



**ACCESS4ME™**

Patient Support &  
Financial Assistance  
Programs

ACCESS4Me™ is Committed to  
Ensuring Your Eligible Patients Have  
Access to ROLVEDON®.

 **SPECTRUM**  
**ACCESS4ME™**

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

## ACCESS4ME™ OFFERS A COMPREHENSIVE LIST OF PROGRAMS

The ACCESS4Me™ team is readily available to provide information and assistance throughout the access process. Our dedicated Reimbursement Specialists will determine patient eligibility and help investigate options.\* We are available in person, virtually, online, or by phone.

*\*Patients must be enrolled in ACCESS4Me. Patient consent required.*

## ROLVEDON® BRIDGE PROGRAM (OFFICE SETTINGS ONLY)

### NO INCOME REQUIREMENT

Commercially insured patients can receive one free dose\* of ROLVEDON® free of charge for patients that are:

- ▶ Experiencing a lapse or delay in coverage
- ▶ Waiting for approval from their insurance provide

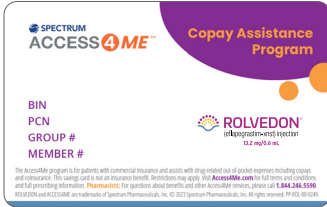
### Patient Eligibility

- ▶ Patient must be new to ROLVEDON
  - » Limited to ONE free dose\* per patient
  - » Must have a commercial/private coverage per patient
  - » Prescribed FDA-approved indication
  - » No income requirement
  - » Will experience an insurance-related access delay due to a requirement for Prior Authorization approval
  - » Patient has medical or prescription drug insurance
  - » Patient must be 18 years of age and reside in the US
  - » ROLVEDON is administered in office settings only

*\*Eligibility is subject to all terms and conditions of ACCESS4Me and the Bridge program.*

*Please visit [ACCESS4Me.com](https://ACCESS4Me.com) for complete terms and conditions, including limitations and availability.*

## ROLVEDON® COMMERCIAL COPAY ASSISTANCE PROGRAM



- ▶ Reduces out-of-pocket costs for patients with commercial insurance
- ▶ Ensures \$0 out-of-pocket costs for each ROLVEDON® dose

- ▶ Maximum annual benefit of \$15,000 per 12-month enrollment period
- ▶ No income requirement

Upon approval, the copay card is activated and shipped directly to the provider or injection center.

The program covers up to \$15,000 in assistance each calendar year toward product-specific copay, coinsurance, and insurance deductibles for ROLVEDON treatments. Patients are responsible for all additional copay costs that exceed the program assistance limit.

### Patient Eligibility

- ▶ Must have commercial or private insurance that covers ROLVEDON
- ▶ Must have a copay for ROLVEDON
- ▶ Must be a resident of the United States
- ▶ Diagnosis that is consistent with the FDA-approved indication for ROLVEDON

*Subject to annual assistance limit. Not an insurance or debit card program. This program is not valid for prescriptions covered by or submitted for reimbursement under Medicaid, Medicare, VA, DOD, TRICARE, or similar federal or state programs. This program does not cover or provide support for supplies, procedures, or any physician-related service associated with ROLVEDON. Patient or provider must not seek reimbursement for amount received from any third-party payors, including flexible spending accounts or healthcare savings accounts. If at any time a patient starts receiving coverage through a federal, state, or government-funded healthcare program, the patient will no longer be eligible for the program. General, non-product-specific copay, coinsurance, or insurance deductibles are not covered. This program is not valid where prohibited by law, taxed, or restricted. ACCESS4Me™ reserves the right to rescind, revoke, terminate, or amend this offer, eligibility, and terms of use at any time without notice. Additional program conditions may apply.*

## ROLVEDON® PATIENT ASSISTANCE PROGRAM (PAP)

Patients who are uninsured or underinsured may be eligible to receive ROLVEDON® at no cost through the Patient Assistance Program.

### Patient Eligibility

- ▶ Uninsured or underinsured for ROLVEDON
- ▶ Must be a resident of the United States
- ▶ Eligible patients must have an annual income of <500% of the federal poverty level (FPL) adjusted for family size (eg, \$156,000/year for a family of 4 in 2024). See [www.aspe.hhs.gov/poverty-guidelines](http://www.aspe.hhs.gov/poverty-guidelines)\* for US federal poverty guidelines

*\*Spectrum Pharmaceuticals, Inc. is not responsible for the content displayed on this website.*

## ROLVEDON FIRST CYCLE PATIENT SUPPORT PROGRAM (HOSPITAL OUTPATIENT SETTINGS ONLY)

### NO INCOME REQUIREMENT

Eligible new patients can receive their first-cycle dose of ROLVEDON free of charge. Simply select “First Cycle Patient Support” when enrolling the patient in ACCESS4Me™.\*

### Patient Eligibility

- ▶ Limited to ONE dose\* per patient
  - » Patient must be new to ROLVEDON
  - » Patient must be a US resident with a legal US mailing address
  - » Patient’s diagnosis is consistent with the FDA-approved indication for ROLVEDON
  - » Patient is enrolled in ACCESS4Me Patient Support Program
  - » ROLVEDON is administered in hospital outpatient settings only

*\*Enrollment form must be received prior to the date of injection. For complete terms and conditions, including limitations and availability, visit [www.ACCESS4Me.com](http://www.ACCESS4Me.com).*

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

## INDEPENDENT CHARITABLE FOUNDATION INFORMATION

**For patients with government insurance, ACCESS4Me™ can provide information on financial support available through independent charitable foundations.**

Reimbursement Specialists can assist by:

- ▶ Verifying coverage and determining patient out-of-pocket costs for ROLVEDON®
- ▶ Identifying independent charitable foundations with available funding for the FDA-approved indication
- ▶ Providing information to assist patients when applying to their foundation(s) of choice

*Independent foundations have their own eligibility rules and requirements. Spectrum Pharmaceuticals does not endorse nor prefer any particular foundation, and cannot guarantee support will be provided.*

# PRODUCT REPLACEMENT PROCESS FOR BRIDGE PROGRAM, FIRST CYCLE PATIENT SUPPORT AND PAP

Programs are designed so you can utilize product on hand without waiting for patient-specific shipments. For approved patients, simply utilize ROLVEDON® from your existing supply, then submit the Product Replacement Form. Replacement product will be shipped directly to the facility address where product was administered.

## Product Replacement Form

Product Replacement Form available at ACCESS4Me.com.



Phone: 1-866-582-2737  
(846)584-0800  
Fax: 1-833-281-7414  
www.ACCESS4Me.com

**Product Replacement Form**

Please use this form to request ROLVEDON® (eflapegrastim-xnst) injection replacement supplies for patients approved for the ACCESS4Me® Bridge Program (BP) (Over-the-Counter Only) First Cycle Patient Support Program (FCPS) (Prescriber Outpatient Settings Only), or the Patient Assistance Program (PAP).

For complete program terms and conditions, please visit www.ACCESS4Me.com. Product replacement is subject to eligibility and only available after product has been administered.

**Complete, sign, and fax both pages to ACCESS4Me at 1-833-281-7414.**

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**Prescriber Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Title: \_\_\_\_\_ State License Number: \_\_\_\_\_  
 Facility Name: \_\_\_\_\_ Facility Tax ID #: \_\_\_\_\_  
 Shipping Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Office Contact Name: \_\_\_\_\_ Contact Title/Role: \_\_\_\_\_  
 Contact Phone Number: \_\_\_\_\_ Contact Fax Number: \_\_\_\_\_


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**Patient Information**

Patient Name	Date of Birth	Medication Administered	Date(s) of Administration	Program Requested (Check box)
ROLVEDON (eflapegrastim-xnst) injection				<input type="checkbox"/> BP <input type="checkbox"/> FCPS <input type="checkbox"/> PAP
ROLVEDON (eflapegrastim-xnst) injection				<input type="checkbox"/> BP <input type="checkbox"/> FCPS <input type="checkbox"/> PAP
ROLVEDON (eflapegrastim-xnst) injection				<input type="checkbox"/> BP <input type="checkbox"/> FCPS <input type="checkbox"/> PAP
ROLVEDON (eflapegrastim-xnst) injection				<input type="checkbox"/> BP <input type="checkbox"/> FCPS <input type="checkbox"/> PAP
ROLVEDON (eflapegrastim-xnst) injection				<input type="checkbox"/> BP <input type="checkbox"/> FCPS <input type="checkbox"/> PAP
ROLVEDON (eflapegrastim-xnst) injection				<input type="checkbox"/> BP <input type="checkbox"/> FCPS <input type="checkbox"/> PAP

BP: Bridge Program; FCPS: First Cycle Patient Support Program; PAP: Patient Assistance Program



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**Product Replacement Form**

**Letter of Attestation and Attestation:**



I certify that I am (a) affiliated with the entity(ies) and location(s) identified on this application, (b) will be responsible in all respects for the receipt and accountability of the pharmaceutical products shipped to this entity at such location and will immediately notify the Program in any of the foregoing statements if no longer true.

**My signature below attests that I have the patient's HIPAA consent and applicable federal and state authorizations, consents, and notices required, on file authorizing the release of the patient's PHI (and insurance information) to Spectrum Pharmaceuticals, Inc. and its business partners.**

I understand the program only provides replacement product and does not cover any costs related to the office visit or administration of the product. Acceptance of this replacement product in no way obligates me or my facility to use the selected product for other patients. I also understand that the product received is not a sample, but a replacement of product I previously purchased. I further attest that I will not seek reimbursement for ROLVEDON® from any insurer, payer including, without limitation any federal health care program (ie Medicare, Medicaid, or any third party payer for any ROLVEDON administered to patients enrolled in the ACCESS4Me® Bridge Program, First Cycle Patient Support Program or Patient Assistance Program), or through the product, pursuant to this replacement request, to be shipped to the shipping address for in-facility use. I understand to ensure the ACCESS4Me Program requirements are met, the Program reserves the right to perform a physical audit of appropriate records (including patient records) at the facility with a 30-day advance notice, and/or within any patient or facility from further participation in the Program.

Physician Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

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NOTE: Product Replacement requests need to be submitted by end of month after treatment.



## HOW TO ENROLL YOUR PATIENTS

There are 3 ways to enroll:

1  ACCESS4ME™ ONLINE PORTAL

Enroll your patients through the ACCESS4Me™ provider portal. A one-stop online destination for reimbursement and patient support.

[ACCESS4Meportal.com](http://ACCESS4Meportal.com)

OR

2  FAX

Complete, sign, and fax the ACCESS4Me Program enrollment form.

*Enrollment form available at [ACCESS4Me.com](http://ACCESS4Me.com).*

**Fax: (833) 281-7416**

OR

3  CALL

Simply call and a Reimbursement Specialist will assist you with enrollment.

**(866) 582-2737 (1-866-58-CARES)**

## HELP IS JUST A CALL OR CLICK AWAY!



Communicate directly with your assigned Field Reimbursement Manager or contact ACCESS4Me™ at **(866) 582-2737 (866-58-CARES)**.

Monday—Friday | 8:00 AM—8:00 PM ET



Visit [ACCESS4Me.com](http://ACCESS4Me.com) for online enrollment and access to tools, forms and resources.



Open your camera app and point it here to visit our website ([www.ACCESS4Me.com](http://www.ACCESS4Me.com)).

*Spectrum Pharmaceuticals reserves the right, at its sole discretion, to discontinue the Bridge Program, Copay Assistance Program, Patient Assistance Program, First Cycle Patient Support Program, or the Claims Denial Program or may revise, change, or terminate these programs at any time. Please visit [www.ACCESS4Me.com](http://www.ACCESS4Me.com) for complete program rules, terms and conditions.*



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