HEALTHCARE PROVIDER REQUEST FORM

Phone: 1-844-KIMYRSA (1-844-546-9772) **Fax:** 1-855-886-2482
Hours: Monday through Friday, 8am – 8pm ET

KIMYRSA® Support Programs
ASPN Pharmacies, LLC
290 W. Mt. Pleasant Ave
Building 2, 4th Fl., Suite 4210
Livingston, NJ 07039

Kimyrsa™ (oritavancin) for injection 1,200 mg

SERVICE (S) REQUESTED

Check all that apply:
(*NOTE: Complete and sign all relevant sections on page 2)

- ☐ **Insurance Benefit Verification**
  - ☐ **Include ORBACTIV insurance verification**
- ☐ **Setting of Care Research**
- ☐ **Copay Savings Program***
- ☐ **Prior Authorization Assistance**
- ☐ **Claims Assistance**
- ☐ **Patient Assistance Program (PAP)***

PATIENT INFORMATION (Required)

Patient Name	Date of Birth	SSN/ID# (last 4 digits)	
Phone#	US Resident? ☐ Yes ☐ No	Gender ☐ M ☐ F	
Patient Address	City	State	Zip Code

PATIENT INSURANCE INFORMATION (Attach a copy of both the front and back of insurance cards, if available)

Primary Insurance	Insurer Phone#	Policy#	Group#
Policy Holder's Name	Policy Holder's Date of Birth		
Secondary/Supplemental Insurance	Insurer Phone#	Policy#	Group#
Policy Holder's Name	Policy Holder's Date of Birth		
Check Here if Uninsured ☐			

DIAGNOSIS and TREATMENT INFORMATION (Required)

Anticipated Date of Service:	ICD-10 Code:

AUTHORIZING HEALTHCARE PROVIDER (HCP) INFORMATION (Required)

HCP Name:	Specialty:
HCP Tax ID#	HCP NPI#

Contact for Support Program Correspondence:

Name:	Phone#	Fax#	Email:

Preferred Method of Contact

What is your preferred method to receive program communication? ☐ Fax ☐ Email (If checked, please provide email address:_____)
(**Please note:** All communication is sent via fax if this is not checked)

TREATING SETTING of CARE (At least one Setting of Care is required to complete Drug Benefit Verification Research)
(Patient Assistance Program (PAP) requests will be shipped to the address listed below. See Page 2 for PAP criteria.)

Setting of Care: ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Physician's Office ☐ Infusion Center ☐ Home Infusion ☐ ER

Treating Facility Name			
Facility Billing Address	City	State	Zip Code
Phone#	Fax#	Facility Billing NPI#	Facility Tax ID#

ADDITIONAL SETTING OF CARE RESEARCH (Please complete the below section to confirm additional coverage, missing information may delay results)

Setting of Care: ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Physician's Office ☐ Infusion Center ☐ Home Infusion ☐ ER

Treating Facility Name			
Facility Address	City	State	Zip Code
Phone#	Fax#	Facility NPI#	Facility Tax ID#

Setting of Care: ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Physician's Office ☐ Infusion Center ☐ Home Infusion ☐ ER

Treating Facility Name			
Facility Address	City	State	Zip Code
Phone#	Fax#	Facility NPI#	Facility Tax ID#

Not required but please include, if available.

AUTHORIZING HEALTHCARE PROVIDER CERTIFICATION AND CONSENT (Signature Required for any Service)

I certify to the best of my knowledge that the information above is accurate and complete. I have requested and received consent from the patient or the patient's guardian to enroll the patient in the designated KIMYRSA® Support Programs and I agree to allow the KIMYRSA® Support Programs, or its authorized representative, to review the medical, financial and insurance records for this patient at any time for the purpose of verifying the patient's eligibility status. I also attest that I have secured the patient's or the patient's guardian's written permission, to the extent and in the form required by law, to disclose the information to the KIMYRSA® Support Program's authorized representative. If Patient Assistance Program (PAP) services are requested, I represent that this patient has no medical or prescription insurance coverage for the applied for drug, including all public programs; my signature further certifies that no claims for payment for product provided under the PAP will be made to any private, federal or state healthcare program, or to the patient. I further agree that the KIMYRSA® Support Programs may contact me and my office via telephone, fax and e-mail regarding this enrollment request and related follow-up, and that I can revoke my consent at any time.

X_____ Sign Here _____
Authorizing HCP's original signature (no stamped signatures) Date

Authorizing HCP:
I have read and agree to the terms detailed on this form.

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PATIENT INFORMATION (Required)

Patient Name: Date of Birth:

Complete this section only if applying for the Patient Assistance Program (PAP)

REQUIRED FOR PAP

Patient's Total Annual Household Income* $ Household Size (including patient)

PRESCRIPTION FOR KIMYRSA™ (ORITAVANCIN FOR INJECTION) FOR INTRAVENOUS USE

Directions	Quantity	Refills
☐ Administer 1,200mg as a single dose by intravenous infusion over 1 hour	_____ vial(s)	_____
☐ Other: _____	_____ vial(s)	_____

Prescribing HCP Signature Required

X_____ _____
Authorizing HCP's original signature (no stamped signatures) Date

PATIENT, AUTHORIZED CAREGIVER, or AUTHORIZING HEALTHCARE PROVIDER PAP ATTESTATION and AUTHORIZATION

I attest that the information supplied above is complete and accurate, to the best of my knowledge. The patient does not receive prescription drug coverage from any government funded healthcare program, including but not limited to Medicare, Medicaid, including managed Medicaid or Tricare. I acknowledge, or, if not the patient, I acknowledge on the patient's behalf, that Melinta Therapeutics may discontinue this program or change its eligibility criteria at any time and without notice, and that the KIMYRSA® Support Programs may contact me vial mail, telephone, fax and e-mail regarding this enrollment request and related follow-up, and that I can revoke my consent at any time. Disclaimer: **MELINTA THERAPEUTICS** reserves the right to request additional documentation to confirm eligibility and may conduct an e-income verification which will include a soft credit check to determine household income.

Print Name: Indicate Relationship to Patient: ☐ Patient (self) ☐ Authorized Caregiver ☐ Healthcare Provider

Signature: Sign Here Date:

Complete this section only if applying for the Copay Savings Program

REQUIRED FOR COPAY SAVINGS PROGRAM

Payment will be in the form of a Virtual Debit Card (VDC) via email – Please provide HCP's email address:_____

A copy of the email will be sent to the patient. Please provide the patient's email address: _____

This email address needs to be an active email address. Please note that SPAM filters should be checked in the event they filter as SPAM. The email handle will be @amgb2b.com email address.

COPAY SAVINGS PROGRAM DISCLAIMER

Patients must be United States residents and be 18 years of age or older. Eligible patients must have a minimum of a $50 copayment, coinsurance or deductible obligation for KIMYRSA® (oritavancin) for Injection. The Program will cover up to $1,200 of a patient's obligation, and the patient must contribute $50 toward their copay/coinsurance. Patients who pay cash or who receive prescription drug coverage through any type of government insurance or reimbursement programs, including but not limited to Medicare, Medicaid, including managed Medicaid, and Tricare are not eligible. As a condition precedent of the copayment or coinsurance support provided under this program, (e.g., copay or coinsurance amounts paid to administering providers): 1) participating patients and administering providers are obligated to inform insurance companies and third-party payors of any benefits received and the value of this program, as required by contract or otherwise; and 2) administering providers may not bill patients for any amounts received under this program. Void where prohibited by law, taxed, or restricted. Additional terms and conditions may apply. Patients enrolled in the KIMYRSA® Patient Assistance Program are not eligible. Melinta Therapeutics may determine eligibility, monitor participation, and modify or discontinue any aspect of this Program at any time. For additional information regarding KIMYRSA®, including Important Safety Information, please see the Full Prescribing Information available at https://kimyrsa.com/.

Thank you for contacting the KIMYRSA Support Programs. We are here to help you and your patients.
Please contact us at 1-844-KIMYRSA (1-844-546-9772), fax 1-855-886-2482,
or send written communication to:
KIMYRSA Support Program
ASPN Pharmacies, LLC
ATTN: Pharmacist in Charge
290 W. Mt. Pleasant Ave. Building 2, 4th Fl., Suite 4210
Livingston, NJ 07039

This verification of benefits is not a guarantee of payment. This verification cannot take the place of written policy information from the payer. For additional assistance please contact the KIMYRSA Support Programs at 1-844-KIMYRSA.

Confidentiality notice: The information contained in this facsimile may be confidential and legally protected. It is intended only for use of the individual named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action in regard to the contents of this fax – except its direct delivery to the intended recipient – is strictly prohibited. If you have received this fax in error, please notify the sender immediately and destroy this document and delete from your system, if applicable.

To opt-out of receiving future faxes, please contact us at 1-844-KIMYRSA (1-844-546-9772) (phone) or 1-855-886-2482 (fax).

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