Access Services by Bayer™

Helping Your Patients Get Their Bayer Medications Through Access Services by Bayer™

The annotated directions below can be used as a guide to ensure that all critical components of the **Patient Support Service Request Form (SRF)** are filled out to prevent delays.

Select all services that apply:

Benefits Verification ***(complete steps 1-5)***

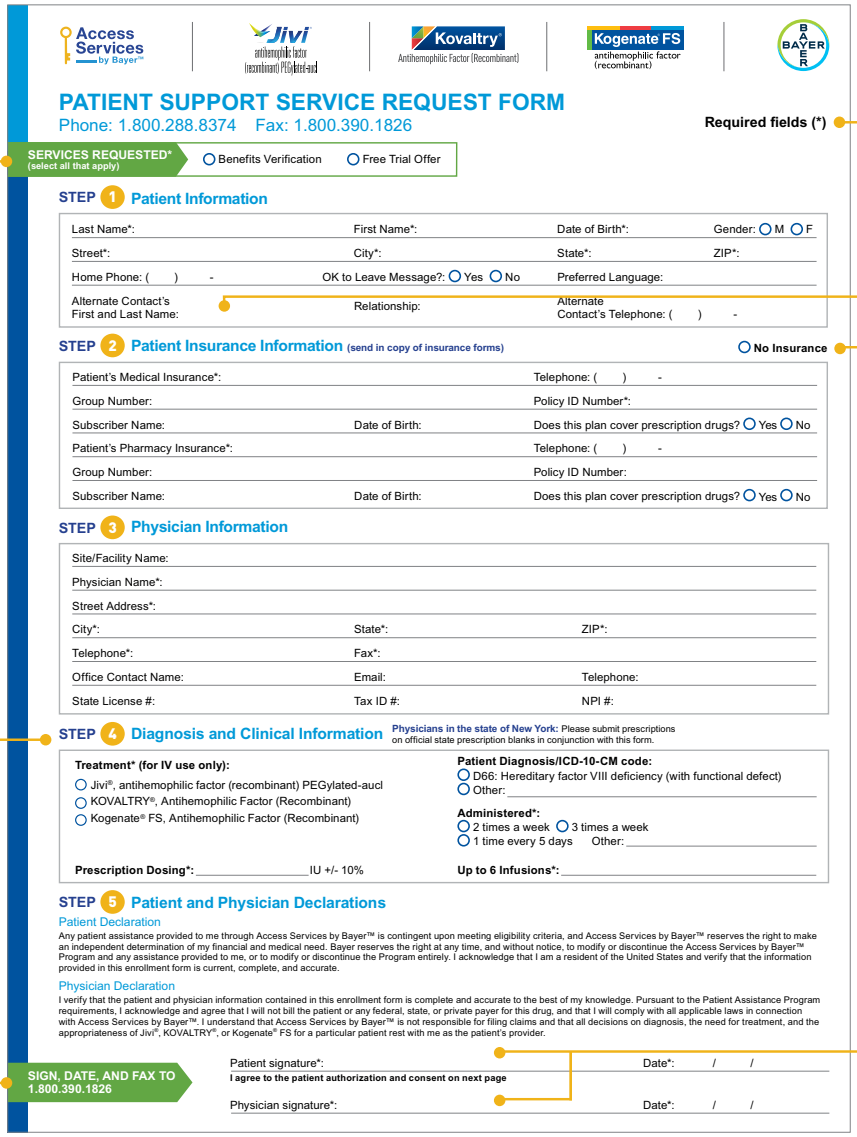
- Patient's insurance coverage information
- Eligible patients auto-enrolled in the $0 Co-pay Card Program
- Eligible patients auto-enrolled in the Loyalty Program

Free Trial Offer ***(complete steps 1,3,4,and 5)***

- Eligible patients receive a maximum of 6 infusions (not to exceed 40,000 IU)
- Step 2 is optional but can be completed to find out the patient's insurance coverage

Complete all required fields to avoid delays in filling the patient's prescription

Both the physician and patient must sign



Access Services by Bayer™ | Jivi® antihemophilic factor (recombinant) PEGylated-aucl | Kovaltry® Antihemophilic Factor (Recombinant) | Kogenate FS® antihemophilic factor (recombinant)

PATIENT SUPPORT SERVICE REQUEST FORM

Phone: 1.800.288.8374 Fax: 1.800.390.1826

Required fields (*)

SERVICES REQUESTED* (select all that apply) ○ Benefits Verification ○ Free Trial Offer

STEP 1 Patient Information

Last Name*: First Name*: Date of Birth*: Gender: ○ M ○ F

Street*: City*: State*: ZIP*:

Home Phone: ( ) - OK to Leave Message?: ○ Yes ○ No Preferred Language:

Alternate Contact's First and Last Name: Relationship: Alternate Contact's Telephone: ( ) -

STEP 2 Patient Insurance Information (send in copy of insurance forms) ○ No Insurance

Patient's Medical Insurance*: Telephone: ( ) -

Group Number: Policy ID Number*:

Subscriber Name: Date of Birth: Does this plan cover prescription drugs? ○ Yes ○ No

Patient's Pharmacy Insurance*: Telephone: ( ) -

Group Number: Policy ID Number:

Subscriber Name: Date of Birth: Does this plan cover prescription drugs? ○ Yes ○ No

STEP 3 Physician Information

Site/Facility Name:

Physician Name*:

Street Address*:

City*: State*: ZIP*:

Telephone*: Fax*:

Office Contact Name: Email: Telephone:

State License #: Tax ID #: NPI #:

STEP 4 Diagnosis and Clinical Information Physicians in the state of New York: Please submit prescriptions on official state prescription blanks in conjunction with this form.

Treatment* (for IV use only):

○ Jivi®, antihemophilic factor (recombinant) PEGylated-aucl
○ KOVALTRY®, Antihemophilic Factor (Recombinant)
○ Kogenate® FS, Antihemophilic Factor (Recombinant)

Patient Diagnosis/ICD-10-CM code:

○ D66: Hereditary factor VIII deficiency (with functional defect)
○ Other:

Administered*:

○ 2 times a week ○ 3 times a week
○ 1 time every 5 days Other:

Prescription Dosing*: IU +/- 10% **Up to 6 Infusions*:**

STEP 5 Patient and Physician Declarations

Patient Declaration

Any patient assistance provided to me through Access Services by Bayer™ is contingent upon meeting eligibility criteria, and Access Services by Bayer™ reserves the right to make an independent determination of my financial and medical need. Bayer reserves the right at any time, and without notice, to modify or discontinue the Access Services by Bayer™ Program and any assistance provided to me, or to modify or discontinue the Program entirely. I acknowledge that I am a resident of the United States and verify that the information provided in this enrollment form is current, complete, and accurate.

Physician Declaration

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. Pursuant to the Patient Assistance Program requirements, I acknowledge and agree that I will not bill the patient or any federal, state, or private payer for this drug, and that I will comply with all applicable laws in connection with Access Services by Bayer™. I understand that Access Services by Bayer™ is not responsible for filing claims and that all decisions on diagnosis, the need for treatment, and the appropriateness of Jivi®, KOVALTRY®, or Kogenate® FS for a particular patient rest with me as the patient's provider.

SIGN, DATE, AND FAX TO 1.800.390.1826

Patient signature*: Date*: / /

I agree to the patient authorization and consent on next page

Physician signature*: Date*: / /

Complete all required fields to avoid delays in treatment

Alternate contacts may include family members to whom the patient has given permission to speak with Access Services by Bayer™ on their behalf

Check this circle if the patient does not have health insurance

Missing signatures **will** cause a delay in processing

Access Services by Bayer™ | Jivi antihemophilic factor (recombinant) PEGylated-aucl | Kovaltry® Antihemophilic Factor (Recombinant) | Kogenate® FS antihemophilic factor (recombinant) | BAYER

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Required fields (*)

SERVICES REQUESTED* (select all that apply) ○ Benefits Verification ○ Free Trial Offer

STEP 1 Patient Information

Last Name*: First Name*: Date of Birth*: Gender: ○ M ○ F

Street*: City*: State*: ZIP*:

Home Phone: ( ) - OK to Leave Message?: ○ Yes ○ No Preferred Language:

Alternate Contact's First and Last Name: Relationship: Alternate Contact's Telephone: ( ) -

STEP 2 Patient Insurance Information (send in copy of insurance forms)

○ **No Insurance**

Patient's Medical Insurance*: Telephone: ( ) -

Group Number: Policy ID Number*:

Subscriber Name: Date of Birth: Does this plan cover prescription drugs? ○ Yes ○ No

Patient's Pharmacy Insurance*: Telephone: ( ) -

Group Number: Policy ID Number:

Subscriber Name: Date of Birth: Does this plan cover prescription drugs? ○ Yes ○ No

STEP 3 Physician Information

Site/Facility Name:

Physician Name*:

Street Address*:

City*: State*: ZIP*:

Telephone*: Fax*:

Office Contact Name: Email: Telephone:

State License #: Tax ID #: NPI #:

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Up to 6 Infusions*:

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Patient Declaration

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Physician Declaration

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. Pursuant to the Patient Assistance Program requirements, I acknowledge and agree that I will not bill the patient or any federal, state, or private payer for this drug, and that I will comply with all applicable laws in connection with Access Services by Bayer™. I understand that Access Services by Bayer™ is not responsible for filing claims and that all decisions on diagnosis, the need for treatment, and the appropriateness of Jivi®, KOVALTRY®, or Kogenate® FS for a particular patient rest with me as the patient's provider.

SIGN, DATE, AND FAX TO 1.800.390.1826

Patient signature*: Date*: / /

I agree to the patient authorization and consent on next page

Physician signature*: Date*: / /

PATIENT AUTHORIZATION FOR ACCESS SERVICES BY BAYER™

Phone: 1.800.288.8374 Fax: 1.800.390.1826

I authorize the use and/or disclosure of my private health information, described below, which may include "Protected Health Information" or "PHI" as defined by the Health Insurance Portability and Accountability Act of 1996, which was amended by the Health Information Technology for Economic and Clinical Health Act (as amended, "HIPAA"). In general terms, I understand that Protected Health Information is health information that identifies me or that could reasonably be used to identify me. I understand that this authorization is voluntary.

I authorize my health care provider, including my physicians, pharmacies, and my health plan insurers, to disclose my name, address, and telephone number along with certain medical records and financial information with respect to my treatment, my eligibility for assistance, the coordination of my treatment, the receipt of my medication, and my participation in the Access Services by Bayer™ Program to Bayer and their agents. These agents include a company that aggregates data and produces reports from aggregated data, and an administrative contractor that administers the Program (collectively "Bayer"). Access Services by Bayer™ is a reimbursement assistance program to help me access my Jivi®, antihemophilic factor (recombinant) PEGylated-aucl, KOVALTRY®, Antihemophilic Factor (Recombinant), or Kogenate® FS, Antihemophilic Factor (Recombinant) treatment and provides patient support through product-related informational materials. Access Services by Bayer™ is sponsored by Bayer.

I understand that certain health care providers, such as my pharmacies, may receive payment from Bayer in connection with the use and disclosure of my PHI as described in this authorization. If I report an adverse event related to my treatment, this will need to be reported to Bayer. Bayer may need to follow up directly with me or with my physician.

I allow the use and disclosure of my PHI for the following purposes:

(1) To verify my financial or insurance information; (2) to ensure the accuracy and completeness of the Program enrollment form; (3) to help with my reimbursement questions; (4) to see if I qualify for patient assistance; (5) to refer me to or determine my eligibility for other programs, foundations, or alternative sources of funding or coverage to help me with the costs of my Jivi®, KOVALTRY®, or Kogenate® FS treatment, to provide services to me and otherwise administer the Program; (6) to provide education, training, and ongoing support on the use of Jivi®, KOVALTRY®, or Kogenate® FS; (7) to send me information or materials related to Jivi®, KOVALTRY®, or Kogenate® FS, or other related products or services in which I might be interested; (8) to send me refill reminders for my prescription for Jivi®, KOVALTRY®, or Kogenate® FS and to encourage me to take Jivi®, KOVALTRY®, or Kogenate® FS as prescribed; (9) to communicate with me, my health care providers and health plan insurers about my medical care, including treatment with Jivi®, KOVALTRY®, or Kogenate® FS; (10) to contact me on occasion for feedback for market research purposes about Jivi®, KOVALTRY®, or Kogenate® FS or the Program to operate and improve the quality of the Program; (11) for sales purposes, including to evaluate health care provider prescribing patterns and (12) to comply with applicable law.

This authorization expires at the end of my participation in the Program or 3 years after I sign it, whichever comes first. I can revoke (ie, take back) this authorization any time. I understand that if I revoke this authorization, it will not have any effect on any actions my health care providers or my health plan may have taken before receiving the revocation.

I can revoke this authorization by writing to: Bayer, Attn: Medical Communications, 100 Bayer Boulevard, PO Box 915, Whippany, NJ 07981.

I also understand that persons or entities that receive my PHI under this authorization may not be required by privacy laws (such as the HIPAA Privacy Rule) to protect the information and may share it with others without my permission, if permitted by laws applicable to them.

My health care providers and health plan insurer will not condition my medical treatment or its payment, insurance enrollment, or eligibility for insurance benefits on my signing this form. However, the Program needs access to PHI to provide assistance to me. So, I understand that if I do not agree to the sharing of my PHI as described in this form, Bayer will not be able to provide assistance under the Program to me.

I have read this authorization and/or had its contents read to me. I have had an opportunity to ask questions about the uses and disclosures of PHI described above and all of my questions have been answered to my satisfaction.

I authorize the use and disclosure of my information as described in this form.

I understand that I am entitled to receive a signed copy of this authorization.

By submitting this form, I agree to receive communications from Bayer in the form of mail, email, phone, and/or other electronic means.