# Get started with ACCESS4ME®

## Patient Access and Reimbursement Support

The ACCESS4Me® team is available to provide information and assistance to support your eligible patients throughout the access process. Our team of Reimbursement Specialists are available in person, online, or by phone.

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### Help is just a call or click away!

Communicate directly with an assigned Spectrum Pharmaceuticals Field Reimbursement Manager or Reimbursement Specialist at **866-582-2737 (866-58-CARES)** 8:00 AM to 8:00 PM (ET), Monday - Friday

Visit **ACCESS4Me.com** for online enrollment and access to tools, forms, and resources

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

# SUPPORTING PATIENT ACCESS

Your ACCESS4Me® team has over 40 years of collective experience.
We look forward to being a trusted resource through the access process.

### Patient Support Services

- Bridge Program
- Co-pay Assistance
- Patient Assistance Program (PAP)
- Independent Charitable Foundation Information*

### Reimbursement Programs

- Verification of Patient-Specific Insurance Benefits
- Billing and Coding Information
- Prior Authorization Assistance
- Appeals Resources

### Resources at Your Fingertips

- User Guides
- Forms and Documents
- Reimbursement Tools
- Program Brochures

*Independent foundations have their own eligibility rules and requirements. We do not endorse nor prefer any particular foundation.


## ACCESS4Me Provider Portal

**The online portal is a fast, secure, and convenient way to enroll your patients and receive real-time information on insurance approval and patient status.**

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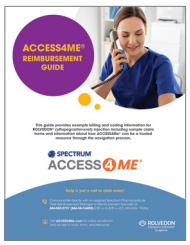
# REIMBURSEMENT PROGRAMS

Our team works with you to provide information on billing, coding, payor policies, and coverage requirements. Reimbursement support programs include:

- **Benefits Investigation**
  - Patient-specific insurance benefit verification with detailed results within 48 hours (2 business days)*
- **Prior Authorization (PA) Assistance**
  - Help obtaining PA forms and understanding payor requirements. We will also track the PA and provide updates, information, and resources for the appeals process, if necessary
- **Billing and Coding Information**
  - Address any questions up front prior to submitting a claim. We also provide information on coverage, product codes, and reimbursement†
- **Appeals Information and Resources**
  - Information and resources on pursuing levels of appeal as needed




Refer to the ACCESS4Me® Reimbursement Guide for more information, available at **ACCESS4Me.com**.

*Dependent upon receipt of a completed and signed enrollment form via fax or provider portal.

†ACCESS4Me cannot guarantee reimbursement or claims adjudication. Please note that it is the sole responsibility of the provider to select proper coding for rendered products or services and to ensure the accuracy of all claims used in seeking reimbursement.

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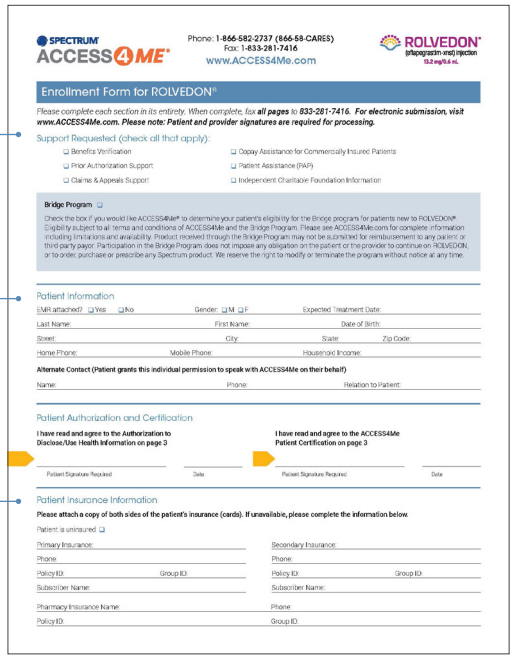
# HOW TO COMPLETE THE ROLVEDON® ENROLLMENT FORM

Use the information below as a helpful guide to filling out the enrollment form for any ACCESS4Me® support services. Ensure that you have all information before completing the form.

Select the support requested; multiple programs may apply

Provide patient's personal information

Provide patient's insurance information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Phone: 1-866-582-2737 (866-58-CARES)
Fax: 1-833-281-7416
www.ACCESS4Me.com

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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:  Secondary Insurance:

Phone:  Phone:

Policy ID:  Group ID:  Policy ID:  Group ID:

Subscriber Name:  Subscriber Name:

Pharmacy Insurance Name:  Phone:

Policy ID:  Group ID:

Include diagnosis codes

Complete physician's information

A signature is required by both the patient and the prescriber; be sure to obtain both signatures prior to submitting to ACCESS4Me


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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 patient's 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, for whom, therapy was based solely on my clinical evaluation 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 therein 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 practice 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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You can also enroll by faxing the enrollment form to 833-281-7416.
Visit **ACCESS4Me.com** for more information.

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# SUMMARY OF INSURANCE BENEFITS AND ELIGIBLE SUPPORT PROGRAMS

A benefits verification is an effective way to determine how ROLVEDON® will be covered. Here is a sample Summary of Benefits Form.

- Patient's personal information
- Information about patient's insurance policy
- Patient's primary diagnosis
- Summary of major medical coverage including PA, copays, and appropriate billing codes
- Summary of pharmacy benefit including PA, copays, and deductibles
- Available financial assistance programs for this patient

## SUMMARY OF BENEFITS FORM

**ROLVEDON® (eflapegrastim) Injection (13.2 mg/0.6 mL prefilled syringe)**

**Patient Name: Ella Cinder**
**Payer Name:** Blue Cross Blue Shield
**Plan Name:** Blue PPO
**Policy Number:** RJP47228472
**Policy Level:** Primary
**Policy End Date:** 01/01/2021
**Payer Contact:** Tiffany W
**Verified for Primary Diagnosis:** D70.9

**Date of Birth: 09/12/1984**
**Patient Record ID:** 00147201
**Plan Type:** PP0
**Group Number:** 365
**Policy Effective Date:** 01/01/2020
**Payer Phone:** 866-222-3333
**Self-Funded:** Fully

| | | | |
|---|---|---|---|
| **Major Medical** | **Coverage for Rolvedon Available? Yes** | **Prior Authorization Required:** Yes | **Prior Authorization Process:** Prior Authorization is required and is currently not on file. Please provide clinical notes, treatment regimen, patient name, and policy number on the request and fax to Medical Review at 866-999-7777. Processing time is 2 business days and notification will be sent via fax. |

**Additional Instructions:** Rolvedon is subject to a 10% co-insurance up to a $2,500 out of pocket max $900 met. Whether office visit (OV) is billed or not, the patient will be responsible for a $25 co-pay which will cover admin and the OV. No deductible applies. Co-pays do contribute to the OOP max. Once out of pocket max is met, co-pays will be waived, and coverage increases to 100% of the allowable rate.

Use J1449 for Rolvedon. The suggested administration code is 96372. Coverage is based upon medical necessity. Actual reimbursement is based on payer contracts or fee schedule.

| | | | |
|---|---|---|---|
| **ROLVEDON Billing Code:** J1449 | | **Allowable Amount*:** $3,000 | |
| **Deductible (Individual):** $1,400 | **Met:** $900 | **Lifetime Maximum:** $1,000,000 | **Met:** $900 |
| **Deductible (Family):** $1,400 | **Met:** $900 | **Benefit Cap:** $80,000 | **Met:** $900 |
| **Out-of-Pocket Maximum:** $2,500 | **Met:** $900 | **Copay for ROLVEDON** 10% | |
| **Office Visit Copay:** $25.00 | | | |

| | | | |
|---|---|---|---|
| **Pharmacy Benefit** | **Coverage for Rolvedon Available? Yes** | **Prior Authorization Required:** Yes | **Prior Authorization Process:** Prior Authorization is required and is currently not on file. To initiate the approval process, contact the CVS/Caremark Medical Review department at 866-321-0321 and provide clinical notes, treatment regimen, patient name, and policy number. Processing time is 4 days. Notification method is by phone. |

**Additional Instructions:** Rolvedon is covered through CVS/Caremark pharmacy. Patient will be responsible for a $250 copay for specialty pharmacy mail order benefits.

| | | | |
|---|---|---|---|
| **Deductible (Individual):** $200 | **Met:** $200 | **Pharmacy Cap:** N/A | **Met:** $0 |
| **Deductible (Family):** $400 | **Met:** $200 | **Benefit Cap:** N/A | **Met:** $0 |
| **Out-of-Pocket Maximum:** $1500 | **Met:** $200 | **Copay for ROLVEDON :** $250 | |

*Summary of Benefits Completed on 09/14/2022 by Dameon Mills.*

* Reimbursement amount will be determined by provider/facility specific contract with the insurance carrier

■ This patient has qualified for the ROLVEDON Copay Assistance Program. Instructions to follow.

☐ This patient may be eligible for Foundation support and/or the ROLVEDON Patient Assistance Program. Contact ACCESS4ME® at 1-866-58-CARES (1-866-582-2737) or visit www.ACCESS4Me.com for more information.

**If you have any questions about this Summary of Benefits for ROLVEDON, please call ACCESS4Me at 1-866-582-2737, Monday through Friday, 8am to 8pm, Eastern Time.**

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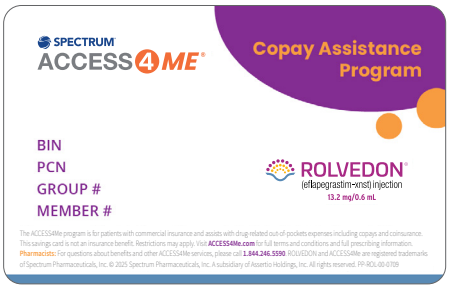
# ACCESS4ME®
# OFFERS SUPPORT FOR ELIGIBLE PATIENTS

Our Dedicated Reimbursement Specialists Will Determine Patient Eligibility and Help Investigate Options.

- **Bridge Program**
  - Eligible new patients with commercial insurance can receive ROLVEDON® free of charge
- **ROLVEDON Commercial Copay Assistance Program**
  - Pay as little as $0 out-of-pocket cost for eligible patients with commercial insurance
- **ROLVEDON Patient Assistance Program**
  - Patients who are uninsured or underinsured may be eligible to receive ROLVEDON at no cost
- **Alternate Funding Information**
  - ACCESS4Me® can provide information about financial assistance from independent charitable foundations*

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Open your camera app and point it here to visit our website.

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