BAYER access solutions

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# PHYSICIAN FORM
## Fax to 1.800.390.1826

Complete to the fullest extent possible. If an item does not apply, please fill in "N/A" on that line.

## Enrollment

All 3 forms must be completed and signed for the patient to become eligible to receive assistance through Bayer Access Solutions. Please note, applicants will be assessed for assistance through the Patient Assistance Program, Commercial Co-pay Assistance Program, Reimbursement Support Services, or the Free Trial Program. Upon submission of an enrollment form, a specialist will reach out to you to better understand your needs and help locate a program that will best support the applicant.

### PHYSICIAN INFORMATION

Site/Facility Name:

Physician Name:

Street Address:

City: State: Zip:

Telephone: Fax:

Office Contact Email:

State License #: Tax ID #: NPI #:

### PATIENT DIAGNOSIS INFORMATION

Patient Diagnosis/ICD Code:

- ○ KOGENATE® FS, Antihemophilic Factor (Recombinant)
- ○ KOVALTRY®, Antihemophilic Factor (Recombinant)

℞

Name: Date:

Address:

Dose: Quantity: Refills:

Physician Signature: MD

Upon confirmation of insurance coverage (or the patient's approval for assistance through Bayer Access Solutions), medication will be shipped via specialty pharmacy provider to the patient's home address (listed on the next page) unless otherwise indicated by practitioner.

## 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 Bayer Access Solutions.

I understand that Bayer Access Solutions is not responsible for filing claims and that all decisions on diagnosis, the need for treatment, and the appropriateness of KOGENATE FS or KOVALTRY for a particular patient rest with me as the patient's provider.

Physician Signature: MD Date:

Kovaltry® Antihemophilic Factor (Recombinant)

Kogenate® FS antihemophilic factor (recombinant)

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# PATIENT FORM
## Fax to 1.800.390.1826

Complete to the fullest extent possible. If an item does not apply, please fill in "N/A" on that line.

## Enrollment

Bayer Access Solutions is a reimbursement assistance program to help you access your KOGENATE® FS, Antihemophilic Factor (Recombinant), or KOVALTRY®, Antihemophilic Factor (Recombinant), and provides patient support through product-related informational materials. Bayer Access Solutions is sponsored by Bayer.

### PATIENT INFORMATION

Patient Name: Date of Birth: SSN:

Street Address:

City: State: Zip:

Telephone: Best time to call: ○ MORNING ○ AFTERNOON ○ EVENING

Primary Language: Email:

Alternate Contact's Name: Alternate Contact's Telephone:

### PATIENT INSURANCE INFORMATION

Primary Rx Insurer: Telephone:

Group Number: Policy ID Number:

Subscriber Name: Date of Birth:

Does this plan cover prescription drugs? ○ YES ○ NO

Secondary Rx Insurer: Telephone:

Group Number: Policy ID Number:

Subscriber Name: Date of Birth:

Does this plan cover prescription drugs? ○ YES ○ NO

### PATIENT FINANCIAL INFORMATION*

Current annual household income: $

Number of household members dependent on income stated above (including applicant):

*Income documentation will be required in order to assess Patient Assistance Program eligibility (eg, 1040 tax return, SSA-1099, W-2 Form, etc).

## Patient Declaration

Any patient assistance provided to me through Bayer Access Solutions is contingent upon meeting eligibility criteria, and Bayer Access Solutions 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 Bayer Access Solutions 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.

Patient's or Patient Representative's Signature:

Date: Relationship to Patient:

If signed by the patient's representative, a description of the representative's relationship to the patient and such person's authority to act for the patient (eg, parent, guardian, spouse, etc) must be provided in the space above that follows the date.

Kovaltry® Antihemophilic Factor (Recombinant)

Kogenate® FS antihemophilic factor (recombinant)

BAYER access solutions

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# PATIENT AUTHORIZATION FOR BAYER ACCESS SOLUTIONS

Fax to 1.800.390.1826

## Enrollment

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 Bayer Access Solutions 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"). Bayer Access Solutions is a reimbursement assistance program to help me access my KOGENATE® FS, Antihemophilic Factor (Recombinant), or KOVALTRY®, Antihemophilic Factor (Recombinant), treatment and provides patient support through product-related informational materials. Bayer Access Solutions 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 you report an adverse event related to your treatment, this will need to be reported to Bayer. Bayer may need to follow up directly with you or with your 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 KOGENATE FS or KOVALTRY treatment, to provide services to me and otherwise administer the Program; (6) to provide education, training, and ongoing support on the use of KOGENATE FS or KOVALTRY; (7) to send me information or materials related to KOGENATE FS or KOVALTRY, or other related products or services in which I might be interested; (8) to send me refill reminders for my prescription for KOGENATE FS or KOVALTRY and to encourage me to take KOGENATE FS or KOVALTRY as prescribed; (9) to communicate with me, my health care providers and health plan insurers about my medical care, including treatment with KOGENATE FS or KOVALTRY; (10) to contact me on occasion for feedback for market research purposes about KOGENATE FS or KOVALTRY 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.

Patient's or Patient Representative's Signature: _____

Date: _____ Relationship to Patient: _____

If signed by the patient's representative, a description of the representative's relationship to the patient and such person's authority to act for the patient (eg, parent, guardian, spouse, etc) must be provided in the space above that follows the date.

Kovaltry®
Antihemophilic Factor (Recombinant)

Kogenate® FS
antihemophilic factor (recombinant)

Bayer, 100 Bayer Boulevard,
PO Box 915, Whippany, NJ 07981 USA

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