



**CP-054-1: Celltrion USA, Inc.
Product Replacement Form**

Instructions: Please complete this form and submit all required documentation to: productreplacement_usa@celltrionhc.com.	Date of Request: _____
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The Celltrion Product Replacement Program allows Customers of Celltrion USA Inc., which include Healthcare Providers (HCPs) and Healthcare Organizations (HCOs) to receive a Product Replacement for certain products if all eligibility criteria are met (See Product Replacement Program Terms and Conditions).

List product to be replaced including quantity, lot numbers and any other specific product information:

Provide a detailed explanation on how the product loss occurred, including the date, duration and impact of the occurrence:

Office Contact Name	Lot Number	Physician NPI
Administering Physician's Name	Expiration Date	Physician State License Number
Phone/Fax Number	NDC Number	Are photographs included:
		<input type="checkbox"/> Yes or <input type="checkbox"/> No
Email	Serialization Number	Is there a redundant system in place to store product according to the product label (i.e. backup generator, temperature monitor, etc.):
Healthcare Practice Address	Other Information	
		<input type="checkbox"/> Yes or <input type="checkbox"/> No



Was any portion of the spoiled product administered: <input type="checkbox"/> Yes or <input type="checkbox"/> No	Does insurance policy coverage exist for replacement: <input type="checkbox"/> Yes or <input type="checkbox"/> No	Has an insurance claim or bill been submitted to any payer or patient for the replacement request: <input type="checkbox"/> Yes or <input type="checkbox"/> No
Was the spoilage beyond the control of the HCP: <input type="checkbox"/> Yes or <input type="checkbox"/> No	Please indicate days on which Physician's office is unable to accept replacement product delivery:	
Celltrion may seek additional information, including without limitation: proof of destruction, proof of purchase, photographs of the Spoiled Product and Celltrion USA will not ship replacements if the product was prepared for an off-label indication or if the product has been administered. Additionally, Celltrion USA has the right to discontinue or modify its replacement program at any time.		
<p>I attest that I have not, and that I will not receive any payment or insurance reimbursement for any Celltrion product replacement product quantities. I acknowledge that this product replacement quantity must be returned if payment is recognized at any time in the future.</p> <p>Office Contact (Name): _____ Date: _____</p> <p>Office Contact Signature: _____</p> <p>HCP Signature: _____ Date: _____</p>		
TO BE COMPLETED BY CELLTRION USA INC.		
Celltrion USA Departments reviewing this request (check all that apply): <input type="checkbox"/> Field Reimbursement Manager <input type="checkbox"/> Legal and Compliance <input type="checkbox"/> Patient Services <input type="checkbox"/> Other (Please Describe) <input type="checkbox"/> Supply Chain		Additional information needed by Celltrion for this request:
To be completed by Celltrion USA's Field Reimbursement Manager (FRM): I, _____ (FRM), hereby attest that I: (1) performed a complete and thorough review pertaining to this request, (2) certify that this request complies with Celltrion USA CP-054 Procedure on Product Replacement, (3) believe that based on this review a product replacement <input type="checkbox"/> is or <input type="checkbox"/> is not warranted.		
Signature	Name (Print)	Date

PRODUCT REPLACEMENT PROGRAM ELIGIBILITY AND TERMS AND CONDITIONS

To be eligible for a Celltrion Product Replacement, this form must be filled out in its entirety by a Healthcare Provider (HCP) or a Healthcare Organization (HCO). All eligibility criteria and terms and conditions must be satisfied to qualify for a Product Replacement. Celltrion reserves the right to modify those requirements, terms and conditions and discontinue this program. In determining whether to issue a Product Replacement, Celltrion adheres to the following eligibility criteria, terms, and conditions.

Celltrion will not ship replacement products if the replacement product was prepared for an off-label indication. Additionally, Celltrion will only ship replacement products to licensed HCPs or HCOs who purchase the product directly from Celltrion or products provided by Celltrion directly to an HCP or HCO. Celltrion will not replace products if any portion of the product has been administered. Celltrion may require pictures, purchase invoices, or other documentation. Celltrion will not replace a product that was previously designated as “nonreturnable,” nor will it replace a product that was otherwise adulterated, misbranded, or counterfeit, as determined by Celltrion in its sole discretion. Celltrion will also not replace a product that has expired or been repackaged. Moreover, Celltrion will not replace a product that was purchased for research or clinical trials, or one that was shipped as a no-cost item. HCPs and HCOs are prohibited from billing the patient for any of Celltrion’s products replaced under this program. This program is monitored for trends and excessive use by Celltrion. Celltrion strives towards answering these requests within thirty (30) days and will notify the HCP or HCO of its decision. All questions about a Product Replacement should be directed to Celltrion at: productreplacement_usa@celltrionhc.com.