SPECTRUM ACCESS4ME®

Phone: **1-866-582-2737 (866-58-CARES)**
Fax: **1-833-281-7416**
www.ACCESS4Me.com

ROLVEDON®
(eflapegrastim-xnst) injection
13.2 mg/0.6 mL

Enrollment Form for ROLVEDON®

Please complete each section in its entirety. When complete, fax ***all pages*** *to* ***833-281-7416. For electronic submission, visit www.ACCESS4Me.com. Please note: Patient and provider signatures are required for processing.***

Support Requested (check all that apply):

- ❑ Benefits Verification
- ❑ Prior Authorization Support
- ❑ Claims & Appeals Support
- ❑ Copay Assistance for Commercially Insured Patients
- ❑ Patient Assistance (PAP)
- ❑ Independent Charitable Foundation Information

Bridge Program ❑

Check the box if you would like ACCESS4Me® to determine your patient's eligibility for the Bridge program for patients new to ROLVEDON®. Eligibility subject to all terms and conditions of ACCESS4Me and the Bridge Program. Please see ACCESS4Me.com for complete information including limitations and availability. Product received through the Bridge Program may not be submitted for reimbursement to any patient or third-party payor. Participation in the Bridge Program does not impose any obligation on the patient or the provider to continue on ROLVEDON, or to order, purchase or prescribe any Spectrum product. We reserve the right to modify or terminate the program without notice at any time.

Patient Information

EMR attached? ❑ Yes ❑ No Gender: ❑ M ❑ F Expected Treatment Date:

Last Name: First Name: Date of Birth:

Street: City: State: Zip Code:

Home Phone: Mobile Phone: Household Income:

Alternate Contact (Patient grants this individual permission to speak with ACCESS4Me on their behalf)

Name: Phone: Relation to Patient:

Patient Authorization and Certification

I have read and agree to the Authorization to Disclose/Use Health Information on page 3

Patient Signature Required Date

I have read and agree to the ACCESS4Me Patient Certification on page 3

Patient Signature Required Date

Patient Insurance Information

Please attach a copy of both sides of the patient's insurance (cards). If unavailable, please complete the information below.

Patient is uninsured ❑

Primary Insurance:

Phone:

Policy ID: Group ID:

Subscriber Name:

Secondary Insurance:

Phone:

Policy ID: Group ID:

Subscriber Name:

Pharmacy Insurance Name: Phone:

Policy ID: Group ID:

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Clinical Information

Primary Diagnosis/ICD-10 Code: Secondary Diagnosis/ICD-10 Code:

Prescriber Information

Prescriber Name: DEA Number:

NPI Number: State License Number: TAX ID Number:

Facility Name:

Site of Service: ◉ Hosp Outpatient ○ Physician Office ○ Freestanding Infusion Center

Street: City: State: Zip Code:

Office Contact Name: Contact Title/Role:

Contact Phone: Contact Fax: Contact Email:

Prescriber Attestation

I, _____, attest that the information in this form is complete and accurate to the best of my knowledge. I understand and agree to comply with the requirements stated below and as provided by the ACCESS4Me® Program, also available at website.

HIPAA Authorization

I attest that I have obtained a HIPAA authorization from my patient permitting me to use and disclose my patients' protected health information, including insurance and financial information, to Spectrum Pharmaceuticals, Inc., its affiliates, agents, and service providers, ("Spectrum") for the purpose of providing patient support programs, copay assistance, and/or reimbursement support as part of the patient's treatment with ROLVEDON®. I maintain records of this authorization consistent with all applicable law.

I further attest that

- Neither I nor my affiliated facility will bill or seek reimbursement for any ROLVEDON provided through ACCESS4Me from the patient, or any third-party payor or insurer (including federal health care programs).
- Any support provided to patients through ACCESS4Me is not made in exchange or return for, directly or indirectly, my recommendation, prescription, or use of ROLVEDON or any other Spectrum product, and (b) my decision to prescribe the above therapy was based solely on my determination of medical necessity. I understand that Spectrum may change or terminate the ACCESS4Me program in whole or in part.
- I understand that the completion and submission of coding, coverage, or reimbursement-related documentation are the responsibility of the patient and healthcare provider. This form has been completed exclusively by the health care provider or health care provider office identified on the form.
- I understand that Spectrum makes no representation or guarantee concerning coverage or reimbursement for any item or service.
- I understand that information concerning program participants may be summarized for statistical or other purposes and provided to Spectrum and/or the Program only for use in an aggregated, de-identified format.
- I am authorized pursuant to the laws of my state of license to prescribe and administer ROLVEDON. I consent to receiving communications related to the program via telephone, email, and/or fax.
- Any ROLVEDON that is provided through this enrollment application on behalf of the patient named herein will be for the replacement of ROLVEDON that was administered on the patient identified in this application.

Patient Assistance Program

I understand that I need to notify ACCESS4Me if the patient's financial, insurance, or other circumstances have changed that might affect their eligibility for the PAP program. I also attest that my practice, facility, or institution is under no legal obligation under federal, state, or local law or regulation to treat the patient, and has not and will not be receiving a payment for services that includes the provision of ROLVEDON.

Bridge Program

I understand that a patient's participation in the Bridge Program does not impose any future obligation on me or my patient to use, order, prescribe, or purchase ROLVEDON or any other Spectrum product or service. I understand that patients are eligible for multiple doses of ROLVEDON while the Prior Authorization process is pending, and I attest that, to the best of my knowledge, the patient has not previously used ROLVEDON.

Commercial Copay Assistance Program

By submitting a claim to the ROLVEDON Commercial Copay Assistance Program, I attest that the patient is not insured by a federal health care program like Medicare, Medicaid, Tricare, or the VA, and that I will not be submitting a ROLVEDON claim for the patient to any federal health care program.

_____ _____

Prescriber Signature Required Date

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Patient Authorization to Disclose/Use Health Information

I, _____, authorize my healthcare providers and my health insurers to disclose my health information, including but not limited to information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, insurance plan and group number (together, "Health Information") to Spectrum Pharmaceuticals and ACCESS4Me®, its affiliates, agents, and service providers ("Spectrum") for the following purposes:

I understand that ACCESS4Me will receive, use, and disclose my Health Information in order to (i) enroll me in, determine my eligibility for, and contact me about, ACCESS4Me support Programs, (ii) verify, investigate and assist with determining my coverage for ROLVEDON® with my insurers, (iii) proactively enroll me in the ROLVEDON Commercial Copay Assistance Program, if I am eligible, (iv) provide me with information about alternate sources of funding, and (v) provide me with educational materials, information, and other potential assistance related to ROLVEDON. I understand that the Program will make every effort to keep my information private. Further, I understand that if my information is shared, federal privacy laws do not require that the person or party receiving it not disclose the information further and that such information provided to a third party may no longer be protected by federal privacy laws.

I understand that I am not required to sign this Patient Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me or pay for my care. If I refuse to sign the Patient Authorization, or cancel my authorization later, I understand that I will not be able to participate or receive assistance from ACCESS4Me.

I understand that my information may be summarized for statistical or other purposes and provided to Spectrum and/or the Programs for use in an aggregated, de-identified format.

My authorization ends at the end of my participation in the Program or 5 years after I sign it (or earlier where required by state law). I can cancel this authorization at any time by writing to the CoverMyMeds, 10 John Street Columbus, OH. 43222, or by calling ACCESS4Me at 866-58-CARES (866-582-2737) to withdraw from the Program. If I cancel my authorization, it will affect disclosures of my Health Information going forward but will not affect information already disclosed. I have the right to a copy of this form.

Patient Certification

I, _____, attest that the information I have provided in this form is accurate to the best of my knowledge. I understand that by enrolling in the ACCESS4Me Program (the "Program"), I agree to comply with the requirements of the Program and the applicable Terms and Conditions noted below.

- I understand that Spectrum or the Program make no representation or guarantee concerning coverage or reimbursement for any item or service.
- I understand that Spectrum or the Program make no representation or guarantee concerning my eligibility to participate in any of the ACCESS4Me Support Programs.
- Participation in the Program does not obligate me to use any specific health care provider, and I am free to change providers at any time.
- I understand that Spectrum reserves the right to amend or discontinue the Program, in whole or in part, at any time and without notice.
- The Program is void where prohibited by law.

Bridge Program Terms and Conditions

I understand that ROLVEDON provided under the Bridge Program is provided at no charge for my benefit and neither I nor anyone acting on my behalf will seek reimbursement for the value of ROLVEDON received from this Program from any third-party, including any federal health care Program, third- party payor, or any flexible spending accounts or healthcare savings accounts. I understand that depending on my insurance, I may have costs for health care provider charges related to the administration of the product or other treatment costs. I understand that participation in the Bridge Program does not impose any future obligation for me to use or purchase ROLVEDON or any other Spectrum product or services. I understand that patients are eligible for multiple doses of ROLVEDON while Prior Authorization process is pending. I attest that to the best of my knowledge, the patient has not previously used ROLVEDON. This is not health insurance.

Commercial Copay Assistance Program Terms and Conditions

I understand that to be eligible for the Copay Assistance Program, I must be insured by commercial or private insurance, have coverage for ROLVEDON, and not participate in any federal health care programs including, without limitation, Medicare, Medicaid, Veterans Affairs (VA), Tricare or the Department of Defense (DOD) programs.

Eligible patients may pay as low as $0 on each ROLVEDON dose up to a maximum benefit of $15,000 per 12-month eligibility period. Once I exceed the maximum benefit, I will be responsible for all remaining deductible, copay, co-insurance or cost sharing obligations for ROLVEDON. I understand that the Copay Assistance Program only provides assistance for the cost for ROLVEDON. Depending on my insurance, I will have responsibility for any costs for health care provider charges related to the administration of the product or other treatment costs. My insurance company or provider may impose certain requirements on me in connection with the use of Copay Assistance Program and I certify that I will comply with any such requirements, including reporting the receipt of Program benefits as required by my insurer or by law.

I agree not to seek reimbursement for, or cause anyone acting on my behalf of seek reimbursement for, all or part of the benefit received under the Copay Assistance Program from any third-party payor, or from any health savings, flexible spending, or other health care reimbursement account.

This Copay Assistance Program is not health insurance. The Copay Assistance Program is not transferable, and the amount of the savings cannot exceed the patient's out-of-pocket costs. Cannot be combined with any other rebate/coupon, cash discount card, free trial, or similar offer for the specified prescription. This copay assistance is not redeemable for cash. This copay assistance is not valid for product dispensed by a 340B covered entity that purchased the product at discounted pricing under the 340B drug pricing program. [This copay assistance is not valid if the patient's commercial health insurance plan or pharmacy benefit manager uses a copay adjustment program (often termed "maximizer" or "accumulator" program) that restricts any form of copay assistance from being counted toward the patient's cost-sharing limits.

This is not health insurance.

I understand that if I am eligible for the Commercial Copay Assistance Program the program benefit will be applied directly by my site of care or health care provider.

Patient Assistance Program (PAP)

ACCESS4Me and its authorized third-party agents will use my date of birth 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. I understand the free product financial approval tool (via soft credit inquiry) will not impact my credit score. Additional supporting documentation may be required.

I attest that neither I nor anyone acting on my behalf will seek reimbursement for any product received as part of the PAP Program from any government health care program or any other third-party insurer or payor, health savings account, or flexible spending account.

I understand that the PAP Program reserves the right to request additional documentation from me to determine program eligibility, and may independently verify information provided.

I understand that I must inform the PAP if my financial circumstance, insurance, or any other eligibility criteria changes.

Please complete this form and submit by fax to 1-833-281-7416. If enrolling your patient via the Provider Portal, please retain the patient-signed form on file at your office.

SPECTRUM® PHARMACEUTICALS