Coherus Solutions™

Coherus Solutions™ Enrollment Form

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

Check for services requested (check all that apply):

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

All fields in **orange** are required to be completed before form submission.

1 PATIENT INFORMATION

Patient's Name: Gender: ☐ Male ☐ Female DOB: (MM/DD/YYYY) / /

Patient's Address: City: State: ZIP:

Patient's Preferred Phone #: ☐ Home ☐ Cell 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

If the patient is uninsured, *please complete the Patient Assistance program application available at CoherusSolutions.com*

Benefit Verification Preference: ☐ MEDICAL ☐ PHARMACY ☐ BOTH

PLEASE COMPLETE THE INSURANCE 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		

PHARMACY BENEFIT PLAN (If Applicable)

Insurance Name: Phone Number:

ID Number: Group Number: BIN: PCN:

Policyholder's Name: Policyholder's Date of Birth: / /

3 CLINICAL INFORMATION

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

Site of Care: ☐ Freestanding Infusion Center ☐ Physician Office ☐ Hospital Outpatient Clinic 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 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, and/or patient 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.

Signature (Required): _____

*To download a Coherus Solutions™ Patient Consent form for the patient to complete, please visit CoherusSolutions.com and access the Resource tab.

Coherus BIOSCIENCES