Access Services by Bayer™

Lab Monitoring Co-pay Program for Kovaltry®* Antihemophilic Factor (Recombinant)

Patients may receive up to $250 per year to apply toward out-of-pocket costs for lab monitoring of Kovaltry®

HOW IT WORKS

If you and your healthcare provider decide that lab monitoring of Kovaltry® is needed, you may receive up to $250 per year toward related out-of-pocket costs.

You and your healthcare provider identify a lab that can accurately conduct the lab testing of Kovaltry®.

A co-payment for your lab testing may be collected at the time of service. The lab will also submit a claim to your insurance company for the remaining payment for their services.

You will receive an Explanation of Benefits (EOB) from your insurance company, which shows how much your insurance covers and how much you owe.

To receive up to $250 per year for any out-of-pocket expenses related to the lab testing of Kovaltry® that are not covered by insurance, you must submit the following within 180 days from the date of service:

- This completed claim form
- A copy of the EOB from your insurance company
- A bill or a dated receipt from your lab
  - If a bill from your lab is provided, Bayer will reimburse your lab directly, up to $250 per year
  - If you have already paid your lab bill, please submit a receipt of payment from your lab and Bayer will reimburse you directly, up to $250 per year

* Patients who are enrolled in any type of government insurance are not eligible. Bayer reserves the right to rescind, revoke, or amend this offer without notice at any time.

This offer may not be redeemed for cash. Only one offer per patient annually.

If you have any questions, contact Access Services by Bayer™ at 1-800-288-8374.

Kovaltry® Antihemophilic Factor (Recombinant)

Kovaltry®

Antihemophilic Factor (Recombinant)

BAYER

Reimbursement Form

BILLING LABORATORY INFORMATION

(*Required Field)

Billing Laboratory Name*

Address 1* | Address 2

City* | State* | ZIP Code*

Phone Number* | Email Address

ORDERING PRESCRIBER INFORMATION

First Name* | Last Name* | Prescriber NPI*

Prescriber Stamp (preferred) or Signature* | Date*

☐ I attest that I have ordered lab testing for this patient while on Kovaltry®.

PRIMARY INSURANCE INFORMATION

Primary Insurer* | Group #* | Phone Number* | Subscriber ID*

PATIENT INFORMATION

First Name* | Middle | Last Name*

Address 1* | Address 2

City* | State* | ZIP Code*

Date of Birth* | Phone Number* | Gender* ☐ Male ☐ Female

I hereby authorize and direct Access Services by Bayer™ to issue payment (check one)*:

☐ Directly to my billing laboratory (lab bill required) ☐ Directly to me (receipt of payment required)

Confirm the following*:

☐ I understand it is my responsibility to pay my cost-share for my lab testing of Kovaltry®, including any remaining balance.

Patient Signature* | Date*

MAIL OR FAX THIS COMPLETED CLAIM FORM AND SUPPORTING DOCUMENTS, WITHIN 180 DAYS FROM THE DATE OF SERVICE, TO:

FAX: 833-270-4332

MAIL: ConnectiveRx
Attn: Kovaltry Reimbursement for Lab Testing
100 Passaic Ave., Suite 245
Fairfield, NJ 07004