

## Product Replacement Form

Please use this form to request ROLVEDON® (eflapegrastim-xnst) injection replacement syringes for patients approved for the ACCESS4Me® Bridge Program (BP), or the Patient Assistance Program (PAP).

For complete program terms and conditions, please visit [www.ACCESS4Me.com](http://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		<input type="checkbox"/> BP <input type="checkbox"/> PAP
		ROLVEDON (eflapegrastim-xnst) injection		<input type="checkbox"/> BP <input type="checkbox"/> PAP
		ROLVEDON (eflapegrastim-xnst) injection		<input type="checkbox"/> BP <input type="checkbox"/> PAP
		ROLVEDON (eflapegrastim-xnst) injection		<input type="checkbox"/> BP <input type="checkbox"/> PAP
		ROLVEDON (eflapegrastim-xnst) injection		<input type="checkbox"/> BP <input type="checkbox"/> PAP

BP (Bridge Program); PAP (Patient Assistance Program)

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### 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 ACCESS4Me® Bridge Program or Patient Assistance Program. 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.

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Physician Name (Print)

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Date



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Physician Signature

