SPECTRUM ACCESS 4 ME™

Phone: **1-866-582-2737**
(866-58-CARES)
Fax: **1-833-281-7416**
www.Access4Me.com

Product Replacement Form

Please use this form to request ROLVEDON™ (eflagpegrastim-xnst) injection replacement syringes for patients approved for the ROLVEDON Patient Assistance Program (PAP) or the ROLVEDON First-Cycle Patient Support Program (FCPS).

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 1-833-281-7416.

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:

Patient Information

Patient Name	Date of Birth	Medication Administered	Date(s) of Administration	Program Requested (Check one)
		ROLVEDON (eflapegrastim-xnst) injection		❑ FCPS ❑ PAP
		ROLVEDON (eflapegrastim-xnst) injection		❑ FCPS ❑ PAP
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		ROLVEDON (eflapegrastim-xnst) injection		❑ FCPS ❑ PAP
		ROLVEDON (eflapegrastim-xnst) injection		❑ FCPS ❑ PAP

FCPS (First-Cycle Patient Support Program); PAP (Patient Assistance Program)

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

SPECTRUM® PHARMACEUTICALS

SPECTRUM ACCESS4ME™

Product Replacement Form

Letter of Affiliation 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 (c) will immediately notify the Program if any of the foregoing statements is 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 I receive 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 like Medicare, Medicaid, or any third-party payer for any ROLVEDON administered to patients enrolled in the First-Cycle Patient Support or Patient Assistance Programs. I authorize 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 withdraw any patient or facility from further participation in the Program.

_____ _____

Physician Name (Print) Date

_____

Physician Signature

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

PP-ROL-00-0263

SPECTRUM® PHARMACEUTICALS