Coherus COMPLETE™
The clear choice for patient support

Patient Financial Services Enrollment

(Patient self-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:

- ☐ 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 AUTHORIZATION

Date: / /

I, _____ (Print Name) authorize my healthcare provider to give my protected health information, including health insurance 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 treatment with UDENYCA™.

Signature (Required): _____

Coherus BIOSCIENCES