Patient Assistance Program (PAP) Application

Phone: 844-BBIOCON (844 224 6266) | Fax: 833 851 4343 | M-F, 8AM to 5PM CST

Please complete application in full, sign and date,

then fax to: 833 851 4343

Or email to: BioconBiologicsPAP@cardinalhealth.com

- The PAP Application must be complete to be considered for patient program eligibility.
- Please ensure all areas of the form are completed in full, including all signatures.

o To be considered for the Biocon Biologics Patient Assistance Program, all applicants must satisfy the following requirements and eligibility criteria:

- Applicants must qualify for the program financial requirements.
- Applicants must be a current resident of the United States or Puerto Rico.
- Applicants must be fully Uninsured, or if Insured, have no prescription drug insurance*.
- The requested product must be prescribed by a licensed U.S. healthcare professional for a Food and Drug Administration (FDA) approved indication.

- Each applicant will be individually assessed for program eligibility based on the information provided within this application.
- Applicants will only be evaluated for eligibility upon receipt of a completed and signed Biocon Biologics Patient Assistance Program Application.

*certain provider-administered products may have different eligibility guidelines.

Biocon Biologics Patient Assistance Program Application

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Biocon Biologics®

Patient Information

Name: First _____ Last _____ Date of Birth: Mo ___ / Day ___ / Year ___ SSN: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Patient Email Address: _____

Preferred Contact: ☐ Cell Phone ☐ Home Phone ☐ Email ☐ Text Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

Insurance: ☐ Commercial ☐ Government ☐ Other Gender ☐ Female ☐ Male ☐ Other ☐ Decline to Answer

Insurance Name: _____ Prescription Coverage ☐ Yes ☐ No

Insurance ID Number: _____ Insurance Group: _____

Prescriber Information

Prescriber Name: _____ Prescriber NPI: _____

Facility Name: _____ State License #: _____ SL# Expiration: _____

Facility Address: _____ City: _____ State: _____ ZIP: _____

Primary Office Contact: _____ Fax Number: _____

Phone Number: _____ Office Contact Email: _____

Prescription Information

Drug Selection: YESINTEK

☐ 90 mg/mL prefilled syringe for SC

☐ 45 mg/0.5 mL prefilled syringe for SC

☐ 45 mg/0.5 mL vial for SC

☐ 130 mg/26 mL vial for infusion

Drug Name and Strength: _____ Qty: _____

Directions: _____ Refills: _____

Current Medications: _____ Weight: _____

Allergies: _____

Prescriber Prescription Shipping Information (Only complete if shipping address is different than address listed above)

Prescriber Name: _____ Facility Name: _____

Shipping Address: _____ City: _____ State: _____ ZIP: _____

Shipping Contact Name: _____ Shipping Fax Number: _____

Shipping Phone Number: _____ Contact Email: _____

Prescriber Certification & Prescription Signature: _____ Date: _____

(original signature required)

Patient Shipping Information: (If you are requesting the 45 mg PFS and 90 mg PFS the product will the shipped to the patient.)

Patient Name: _____

Shipping Address: _____ City: _____ State: _____ ZIP: _____

Shipping Phone Number: _____

Contact Email: _____

Prescriber Certification and Prescription Signature

I certify that the information provided in this Patient Assistance Program Application is complete and accurate to the best of my knowledge, that the Biocon Biologics product I have prescribed to the applicant within this application is based on my professional judgment of medical necessity for a Food and Drug Administration (FDA) approved indication, and that I will supervise the patient's medical treatment. I will notify Biocon Biologics PAP immediately if the Biocon Biologics product is no longer medically necessary for this patient's treatment. I certify that I have obtained from my patient all required written authorizations for the release of my patient's personal identification and insurance information to Biocon Biologics and their agents and representatives.

I understand that any information provided is for the sole use of Biocon Biologics and their agents, service providers, and representatives to verify my patient's insurance coverage status, to assess the patient's eligibility for participation in the Biocon Biologics Patient Assistance Program (collectively, "the Program"), and to otherwise administer the product and related services. I understand that application to the Program does not guarantee that assistance will be obtained. I understand that Biocon Biologics may change or cancel this program at any time. I understand that if my patient's financial and/or insurance status changes, the patient may no longer be eligible for the Program, and I agree to immediately notify a Biocon Biologics PAP representative if I become aware of changes in the patient's financial and/or insurance status. I agree that Biocon Biologics PAP may contact me for additional information relating to this application either by fax, e-mail and/or telephone.

I understand that I am under no obligation to prescribe any Biocon Biologics product and that I have not received, nor will I receive any benefit from Biocon Biologics or their agents or representatives for prescribing a Biocon Biologics product. I agree that I will not sell, submit claims to, or make any attempt to receive reimbursement from any party for any product provided by the Program. By signing this Patient Assistance Program Application, I authorize the release of medical and/or other patient information to agents and service providers of Biocon Biologics (including but not limited to Sonexus Health LLC and the dispensing non-commercial pharmacies) to use and disclose as necessary for verification of patient eligibility, and to furnish any information on this form to the insurer of the applicant for the purpose of verifying benefit eligibility. Program duration per eligibility period is 12 months, and the maximum number of refills per eligible patient is 11 for each unique enrollment.

My signature certifies that I have read and understand the above statements and agree to the outlined terms.
(Note: Prescriber Certification and this signature is only necessary when the shipping information deviates)

Prescriber Name (Print): _____

Prescriber Signature: _____ Date: _____

Patient Authorization and Agreement Signature

By signing this Authorization, I authorize each of my physicians, pharmacists, including any non-commercial pharmacy that receives my prescription ("my Prescribed Product), and other healthcare providers (together "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my Protected Health Information, including but not limited to medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and or group numbers (together, "Protected Health Information") to Biocon Biologics, its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Biocon Biologics") including providers of alternate sources of funding for prescription drug costs, and other service providers supporting the Biocon Biologics Patient Assistance Program (PAP) (collectively, the "Program") for Healthcare Providers and patients for the purposes described below.

Specifically, I authorize disclosure of my Protected Health Information in order to:

I. Enroll me in, and contact me about the Program, including online support, financial assistance services, and co-pay assistance services,
II. Communicate with my Healthcare Providers and Insurers about benefits, coverage, and medical care, including compliance with Product treatments,
III. Facilitate dispensing of my prescription by a non-commercial pharmacy,
IV. Provide me with educational materials, information and services related to my treatment experience with my prescribed medication and my condition,
V. Verify, investigate, and coordinate with my Insurers regarding my prescribed medication,
VI. Contact me as otherwise required or permitted by law.

Biocon Biologics agrees to protect my Protected Health Information by using and disclosing it only for the purposes described in this Authorization or as permitted by law. I understand that I may refuse to sign this Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me, but I will not have access to the Biocon Biologics and the services provided by Biocon Biologics, under the Program. If I refuse to sign the Authorization, or revoke my Authorization later, I understand that this means I will not be able to participate or receive assistance from the Program.

I understand that my signed Authorization is valid for 5 years from date of signature, and that I may revoke this Authorization at any time in the future, except to the extent that actions have been taken in reliance on the Authorization. I understand that to revoke this Authorization I may mail a request to 2730 S. Edmonds Lane, Suite 300 Lewisville, TX 75067, fax to 833 851 4343, or by calling 844-224-6266. I understand that revoking this Authorization will end further uses and disclosure of my Protected Health Information by the parties identified above except to the extent those uses and disclosures have been made in reliance upon this Authorization as permitted by applicable law. I am entitled to receive a copy of this Authorization.

I understand that if I qualify and I am enrolled in the Program sponsored by Biocon Biologics, I will receive my Prescribed Product from Biocon Biologics only pursuant to a legally valid prescription from my health care provider. I understand that if I qualify and I am enrolled in the Program, Biocon Biologics will provide me my Prescribed Product free of charge for the duration of the enrollment period so long as I have a legally valid prescription for my Prescribed Product. I understand that I am not required to continue treatment with my Prescribed Product if I gain insurance coverage, or to receive treatment from any given provider. I understand and agree that I must notify Biocon Biologics at 844-224-6266 immediately if my insurance status changes during the Program enrollment period. I understand and agree that neither I nor my Insurers, if applicable, will be charged for the supply of my Prescribed Product that I received from the Program, and that under NO circumstances may I claim reimbursement from my Insurers or any related third party for the Prescribed Product provided to me free of charge from the Program. I understand that Biocon Biologics reserves the right at any time without notice to modify or discontinue the Program and its criteria.

I understand that I am providing 'written instructions' to Biocon Biologics and its vendor Sonexus Health, LLC under the Fair Credit Reporting Act and authorizing Sonexus Health, LLC on behalf of Biocon Biologics to obtain information from my credit profile or other information from Experian Health. I authorize Biocon Biologics and its service provider Sonexus Health to obtain such information solely for the purpose of determining financial qualifications for the Program. I understand that I must affirmatively agree to the terms in this notice by signing below in order to proceed in the Program financial s creening process.

My signature certifies that I have read and understand the above statements and agree to the outlined terms.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Patient Authorized Representative

I permit Biocon Biologics PAP representatives to speak with the following person about this application form. This includes discussing the status of myapplication, insurance and financial questions, any missing documentation and other issues related to my enrollment, or any other treatment-related issues. I may cancel this Patient Authorized Representative Authorization at any time by calling: 844-224-6266

Name of Authorized Representative: _____ Relationship to Patient: _____

Telephone Number: _____ Email: _____

By signing below, I, the patient, allow this representative to speak on my behalf on any matter regarding my enrollment with the Program.

Patient Signature: _____ Date: _____