SPECTRUM ACCESS4ME®

ACCESS4Me® Patient Authorization and Certification Form

Patient Signature Required: Your healthcare provider has requested one or more of the following services on your behalf

- ACCESS4Me® Bridge Program
- Verification of your insurance coverage for ROLVEDON
- Commercial Copay Assistance
- Eligibility determination for the Patient Assistance Program
- Information on Independent Charitable Foundations

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 affiliated companies, agents and representatives, and other approved service providers authorized to manage, administer, and/or support the Program (collectively, "the Program"), and providers of alternate sources of funding for health care costs 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 the Patient Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me. 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 CoverMyMeds, 910 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.

I have read and agree to the Authorization to Disclose/Use Health Information.

_____ _____

Patient Signature Required Date

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.

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

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Patient Certification Continued

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 payer, 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. Patients may be eligible for multiple doses of ROLVEDON while prior authorization process is pending. I attest that I have not previously been administered ROLVEDON. This Bridge Program 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 payer, 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.

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 payer, 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.

I have read and agree to the ACCESS4Me Patient Certification.

_____ _____

Patient Signature Required Date

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

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

SPECTRUM® PHARMACEUTICALS