Coherus COMPLETE™
The clear choice for patient support

Enrollment Form

Call 1-844-4-UDENYCA (1-844-483-3692)
Monday to Friday • 8 AM to 8 PM ET
FAX 1-877-226-6370
www.CoherusCOMPLETE.com

Check for services requested:

- ☐ Benefits Verification
- ☐ Prior Authorization
- ☐ Claims & Appeals Support
- ☐ Co-Pay Assistance Program
- ☐ Patient Assistance Program (PAP)
- ☐ Alternative Coverage (e.g., Independent Foundations and Non Co-Pay Support)

1 PATIENT INFORMATION

Patient's Name: Sex: ☐ Male ☐ Female DOB: (MM/DD/YYYY) / /

Patient's Address: City: State: ZIP:

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

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.)

PRIMARY INSURANCE

Check the appropriate box: ☐ MEDICARE ☐ MEDICAID ☐ COMMERCIAL/PRIVATE ☐ OTHER ☐ UNINSURED

Insurance Name:

Phone #:

Policy ID #: Group #:

Policyholder's Name:

Policyholder's Date of Birth: / /

Policyholder's Relationship to Patient:

SECONDARY INSURANCE

Check the appropriate box: ☐ MEDICARE ☐ MEDICAID ☐ COMMERCIAL/PRIVATE ☐ OTHER ☐ UNINSURED

Insurance Name:

Phone #:

Policy ID #: Group #:

Policyholder's Name:

Policyholder's Date of Birth: / /

Policyholder's Relationship to Patient:

3 CLINICAL INFORMATION

Primary Diagnosis/ICD-10 Code (REQUIRED): Secondary Diagnosis/ICD-10 Code:

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

CPT Code:

UDENYCA™ (pegfilgrastim-cbqv) Injection (6 mg/0.6 mL prefilled syringe)

Quantity:

4 PRESCRIBER INFORMATION

Prescriber's Name: Prescriber's Specialty:

Practice/Facility Name:

NPI #: DEA #:

Mailing Address: City: State: ZIP:

Office Contact's Name: Office Contact's Email:

Office Contact's Phone #: Fax #:

Tax ID #: Group NPI #: Preferred Method of Contact: ☐ Phone ☐ Email ☐ Fax

5 ATTESTATION

Date: / /

I, _____ (Print Name) attest that I have the patient's HIPAA authorization on file authorizing my disclosure of the patient's protected health information, including insurance 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 patient assistance as part of the patient's treatment with UDENYCA™.

Signature (Required): _____

Coherus BIOSCIENCES

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Patient Assistance Program

Under this program, Coherus BioSciences 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.

- Patient must meet the eligibility criteria
- Provider must complete enrollment form and sign prescription
- Patient must complete and sign the consent and, when applicable, provide income documentation

I understand that the PAP provides UDENYCA™ (pegfilgrastim-cbqv) at no charge and does not include the provider administration fee. I also understand that I am responsible for the administration costs.

Income Verification

Coherus COMPLETE™ and its authorized third-party agents will use my date of birth or Social Security number and/or additional demographic information as needed to access my credit information derived from public and other sources to estimate my income in conjunction with the eligibility determination process. The free product financial approval tool (via soft credit inquiry) will not impact my credit score.

☐ **Opt-out** for the free product financial approval tool (soft credit inquiry): Please do not access my credit information to estimate my income via soft credit inquiry.

I will instead provide one of the following income documents along with this Coherus COMPLETE™ Enrollment Form:

- Copy of W-2 or most recently filed US Income Tax Return (IRS Form 1040, 1040A, 1040EZ, 1040NR, or 1040PR), **or**
- Copy of most recent pay stub **plus** most recently filed US Income Tax Return, **or**
- Copy of transcript received through submission of IRS 4506-T (request for transcript form is not accepted), **or**
- Copy of most recent Social Security/disability monthly check, Award Letter, Benefit Statement or 1099, **or**
- Copy of Unemployment Determination letter

Prescribing Physician to Complete

Rx for UDENYCA™ (pegfilgrastim-cbqv) injection (6mg/0.6 mL prefilled syringe)*

Quantity: _____ Refill(s): _____ Sig instructions: _____

Treatment start date: ___/___/___ Anticipated refill date: ___/___/___ Allergies: _____

If patient qualifies for the PAP, will refill(s) be required? ☐ Yes ☐ No Concurrent Medications: _____

Physician signature: _____ Date: _____

*This is provided for informational purposes only, and is only valid as a prescription if it meets applicable state regulations.

Patient name (required): _____ Patient date of birth (required): _____

Patient or patient representative signature: _____

Patient representative name: _____ Phone: _____

Relationship to patient: _____

Is it OK to contact patient or patient representative for additional information? ☐ Yes ☐ No

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