Therapies: _____

4 HERON CONNECT COPAY ASSISTANCE PROGRAM*

❍ Please select if you are interested in the Heron Connect Copay Assistance Program.* Eligible patients with private commercial (non-government payers) insurance pay $0 in out-of-pocket costs and when applicable, deductible assistance up to $200 per treatment will be covered.

You may be eligible for the Heron Connect Copay Assistance Program* if:

- You have commercial insurance that covers your prescribed medication, but your insurance does not cover the full cost; that is, you have a copay or coinsurance obligation for your prescribed medication
- You are not participating in any state or federal healthcare program including, for example, Medicaid, Medicare, Medigap, CHAMPUS, DoD, VA, TriCare, or any state, patient, or pharmaceutical assistance program. Patients who move from commercial insurance to a state or federal healthcare program will no longer be eligible
- You live in the United States or its territories
- You are prescribed CINVANTI and/or SUSTOL by your physician
- You have been treated within 120 days of your enrollment date and submit your request for reimbursement within 180 days of treatment

*Limitations apply. Offer not valid as follows: (a) patients covered under Medicare, Medicaid, or any federal or state program; (b) where plan covers treatment for the patient for the entire cost of the prescription drug. Patients pay $0 copay per dose per 12-month calendar period. When applicable, deductible assistance up to $200 per treatment will be covered. For cash-paying patients, the program will cover $150 per prescription up to $1,800 per calendar year. Eligibility is for 12 months, after which patient will need to reapply for continued assistance. This offer expires 12/31/2021.

HERON THERAPEUTICS

5 HERON CONNECT PATIENT ASSISTANCE PROGRAM (PAP)†

❍ Please select if you are interested in the Heron Connect PAP.† The Heron Connect PAP† can provide CINVANTI and/or SUSTOL at no cost to patients with financial hardship who meet program eligibility criteria. Depending on your financial situation, resources may be available to help with your costs for CINVANTI and/or SUSTOL.

Number of people in your household: _____ (include yourself, your spouse, and your dependents)

Total household income: $_____ per month OR $_____ per year • US resident: ❍ Yes ❍ No

Your application may be subject to audit or request for additional documentation.

Patients must:

- Have no or limited drug coverage. Limited drug coverage may include all outpatient medications excluded by patient's insurer; specific product exclusion/benefit exclusion (no exceptions process), pending review by patient's insurer; and hospital-only coverage
- In the case of non-commercial insurance, be rendered uninsured after first level of appeal is denied for the initial treatment date (appropriate documentation must be provided)
- Have a yearly income of less than or equal to 500% of the Federal Poverty Level (FPL)
- Be a resident of the US or its territories
- Be using CINVANTI and/or SUSTOL as prescribed by your physician
- Receive treatment that is provided in an outpatient setting

Coverage Limitations

- Eligibility is for 12 months, after which patient will need to reapply for continued assistance

❍ **Provider, please include the necessary CINVANTI and/or SUSTOL prescription(s) when faxing this completed enrollment form.**

6 PHYSICIAN ENROLLMENT CERTIFICATION (REQUIRED)

I verify that the information provided in this enrollment form is complete and accurate to the best of my knowledge. I have obtained my patient's authorization to disclose his/her health information related to treatment with CINVANTI and/or SUSTOL to Lash Group, a designated agent for Heron Therapeutics. I certify that the patient named above has authorized the release and disclosure of the information contained within this enrollment form for the purposes of investigating and resolving insurance, coding, or reimbursement questions. Should my patient be approved for the Heron Connect Copay Assistance Program, I agree that I will not submit any third-party claims for patient cost-sharing expenses (including copays, deductibles, and/or coinsurance) that are covered by the Heron Connect Copay Assistance Program.* I also agree that I will disclose my participation in the Heron Connect Copay Assistance Program* to third-party payers as required. In addition, I certify that my participation in this program is consistent with my obligations as a participating provider with any third-party payers.

Should my patient be approved for enrollment into the Heron Connect Patient Assistance Program, I acknowledge that the medication received will be used for the patient named on this enrollment form and will not be offered for sale, and no claim for reimbursement of CINVANTI, SUSTOL, or related medical procedures and services will be submitted to Medicare, Medicaid, or any third-party payer. I authorize Heron Connect to transmit any prescriptions I submit to Heron Connect to a third party to dispense drug to my office for use by the patient named on this enrollment form.

Please check **one** of the following:

❍ By checking this box, I attest that I have received authorization from the patient named on this enrollment form to sign, on the patient's behalf, the **Patient Authorization and Release for Use/Disclosure of Health Information** for enrollment into Heron Connect and/or the Heron Connect Copay Assistance Program and/or in the Heron Patient Assistance Program (PAP).

❍ I do NOT have the patient's consent.

I understand that Heron Therapeutics may revise, change, or terminate this program at any time. By signing below, I represent that I am the prescriber or that I have the appropriate authority to sign on behalf of the prescriber and/or the practice listed on this form.

Physician or Provider Contact Signature: X _____ **Date:** _____

PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION (MAY BE REQUIRED)

This section must be completed by the patient if the Physician or Provider Contact indicates in the section above that the patient has not authorized the Physician or Provider Contact to sign the Patient Authorization and Release for Use/Disclosure of Health Information or enroll in Heron Connect or its programs on the patient's behalf.

I authorize my prescribing physician and any health insurers, plan, or programs that provide me healthcare benefits (collectively, "Health Plans") to disclose my medical or other information, including information about my treatment with CINVANTI and/or SUSTOL (taken together, "information") and related medical condition to Lash Group, as an agent of Heron Therapeutics, for the use and disclosure of such information for the following specific purposes: conducting reimbursement verification and coverage under my Health Plans; offering direction for appeal of a denial of coverage by my Health Plans; and applying for or making referrals for Patient Assistance Programs† upon request. As it relates to reimbursement programs or services for CINVANTI and/or SUSTOL, I give my permission for Lash Group to contact me if necessary. I understand that, once my information has been disclosed, federal and state privacy laws may no longer protect it. However, the recipients of such information agree to protect my information by using it only for the purposes authorized in this Authorization or as permitted by law. I understand that signing this Authorization is voluntary and, if I do not sign this Authorization, it will not affect my ability to obtain treatment from my prescribing physician or obtain insurance or insurance benefits. I may withdraw this Authorization at any time by calling 1-844-437-6611. Withdrawal of this Authorization will end further uses and disclosures of my information by the parties identified in this Authorization, except to the extent those uses and disclosures have been made in reliance upon this Authorization and as permitted by applicable law. This Authorization expires 10 years from the date indicated below unless I withdraw it earlier. I am entitled to receive a copy of this Authorization.

If I have elected to enroll in the Heron Connect Patient Assistance Program (PAP), I verify that the information I have provided to enroll in is complete and accurate to the best of my knowledge. I agree that if requested I will provide proof of income or any other eligibility requirement in a timely manner. I attest that I would like to receive CINVANTI and/or SUSTOL at no charge under the Heron Connect PAP.† I understand that all the information I provide in connection with this application will be used to determine my eligibility to participate in the program. I certify that I do not have coverage for prescription drugs under Medicare, Medicaid, or any other public or private insurance plan, or that it has been determined that I am functionally uninsured. I understand that Heron Therapeutics reserves the right to modify the eligibility requirements or discontinue the program at any time. I acknowledge that Lash Group, a designated agent of Heron Therapeutics, has the right, pursuant to my authorization for use/disclosure of health information to verify my eligibility for the Heron Connect PAP† to audit reported financial income and insurance information and medical records.

Patient or Legal Authorized Representative: X _____ **Date:** _____

Full Name (please print): _____ **Year of Birth:** _____

Provider, please include the necessary CINVANTI and/or SUSTOL prescription(s) when faxing this completed enrollment form.

*Limitations apply. Offer not valid as follows: (a) patients covered under Medicare, Medicaid, or any federal or state program; (b) where plan covers treatment for the patient for the entire cost of the prescription drug. Patients pay $0 copay per dose per 12-month calendar period. When applicable, deductible assistance up to $200 per treatment will be covered. For cash-paying patients, the program will cover $150 per prescription up to $1,800 per calendar year. Eligibility is for 12 months, after which patient will need to reapply for continued assistance. This offer expires 12/31/2021.

†Heron Therapeutics reserves the right, at its sole discretion, to discontinue the Patient Assistance Program or change the qualifications at any time. All patient information remains confidential. Product supply for the program depends on availability.

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