UDENYCA®
pegfilgrastim-cbqv

UDENYCA Solutions™ Enrollment Form

UDENYCA Solutions™ is part of the Coherus Solutions™ family of programs.

Call 1-844-483-3692
Monday to Friday | 8 AM to 8 PM ET
FAX 1-877-226-6370
www.UDENYCASolutions.com

*Denotes **REQUIRED** Information

Check for services requested (check all that apply):*

- ☐ Benefits Verification
- ☐ Co-pay Savings Program
- ☐ Prior Authorization Support
- ☐ Appeals Support

Please choose the UDENYCA® presentation that will be used:*

- ☐ Prefilled Syringe
- ☐ Prefilled Autoinjector
- ☐ ONBODY

1 PATIENT INFORMATION (ALL PATIENTS ARE REQUIRED TO SIGN SECTION 6 ON PAGE 3.)

Patient's Name:* Gender:* ☐ Male ☐ Female ☐ Other

DOB:* (MM/DD/YYYY) / / Patient's Phone #:* ☐ Home ☐ Cell

Patient's Address:*

City:* State:* ZIP:*

Email:

Alternate contact name:* Phone #:*

2 INSURANCE INFORMATION

(Please attach a copy of both sides of the patient's insurance card(s). If not available, please complete the information below.)

Is the patient insured?*† ☐ Yes ☐ No

Insurance Type:* ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other

Benefit Verification Preference:* ☐ MEDICAL ☐ PHARMACY ☐ BOTH

PLEASE COMPLETE THE SECTION(S) THAT CORRESPOND TO THE PREFERRED BENEFIT VERIFICATION.

	PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE (if applicable)
Insurance Name*		
Phone Number*		
Policy ID Number*		
Group Number*		
Policy Holder's Name*		
Policy Holder's Date-of-birth*	/ /	/ /
Policy Holder's Relationship to Patient*		
Medicare Beneficiary ID Number*		

†If the patient is uninsured, UDENYCA Solutions can provide information about independent foundations that may be able to help. Call 1-844-483-3692 for additional information.

Please see **page 2** for **Prescriber Attestation** and **Required Signature**.

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2 PHARMACY BENEFIT PLAN (If Applicable)

Insurance Name: Phone Number:

ID Number: Group Number:

BIN: PCN:

Policyholder's Name: Policyholder's DOB: / /

3 CLINICAL INFORMATION

Drug Name: **UDENYCA** Primary Diagnosis/ICD-10 Code (REQUIRED):*

Site of Care:* ☐ Freestanding Infusion Center ☐ Physician Office
☐ Hospital Outpatient Clinic ☐ Hospital Inpatient ☐ Home ☐ Other

Anticipated Start Date:* / /

4 PRESCRIBER INFORMATION

Prescriber's Name:*

Practice/Facility Name:* Organization Tax ID Number:*

Individual NPI Number:* Organization NPI Number:*

Mailing Address:* City:* State:* ZIP:*

Office Contact's Name:* Fax Number:*

Office Contact's Phone Number:* Email:*

5 PROVIDER ATTESTATION*

Date: / / I, _____ (Print Name) attest that, where required by applicable law, regulation, or other applicable authority, I have obtained patient consent, permission and/ or a HIPAA authorization ("Legal Permission") permitting me to use and disclose my patients' health, demographic, and other individually identifiable information, including insurance and financial information, to Coherus BioSciences, Inc., its affiliates, its program administrator, and their respective agents, service providers and field reimbursement professionals for the purpose of providing patient support programs, co-pay assistance, reimbursement support as part of the patient's treatment with UDENYCA. **I maintain records of such Legal Permission consistent with applicable law.** I further certify that (a) any reimbursement investigation support provided to patients through Coherus Solutions™ is not made in exchange, directly or indirectly, for my recommendation, prescription, or use of the above therapy or any other product or service for or from anyone, and (b) my decision to prescribe the above therapy was based solely on my determination of medical necessity. For insured patients, I understand that the UDENYCA Solutions™ program does not provide free drug in the instance of an administrative error or a coverage restriction.

Provider Signature (Required):* **Date:*** / /

Please see next page for PATIENT SIGNATURE.

*Denotes **REQUIRED** Information

Patient Name:

6 PATIENT AUTHORIZATION AND CERTIFICATION

I authorize my physician(s) and their staff and my health insurance plan to disclose my personal information, which may include health, demographic, and other individually identifiable information, including insurance and financial information to Coherus BioSciences, Inc., its affiliates, its program administrator, and their respective agents, service providers and field reimbursement professionals for the purpose of:

- Verifying or coordinating insurance coverage or otherwise obtain payment for my treatment with the prescribed drug
- Coordinating my receipt of the prescribed drug
- Determining eligibility and managing the Coherus Solutions™ Patient Support Programs
- Providing me information about the prescribed drug
- Providing me information on external resources that might be available to me
- Assisting me or my provider with co-pay support for the prescribed drug
- Assisting me or my provider with insurance coverage and reimbursement support services, including benefits verification checks, prior authorizations, claim reviews and denials, or searching for alternative funding from charitable foundations

I understand that Coherus will disclose my health information to my pharmacies, health insurer(s), healthcare providers, caregivers, and other third parties for the purposes described above, and Coherus may contact me directly. I understand that once my Protected Health Information is disclosed as permitted by this authorization it may be redisclosed by Coherus and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal privacy laws. I understand that I may refuse to sign this authorization. I may also revoke (withdraw) this authorization at any time in the future by contacting my Prescriber, or Coherus Solutions™ at 1-844-483-3692. My refusal or future revocation will not affect the commencement or continuation of my treatment by my Prescriber; however, if I do not sign or I revoke this authorization, I will no longer be eligible to participate in the Coherus Solutions™ Support Programs. If I revoke this authorization, my revocation will not affect Protected Heath Information previously disclosed in reliance upon this authorization. I understand and agree that this authorization will remain valid for 5 years after the date of my signature, unless I revoke it earlier. I understand that I may receive a copy of this authorization.

I certify that the personal information that I provide to Coherus Solutions™ is true and complete. I agree that, at any time during my participation in Coherus Solutions™ Programs, additional documentation to verify my personal information may be requested, if there is missing information or I do not respond to requests for additional documents, my participation may be delayed, or I may no longer be able to participate.

If I qualify for, and receive, co-pay assistance, I agree to comply with Coherus' program rules and I will not get reimbursed for the assistance I receive from anyone else, including from an insurance program, another charity, or from a health savings, flexible spending, or other health reimbursement account. I understand that the Coherus Solutions™ programs may be discontinued or the rules for participation may change at any time, without notice.

Signature:* **Date:*** / /

Patient or Patient Representative Name:*

Relationship to Patient:* **Patient Date of Birth:*** / /

Coherus Solutions™
Working together to ensure patient access