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