LOQTORZI™ (toripalimab-tpzi)injection

LOQTORZI Solutions™ Enrollment Form

LOQTORZI Solutions™ is part of the Coherus Solutions™ family of programs.

Call 1-844-483-3692
Monday–Friday 8 AM to 8 PM ET
FAX 1-877-226-6370
www.LOQTORZISolutions.com

*Denotes **REQUIRED** Information

Check for services requested:*

- ☐ Benefits Verification
- ☐ Claim Support and Appeals
- ☐ Co-Pay Savings Program
- ☐ Prior Authorization Appeal Support
- ☐ Patient Assistance Program
- ☐ Temporary PAP†
- ☐ Retrospective PAP‡

1 PATIENT INFORMATION (ALL PATIENTS ARE REQUIRED TO SIGN SECTION 8 ON PAGE 4.)

Patient's Name:*

Gender:* ☐ Male ☐ Female ☐ Other DOB:* (MM/DD/YYYY) / /

Patient's Address:*

City:* State:* ZIP:*

Patient's Phone #:* ☐ Home ☐ Cell Email:

Alternate contact name: Phone #:

2 INSURANCE INFORMATION

(Please attach a copy of both sides of the patient's insurance card(s). If not available, please complete the information below.)

Is the patient insured?* ☐ Yes ☐ No

Insurance Type:* ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other

If the patient is uninsured, please complete pages 3 and 5 to enroll in the Patient Assistance Program.

Benefit Verification Preference:* ☐ MEDICAL ☐ PHARMACY ☐ BOTH

PLEASE COMPLETE THE INSURANCE SECTION(S) THAT CORRESPOND TO THE PREFERRED BENEFIT VERIFICATION.

	PRIMARY MEDICAL INSURANCE*	SECONDARY MEDICAL INSURANCE (if applicable)
Insurance Name*		
Phone Number*		
Policy ID Number*		
Group Number*		
Policy Holder's Name*		
Policy Holder's Date-of-birth*	/ /	/ /
Policy Holder's Relationship to Patient*		
Medicare Beneficiary ID Number *(if applicable)*		

PHARMACY BENEFIT PLAN (If Applicable)

Insurance Name: Phone Number:

ID Number: Group Number: BIN: PCN:

Policyholder's Name: Policyholder's Date of Birth: / /

†**Temporary Patient Assistance Program (TPAP):** If a patient does not currently have coverage for the product and has an application for Medicaid pending, the patient may be eligible to enroll into TPAP and receive LOQTORZI™ cost-free on a **temporary basis up to 90 days**.

‡**Retrospective Patient Assistance:** Patients may be eligible if they have received LOQTORZI™ in the past 30 days and meet all other eligibility requirements. Medicare patients are not eligible for retrospective patient assistance.

Please see **page 2** for **Prescriber Attestation** and **Required Signature**.

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3 CLINICAL INFORMATION

Drug Name: LOQTORZI™ Primary Diagnosis/ICD-10 Code:*

(REQUIRED ONLY FOR PAP) Quantity: Refill(s): Frequency of Treatments:

Site of Care:* ☐ Freestanding Infusion Center ☐ Physician Office ☐ Hospital Outpatient Clinic

Anticipated Start Date: / /

4 PRESCRIBER INFORMATION*

Prescriber's Name:*

Practice/Facility Name:* Organization Tax ID Number:*

Individual NPI Number:* Organization NPI Number:*

Mailing Address:* City:* State:* ZIP:*

Office Contact's Name:* Fax Number:*

Office Contact's Phone Number:* Email:*

5 HEALTHCARE PROFESSIONAL ATTESTATION*

Date: / / **I,** _____ (Print Name) attest that, where required by applicable law, regulation, or other applicable authority, I have obtained patient consent, permission and/or a HIPAA authorization ("Legal Permission") permitting me to use and disclose my patients' health, demographic, and other individually identifiable information, including insurance and financial information, to Coherus BioSciences, Inc., its affiliates, its program administrator, and their respective agents, service providers and field reimbursement professionals for the purpose of providing patient support programs, co-pay assistance, and/or patient assistance, reimbursement support as part of the patient's treatment with LOQTORZI™. **I maintain records of such Legal Permission consistent with applicable law.** I further certify that (a) any reimbursement investigation support provided to patients through LOQTORZI Solutions™ is not made in exchange, directly or indirectly, for my recommendation, prescription, or use of the above therapy or any other product or service for or from anyone, and (b) my decision to prescribe the above therapy was based solely on my determination of medical necessity. For insured patients, I understand that the LOQTORZI Solutions™ program does not provide free drug in the instance of an administrative error or a coverage restriction. For certain products where a step edit may not be medically appropriate, and confirmed by the prescribing physician, the LOQTORZI Solutions™ program may consider enrollment following one level of appeal. If patient receives medication from Coherus, to the best of my knowledge, this patient has no prescription insurance coverage (including Medicaid, Medicare, or other public or private programs), or is unable to afford the cost-sharing requirements associated with his/her insurance coverage for this medication.

Healthcare Professional Signature (Required)**:*** _____ **Date:*** / /

Please see **page 3** for additional **information required** for the **Patient Assistance Program**.

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To enroll in the Patient Assistance Program, please be sure Sections 6 - 9 are completed.

6 PATIENT ASSISTANCE PROGRAM: Eligibility Criteria

Under this program, Coherus BioSciences, Inc. agrees to ship product to the provider for patients who qualify for the Patient Assistance Program (PAP). The terms and conditions below must be met in order for a patient to be enrolled in the program:

- Be either: (a) uninsured; (b) functionally underinsured†; or (c) traditional Medicare FFS insured patient(s) that demonstrate financial hardship and cannot afford their cost-sharing obligation as evidenced by a signed attestation from their provider
- Have an adjusted annual household income of ⩽ 500% of Federal Poverty Level (FPL)
- Complete and sign consent form and, when applicable, provide income documentation
- Be under the care of a U.S. licensed provider, and receive LOQTORZI™ in an established practice located in the U.S. incident to the prescribing physician's professional services in the outpatient setting
- Be a U.S. resident of any U.S. state or territory
- Diagnosis and dosing are consistent with FDA-approved indication for LOQTORZI™
- Not have any other financial support options

7 PATIENT FINANCIAL VERIFICATION AUTHORIZATION (ONLY required for PAP enrollment)*

Household size (number of members including you):* **Household Income:***

I understand that by checking the "I Agree" box immediately following this notice, I am providing "written instructions" to Coherus BioSciences, Inc. 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 Coherus 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
- ***For traditional Medicare fee-for-service insured patients, an attestation from the HCP is required demonstrating financial hardship due to inability to afford cost share.***

Please see next page for PATIENT SIGNATURE.

†To be considered underinsured, the patient has insurance but no coverage for LOQTORZI™.

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Patient Name: _____

8 PATIENT AUTHORIZATION AND CERTIFICATION

I authorize my physician(s) and their staff and my health insurance plan to disclose my personal information, which may include health, demographic, and other individually identifiable information, including insurance and financial information to Coherus BioSciences, Inc., its affiliates, its program administrator, and their respective agents, service providers and field reimbursement professionals for the purpose of:

- Verifying or coordinating insurance coverage or otherwise obtain payment for my treatment with the prescribed drug
- Coordinating my receipt of the prescribed drug
- Determining eligibility and managing the Coherus Solutions™ Patient Assistance Program
- Providing me information about the prescribed drug
- Providing me information on external resources that might be available to me
- Assisting me or my provider with co-pay support for the prescribed drug
- Assisting me or my provider with insurance coverage and reimbursement support services, including benefits verification checks, prior authorizations, claim reviews and denials, or searching for alternative funding from charitable foundations

I understand that Coherus will disclose my health information to my pharmacies, health insurer(s), healthcare providers, caregivers, and other third parties for the purposes described above, and Coherus may contact me directly. I understand that once my Protected Health Information is disclosed as permitted by this authorization it may be redisclosed by Coherus and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal privacy laws. I understand that I may refuse to sign this authorization. I may also revoke (withdraw) this authorization at any time in the future by contacting my Prescriber. My refusal or future revocation will not affect the commencement or continuation of my treatment by my Prescriber; however, if I do not sign or I revoke this authorization, I will no longer be eligible to participate in Coherus Solutions™ Patient Access and Support Programs including the Patient Assistance Program (if applicable). If I revoke this authorization, my revocation will not affect Protected Heath Information previously disclosed in reliance upon this authorization. I understand and agree that this authorization will remain valid for 5 years after the date of my signature, unless I revoke it earlier. I understand that I may receive a copy of this authorization.

I understand that if I receive free medication through the Patient Assistance Program, the PAP provides LOQTORZI™ at no charge and does not include the provider administration fee. I also understand that I am responsible for the administration costs. By applying for PAP, I understand and agree that (i) there is no charge to participate and my participation is not contingent upon any requirement to purchase any Coherus product; (ii) completing and signing the application and this authorization does not guarantee my eligibility; (iii) PAP may change or end at any time; (iv) PAP medication received will not count toward my true out-of-pocket costs under Medicare Part D; and (v) I will not seek to be reimbursed or receive credit from any insurance provider, including Medicare Part D plans, for any PAP medication received. In applying for the patient assistance program, I can confirm that I do not have coverage for LOQTORZI™.

I certify that the personal information that I provide to Coherus Solutions™ is true and complete. I understand that if I am not being enrolled in the Patient Assistance Program then the income verification will not apply. I agree that, at any time during my participation in Coherus Solutions™ Programs, additional documentation to verify my personal information may be requested, if there is missing information or I do not respond to requests for additional documents, my participation may be delayed, or I may no longer be able to participate.

If I qualify for, and receive, co-pay assistance or free medication assistance through the PAP, I agree to comply with Coherus' program rules and I will not get reimbursed for the assistance I receive from anyone else, including from an insurance program, another charity, or from a health savings, flexible spending, or other health reimbursement account. I understand that the Coherus Solutions™ programs may be discontinued or the rules for participation may change at any time, without notice.

Signature:* _____ **Date:*** / /

Patient or Patient Representative Name:* _____

Relationship to Patient:* _____ **Patient Date of Birth:*** / /

Coherus Solutions™
Working together to ensure patient access