PATIENT SUPPORT PROGRAM
ENROLLMENT FORM

Vegzelma® bevacizumab-adcd

CELLTRION CONNECT PATIENT SUPPORT PROGRAM

Monday - Friday, 8 AM - 8 PM ET / Phone: 1-877-81CONNC (1-877-812-6662) / Fax: 614-633-2259 / www.CelltrionConnect.com

Required fields are indicated in **bold** on this form. | **Complete online and print, then sign form.** | **Fax all pages to Celltrion CONNECT®: 614-633-2259**

REQUESTED SERVICE(S) (check all that apply): ☐ Benefit Investigation ☐ Prior Authorization Support ☐ Appeals Support ☐ Co-pay Support for Commercially Insured Patients ☐ Claims Support

1. PATIENT INFORMATION

First Name: _____ M.I.: ____ **Last Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Date of Birth: MM / DD / YYYY **Sex:** ☐ Male ☐ Female ☐ Prefer Not to Answer Email: _____

Primary Phone: (_____) _____-_____ ☐ Cell ☐ Home Secondary Phone: (_____) _____-_____ ☐ Cell ☐ Home Preferred Contact Method: ☐ Cell ☐ Home

Alternate Contact: _____ Relationship to Patient: _____ Preferred Contact: ☐ Patient ☐ Alternate Contact

Primary Phone: (_____) _____-_____ ☐ Cell ☐ Home Secondary Phone: (_____) _____-_____ ☐ Cell ☐ Home

2. PATIENT INSURANCE INFORMATION

PLEASE ATTACH A COPY OF THE PATIENT'S INSURANCE CARD(S) (FRONT AND BACK). IF NOT AVAILABLE, PLEASE COMPLETE THE FOLLOWING:

☐ Patient Does Not Have Medical Insurance If patient is uninsured, please complete the Patient Assistance Program application available at www.CelltrionConnect.com.

Primary Medical Insurance Carrier: _____ Insurance Type: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other: _____

Beneficiary/Cardholder Name: _____ **Policy/ID #:** _____ Phone: (_____) _____-_____

Secondary Medical Insurance Carrier: _____ Insurance Type: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other: _____

Beneficiary/Cardholder Name: _____ Policy/ID #: _____

Pharmacy Insurance Carrier (If applicable): _____ Policy/ID#: _____ Group #: _____

BIN: _____ PCN: _____ Phone: (_____) _____-_____

3. PRESCRIBER INFORMATION

Prescriber First Name: _____ M.I.: ____ **Last Name:** _____ **Prescriber NPI:** _____

Prescriber PTAN: _____ **Prescriber Address:** _____ **City:** _____

State: _____ **Zip:** _____ **Phone:** (_____) _____-_____ **Fax:** (_____) _____-_____

Practice Name: _____ Practice Contact First Name: _____ Practice Contact Last Name: _____

Title: _____ Phone: (_____) _____-_____

DRUG INFORMATION

VEGZELMA® (bevacizumab-adcd) Single-dose vial ☐ 100 mg/4 mL ☐ 400 mg/16 mL

Infuse: _____ mg every _____ weeks **Number of Infusions:** _____ **Diagnosis ICD-10 Code:** _____ **CPT Code:** _____

ADMINISTRATION

Site of Administration: ☐ Prescribing Physician's Office ☐ Non-Prescribing Physician's Office ☐ Hospital Outpatient ☐ Infusion Center ☐ Other: _____

If preferred administration site has a different address than the prescribing physician's practice above, please complete the following:

Name of Preferred Site of Administration or Home Infusion Company: _____

Contact Name: _____ **Phone:** (_____) _____-_____ **Fax:** (_____) _____-_____

Site of Administration NPI #: _____ **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

4. PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

By signing this form, the patient gives their permission for their physicians, pharmacies, laboratories, and other healthcare providers ("Healthcare Providers") and their health insurers to share their individually identifiable health information with Celltrion USA, Inc., the Celltrion Patient Assistance Foundation, Celltrion affiliates and its vendors (collectively, "Celltrion").

The patient understands that their individually identifiable health information may include their full name, address, date of birth, demographic information, financial information, insurance information and information related to medical condition, treatment, care management, medication history, and prescriptions (collectively, "Health Information"), whether in written or verbal form, including portions of their medical record.

Please see full Prescribing Information here.

4. PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION (CONTINUED)

The patient's Health Information will be shared with Celltrion so that Celltrion may provide them with various support and information to help them access a Celltrion medicine, which may include the following, depending on the program (collectively, "Patient Support Activities"):

- Processing this Application;
- Verifying the information provided in this Application;
- Providing benefits investigations/verification and reimbursement support, including:
  - Assisting with identification of prior authorization requirements;
  - Assisting with identification of requirements of their insurer for appeal of a denied claim;
- Determining their eligibility for and helping them access co-pay support or free drug programs;
- Communicating with their Healthcare Providers about a Celltrion medicine and Patient Support Activities;
- Coordinating the dispensing and delivery of medication;
- Providing them with financial assistance resources and information if they are eligible; and
- Providing them with disease management and other educational materials, as well as information about Celltrion's products, services, and programs, and may include sending them surveys about their experience with Celltrion products, services, and programs.

Celltrion also may use their Health Information for auditing for compliance with Program requirements, quality assurance purposes, and to evaluate and improve our operations and services.

The patient understands that they do not have to sign this form, and choosing not to sign will not affect their ability to receive treatment from their Healthcare Providers or payment from their health insurer. However, if they do not sign this form, Celltrion may not be able to provide them with assistance.

The patient understands that once their Health Information is shared, it may no longer be protected by federal privacy law. However, Celltrion agrees to protect their Health Information and to use it for the purposes described in this form or as required or permitted by law. Select pharmacies may receive remuneration from Celltrion in exchange for their Health Information and/or for any Patient Support Activities provided to them. The patient understands that this form will remain in effect for [4] years from the date of their signature or shall otherwise expire at a shorter duration as required under applicable State law, unless they provide written notice that they would like to withdraw their approval to share their Health Information sooner. MARYLAND HEALTHCARE PROVIDERS, under Md. Code, Health - Gen. § 4-303(b)(4), this authorization expires ONE YEAR from the date of signature. If the patient would like to withdraw their approval, they may contact Celltrion at PO BOX 610 Columbus, OH 43222. This withdrawal will not affect the use or sharing of their Health Information that took place before they withdraw their approval. The patient understands that they may receive a copy of this form.

By signing below, the patient agrees to HIPAA consent and all other necessary permissions authorizing the release of their identification and insurance information, as well as agrees to the Terms and Conditions specified here.

SIGN & DATE

Patient Signature: _____ **Date:** MM / DD / YYYY

Patient Representative First Name: _____ Patient Representative Last Name: _____

Relationship to Patient: _____

Patient Authorized Representative Signature: _____ Date: MM / DD / YYYY

5. PATIENT AUTHORIZATION TO TELEPHONE CONSUMER PROTECTION ACT (TCPA) INFORMATION

By signing up for text messages from Celltrion, the patient agrees that they are the primary owner of the phone number provided and consent to receiving promotional communications in the form of phone calls or text messages relating to Celltrion products and services and/or their condition or treatment. Messages may be sent from an automated system. Consent is not required for the purchase of any goods or services. Message and Data Rates May Apply. Unsubscribe at any time by replying STOP or clicking the unsubscribe link (where available). Text HELP for help. Message frequency varies. To the maximum extent permitted by law: (i) all information contained in SMS text messages is provided "as is" without warranty of any kind, either express or implied, including, but not limited to, the implied warranties of merchantability, fitness for a particular purpose, or non-infringement; and (ii) Celltrion expressly excludes any liability for any direct, indirect, or consequential loss or damage incurred by any user in connection with the receipt, use, failure of, or inability to use, SMS text messages.

The patient also gives their permission to receive communications from Celltrion and parties acting on its behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided to determine their eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as co-pay support or free drug programs, and for other non-marketing purposes. The patient understands that they can opt-out of these telephonic communications concerning Patient Support Activities at any time by contacting Celltrion at 1-877-81CONNC (1-877-812-6662), Monday - Friday, 8 AM - 8 PM ET, or in writing at PO BOX 610 Columbus, OH 43222.

Celltrion CONNECT®: View our privacy policy: https://www.celltrionconnect.com/patient-privacy-policy | View our terms of use: https://www.celltrionconnect.com/terms-of-use/

By signing below, the patient expressly consents to the terms of this section.

SIGN & DATE

Patient Signature: _____ **Date:** MM / DD / YYYY **Cell Phone:** ( ) -

6. CELLTRION CARES™ CO-PAY ASSISTANCE PROGRAM INFORMATION

The patient authorizes the Celltrion CARES™ Co-pay Assistance Program ("Program") to provide payment directly to their healthcare provider, and not to them, for their out-of-pocket drug costs when their healthcare provider submits the co-pay claim. The patient authorizes their healthcare provider to contact the Program on their behalf to initiate payment for services after they have been rendered. The patient understands that they will be responsible for any out-of-pocket expenses for their Celltrion medicine if (1) their healthcare provider does not request payment within 180 days of the issue date on their Explanation of Benefits (EOB), or (2) if the patient is deemed ineligible for reimbursement from the Program.

Celltrion CARES™ Co-pay Assistance Program Terms and Conditions:

- Patient must have private/commercial health insurance that provides coverage for the cost of VEGZELMA. Patients do not qualify if they are covered, in whole or in part, under Medicaid, Medicare, a Medicare Part D or Medicare Advantage plan (regardless of whether a specific prescription is covered), TRICARE, CHAMPUS, Puerto Rico Government Health Insurance Plan ("Healthcare Reform"), or any other state or federal medical or pharmaceutical benefit program or pharmaceutical assistance program (collectively, "Government Programs")
- Patient must be a resident of in the United States or the Commonwealth of Puerto Rico. Product must originate and be administered to patient in the United States or the Commonwealth of Puerto Rico
- Patient must be 18 years of age or older
- Patient must be prescribed VEGZELMA for an on-label diagnosis

Celltrion CARES™: View our privacy policy: www.celltrionconnect.com/patient-privacy-policy | View our terms and conditions: https://www.celltrioncares.com/vegzelma/terms-and-conditions

☐ **By checking this box,** the patient is eligible to participate in this program and agrees to the Terms and Conditions specified here.

7. PROVIDER ATTESTATION/AUTHORIZATION

Date: MM / DD / YYYY

☐ **By checking this box, the provider,** _____ **(PRINT NAME)** attests that they have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Celltrion and its employees or agents for purposes relating to Celltrion's patient support program, including, assisting the patient with benefits verification, prior authorization/appeals assistance, financial assistance resources and information, such as co-pay support or free drug programs, for which the patient may be eligible, and other support for Celltrion's medication.

The provider certifies that they have obtained consent from the patient or the patient's caregiver to be contacted by Celltrion, Celltrion CONNECT®, and parties acting on their behalf at the phone number(s) provided regarding the purposes described above and for other non-marketing purposes.

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