PATIENT ASSISTANCE PROGRAM **APPLICATION**

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**

1. PATIENT INFORMATION

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

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

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

Primary Phone: (MM) DD - YYYY ☐ 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

☐ Patient Does Not Have Medical Insurance

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

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

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: (___) ____ - _____

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:

Site of Administration NPI: _____ Phone: (____) ____ - _____

Site of Administration Address: _____ City: _____ State: _____ Zip: _____

4. PRESCRIPTION/ORDER INFORMATION

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

Infuse: _____ mg by IV every _____ week(s) **Dispense:** ____# of infusions **Refills:** _____ **Primary Diagnosis/ICD-10 Code:** _____

Drug Allergies: ☐ No ☐ Yes (If yes, please list medication(s) and reaction(s)): _____

Patient Weight (kg): _____ Patient's Concurrent Medications: _____ Treatment Start Date: MM / DD / YYYY

5. PRESCRIBER ATTESTATION/AUTHORIZATION

SIGN & DATE

By signing this document, the prescriber has certified that they have prescribed VEGZELMA for an on-label diagnosis based on their professional judgment of medical necessity and that they will supervise the patient's medical treatment. The prescriber has also read and agrees to the terms, conditions, and authorizations and that all information provided in this application is complete and accurate to the best of their knowledge.

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

6. SHIPPING INFORMATION

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

Office Name: _____ Office Contact's First Name: _____ M.I.: _____ Last Name: _____

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

Phone: (____) _____ - _____ Fax: (____) _____ - _____

Please see full Prescribing Information here.

7. 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.

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.

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

8. PATIENT ASSISTANCE PROGRAM (PAP) CONSENT

By signing the form, I certify that I cannot afford my medication, and I affirm that my answers and my proof-of-income documents are complete, true, and accurate to the best of my knowledge. I will promptly contact the Celltrion Patient Assistance Program if my financial status or insurance coverage changes. I will not seek to have this medicine or any cost from it counted in my Medicare Part D out-of-pocket expenses for prescription drugs. I will not seek reimbursement or credit for the medicine(s) from my prescription insurance provider or payor, including Medicare Part D plans. I will notify my insurance provider of the receipt of any medicines through the Celltrion Patient Assistance Program. I have a signed copy of a current and completed Patient Authorization to Share Health Information on record with my health care provider so that my health care provider may share health information about me with Celltrion's assistance programs, Celltrion USA, Inc., and the Celltrion Patient Assistance Foundation.

The information you provide will be used by Celltrion, the Celltrion Patient Assistance Foundation, and parties acting on their behalf to determine eligibility, to manage and improve Celltrion's assistance programs, to communicate with you about your experience with Celltrion's assistance programs, to help you understand your insurance coverage and help you access certain Celltrion medicines through your insurance, and/or to send you materials and other helpful information and updates relating to Celltrion programs.

I understand that: Completing this enrollment form does not guarantee that I will qualify for Celltrion's assistance programs. Celltrion may contact my insurer, to help me understand my insurance coverage for certain products and may provide me support to obtain coverage through my insurer, including prior authorization and appeals support (if necessary and available). Celltrion may verify the accuracy of the information I have provided and may ask for more financial and insurance information. Any medicines supplied by Celltrion's assistance programs shall not be sold, traded, bartered, or transferred. Celltrion reserves the right to change or cancel Celltrion's assistance programs, or terminate my enrollment, at any time. The support provided through this program is not contingent on any future purchase. If I am enrolled in a Medicare Part D Plan and am eligible for the Celltrion Patient Assistance Program, Celltrion will notify my Part D Plan of my enrollment in the Celltrion Patient Assistance Program.

☐ **By checking this box**, the patient agrees to PAP consent and agrees to the Terms and Conditions specified here.

9. PATIENT FINANCIAL VERIFICATION AUTHORIZATION

I understand that by checking the "I Agree" box immediately following this notice, I am providing "written instructions" to Celltrion CONNECT® and/or its agents and contractors under applicable federal and/or state law authorizing them to perform electronic income verification by obtaining information from my personal credit profile or other information from Experian Health. I authorize Celltrion CONNECT® and/or their agents and contractors to obtain such information solely to validate my income for the purposes of determining my eligibility for patient assistance. As a soft credit check, it will not impact my credit score.

☐ **I AGREE** to the terms above for electronic income verification using Experian Health.

☐ **I DO NOT AGREE** with the terms above and do not wish to have my income verified by using Experian Health. I understand that I will be asked to provide supporting documentation to authenticate my income and eligibility. If additional income documentation is required, the following documents are acceptable for income verification:

• Social Security/Disability benefit statement, monthly check, or 1099 • Previous year tax return or W-2 statement • Unemployment or disability determination letter

10. PATIENT INCOME VERIFICATION

Annual Gross Income (Including salary/wages, Social Security income, disability income, and any other income): _____ **Household Size** (Number of members including you): _____

☐ **By checking this box,** the patient agrees to income information specified here.

PATIENTS ELIGIBLE FOR THE CELLTRION **CONNECT®** **PATIENT ASSISTANCE** PROGRAM

The Celltrion CONNECT® PAP is designed to provide free product to qualified individuals who are uninsured or are functionally uninsured, who have no applicable drug coverage, or who express financial hardship affording their medication. Celltrion CONNECT® will help activate PAP for eligible participants.

To receive PAP benefits, the patient must enroll in the program and meet the following eligibility requirements:

- Patient has no insurance or who is functionally uninsured:
  - Patients who do not have insurance (uninsured) or are insured, but product is not covered by their plan (Patient is responsible for 100% of product cost) (functionally uninsured).
    - Functionally uninsured includes all payor types:
      - For commercial patients who have exhausted their co-pay benefits through Celltrion CARES™ Co-pay Assistance Program.
    - In order to be considered functionally uninsured:
      - The patient has medical and/or pharmacy benefits but the payor/pharmacy benefit manager (PBM) will not approve or pay for either the entirety or any portion of the medication.
        - The payor/PBM must deny one level of appeal of an initial coverage denial.
  - Medicare patients that are underinsured (i.e., patient has coverage with a cost share and has expressed a financial hardship affording their cost share).
- Patient must be 18 years or older.
- Patient must have a valid prescription from a licensed healthcare provider (HCP) for an on-label indication.
- Patient must have an adjusted annual household income of ≤500% of the federal poverty level (FPL).
- Income verification:
  - If the electronic income check fails or the patient has not provided consent for income credit check, then Celltrion CONNECT® will request income documentation from the patient.
  - Income documentation accepted includes tax returns (1040, 1099), W-2s, 30 days of pay stubs, unemployment letters and unemployment government assistance, if applicable. Social Security statements or Social Security verification letter.
- Patient must show proof of residency by providing valid United States or the Commonwealth of Puerto Rico address and product must be administered in the United States or the Commonwealth of Puerto Rico.
- Diagnosis and dosing are consistent with FDA-approved indication for VEGZELMA.
- Patient must not have any other financial support options. Patient has exhausted alternative funding or has confirmed no funds are available.
- If patient is approved through PAP, they must remain in PAP and receive free drug through the Celltrion CONNECT® PAP program until the end of the calendar year that they were approved for. For example, if the patient was approved for PAP in July of 2024, they will remain enrolled in the PAP program until December 31st, 2024.

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