KabiCare
Patient Support Program by Fresenius Kabi

STIMUFEND® (pegfilgrastim-fpgk) Enrollment Form: Authorization for KabiCare Programs

Phone: **1-833-KABICARE (1-833-522-4227)** • Fax all pages to: **1-833-671-1010** *or*
Upload completed enrollment form at kabicare.trialcard.com

FRESENIUS KABI

PATIENT SECTION

Patient Information

⚠ First Name: _____ Last: _____
⚠ Address: _____
⚠ Preferred Phone #: ____-____-_____ ☐ Home ☐ Cell
Please contact: ☐ Me ☐ My Authorized Representative (see below)
☐ Check if OK to leave voicemail

⚠ DOB: ____/____/_____ (MM/DD/YYYY) ⚠ Sex: ☐ Male ☐ Female
⚠ City: _____ ⚠ State: ____ ⚠ Zip: _____
E-mail: _____
Best time to call (check all that apply): ☐ Morning ☐ Afternoon ☐ Evening

Patient's Authorized Representative Information (if applicable)

First Name: _____ Last: _____
Preferred Phone #: ____-____-_____ ☐ Home ☐ Cell
Guardian and/or Power of Attorney: ☐ Yes ☐ No

Relationship to Patient: _____
E-mail: _____

Insurance Information: (Only fill out if a legible copy of both sides of primary and secondary [if applicable] insurance cards are not provided)

Is the patient uninsured? ☐ Yes ☐ No

⚠ **Primary Medical Insurance Carrier:** _____
Policyholder Name: _____ Relationship to patient: _____
⚠ Policyholder ID Number: _____ Group Number: _____
Insurance Phone: ____-____-_____

Secondary Medical Insurance Carrier: _____
Policyholder Name: _____ Relationship to patient: _____
Policyholder ID Number: _____ Group Number: _____
Insurance Phone: ____-____-_____

Prescription Insurance Carrier: _____
Policyholder Name: _____ Rx BIN Number: _____
Prescription Insurance Phone: ____-____-_____

Rx Group Number: _____
Policyholder ID Number: _____ Rx PCN Number: _____

Required Patient Authorization and Additional Consents

☐ **I have read and agree to the Patient Authorization to Share Personal Health Information and STIMUFEND® Enrollment (section 1).**

☐ I have read and agree to receive text messages and calls as explained in the Telephone Consumer Protection Act (TCPA) Consent (see section 2).

☐ Stimufend Co-Pay Program: I have read and agree to the Terms and Conditions for participation (see section 3).

☐ I have read and agree to the Bridge to Commercial Coverage (see section 4 if applicable) and/or PAP if applicable (see section 7).

☐ I have read and agree to the Fair Credit Reporting Act (FCRA) Authorization (see section 5).

⚠ Patient or Authorized Representative Signature: _____ ⚠ Date of Signature: ____/____/_____ (MM/DD/YYYY)
If authorized representative signature, explain authority to act on behalf of the patient: _____

PRESCRIBER SECTION

Prescribing Physician Information

⚠ First Name: _____ Last: _____
Business/Practice Name: _____
⚠ Address: _____
⚠ Fax: _____
Provider Transaction Access Number (PTAN): _____ Physician Tax ID: _____ ⚠ NPI #: _____
Site of Care Name: _____
Product acquisition method: ☐ Buy and Bill OR ☐ Specialty Pharmacy

Office Contact Name: _____
⚠ Office Phone: ____-____-_____
⚠ City: _____ State: _____ Zip: _____
E-mail: _____
Site of Care NPI #: _____
Confirm preferred Specialty Pharmacy: _____

Prescription and Program Information

STIMUFEND® (pegfilgrastim-fpgk) **6 mg / 0.6 mL Pre-filled Syringe** Quantity to Dispense: ____
⚠ ICD-10 Diagnosis: _____ ⚠ CPT Code(s): _____
Secondary ICD-10 Diagnosis: _____ ⚠ Refill: ____
Tertiary ICD-10 Diagnosis: _____
Does the patient weigh less than 45 kg? ☐ YES ☐ NO **If yes, enter weight (kg)** _____
☑ **Bridge to Commercial Coverage (1 refill) at no cost to the patient (if eligible)**
☑ **PAP Coverage (12 refills) at no cost to the patient (if eligible)**

⚠ **Directions For Use:**

⚠ Allergies/Other Medications:

Required Signature and Physician Attestation

You must authorize these instructions by signing below. By signing you are indicating you have read and agree to the Prescriber Certification and Statement of Medical Necessity (see Section 6). We cannot process this form without your signature.

⚠ Prescriber Signature: _____ ⚠ Date of Signature: ____/____/_____ (MM/DD/YYYY)

⚠ CANNOT BE PROCESSED UNLESS ALL FIELDS WITH THIS MARK ARE COMPLETED

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ADDITIONAL TERMS AND CONDITIONS FOR ENROLLMENT

Section 1: Patient Authorization for the Use and Disclosure of Protected Health Information

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE HEALTH INFORMATION

By my signature above, **I agree** to allow my doctors, pharmacies, specialty pharmacy(ies), and health insurers (collectively "Healthcare Providers"), to use and disclose my personal health information related to this enrollment form. I agree to allow my doctors, pharmacies, specialty pharmacy(ies), and health insurers (collectively "Healthcare Providers"), to use and disclose my personal health information related to this enrollment form or my use or potential use of a Program Product to Fresenius Kabi and its agents, authorized representatives, and contractors including without limitation, its HUB provider, as further described below.

Information to Be Disclosed: My protected health information (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder), as well as other state and/or federally protected personal information, including my personal contact and other demographic information, all medical records and financial information, and information relating to my treatment, the coordination of my treatment, and the delivery, packaging, and receipt of certain medication prescribed to me (collectively, my "Information").

Persons to Whom My Information May Be Disclosed: Fresenius Kabi and the KabiCare Patient Support Program, including any third parties responsible for the administration of the KabiCare Patient Support Program.

Purposes for Which the Disclosures Are to Be Made: Disclosures of my Information may be made to KabiCare Patient Support Program so that KabiCare Patient Support Program may use and disclose my Information for purposes of:

1) Communicating with my Healthcare Providers about my prescription and medical condition, including to facilitate the order, fulfillment and delivery of my prescription as needed;
2) Establishing my eligibility for benefits from my health plan or other programs;
3) Contacting my insurer on my behalf to determine if I am eligible for health insurance coverage or other funds;
4) Providing appropriate product and reimbursement support;
5) Contacting me regarding case management and/or educational information or training offered by or through the KabiCare Patient Support Program;
6) Contacting me regarding this Authorization or my use or potential use of my prescriptions and providing me with related communications, including through messages left for me that disclose that I take or may take certain prescription medications;
7) Contacting me to administer, evaluate, and improve the KabiCare Patient Support Programs, including analyzing the usage patterns and the effectiveness of services and helping to develop new products, services, and programs, and for other general business and administrative purposes; and
8) Disclosing my Information to third parties if required by law.

By signing this Authorization, **I acknowledge** my understanding that:

- I understand that I may refuse to sign this Authorization and that my refusal to sign this Authorization will not affect my right to treatment or payment of benefits for health care. I understand that if I refuse to sign, I will not be eligible to receive support through the KabiCare Patient Support Program.
- I have the right to revoke this Authorization at any time by mailing (KabiCare. PO Box 2250 Perimeter Park Dr., Suite 300 Morrisville, NC 27560) or faxing a written request to KabiCare 1-833-671-1010. Revoking this Authorization will prohibit further uses and disclosures of my Information by the KabiCare Patient Support Program, except to the extent those uses and disclosures have been made in reliance on this Authorization and as permitted by applicable law.
- Certain pharmacy providers or other Healthcare Providers may receive remuneration for the use or disclosure of my Information, as permitted by this Authorization.
- Once my Information is released to KabiCare Patient Support Program based on this Authorization, my Information may not be subject to all of the protections and safeguards provided by HIPAA or other federal and state privacy laws. However, I understand that KabiCare Patient Support Program has agreed to use or disclose my Information received only for the purposes described in this Authorization or as required by law.
- This Authorization will remain in effect for a period of two (2) years after I sign it unless a shorter period is required by state law or is revoked by me earlier in writing.
- I am entitled to receive a copy of this signed Authorization.

*The patient, or the patient's authorized representative, **MUST** sign this form to participate in the KabiCare Patient Support Program. My signature, signifying my agreement with this Authorization, is provided on page 1 of this Enrollment Form, where it states, 'I have read and agree to the Patient Authorization for the Use and Disclosure of Protected Health Information (section 1).' If an authorized representative signs for the patient, please indicate relationship to the patient.*

Section 2: Telephone Consumer Protection Act (TCPA) Consent

By checking the first box in the "Required Patient Authorization and Additional Consents" section on page 1, you understand that the personal information you provide will be shared with KabiCare, and its third-party partners, including, without limitation, its HUB provider. You also authorize KabiCare, and its partners, to communicate with you about products, health conditions, copay and financial assistance. You are providing consent that you can be contacted by mail, email, phone or autodialed text messages under the guidelines of the Telephone Consumer Protection Act at the phone number you provide. You may opt out of individual communications from KabiCare or its partners entirely at any time by calling 1-833-KabiCare. KabiCare and companies providing services to KabiCare will not sell or rent your personally identifiable information, as described in the Privacy Policy. For clarity, phone contact includes telephonic contact for the purposes of advertising or telemarketing and may include either or both of (1) autodialed prerecorded voice calls, and (2) autodialed artificial voice calls.

You understand that you are not required to agree to receive any phone, mail, or text messages as a condition of participation in this Program, that message and data rates may apply depending on your phone carrier, and you may stop receiving text messages at any time by texting the word STOP in response to a text received from KabiCare or its partners.

Section 3: KabiCare Copay Assistance Program TERMS & CONDITIONS

To receive benefits under the Copay Assistance Program, the patient may contact the KabiCare Patient Support Program for current Program Product(s) subject to these Terms and Conditions. By participating in the Copay Assistance Program, patient acknowledges and agrees that he/she is eligible to participate and that he/she understands and agrees to comply with these Terms and Conditions.

- Patient must be prescribed the Program Product for an FDA-approved indication.
- Patient must have commercial (private or non-governmental) health insurance that provides coverage for the cost of the Program Product under a pharmacy or medical benefit plan.
- The Copay Assistance Program is valid for patients who have a valid prescription for a Fresenius Kabi medication and who are not reimbursed for the entire cost of the prescription by their commercial insurance plan. The Copay Assistance Program is not valid for patients enrolled in Medicaid, Medicare (including a Medicare Part D or Medicare Advantage plan, a Medigap plan, or an employer-sponsored health plan or prescription drug benefit program for Medicare-eligible retirees), Veteran Affairs health care programs, Department of Defense health care programs, TRICARE, CHAMPUS, Puerto Rico Government Health Insurance Plan , or any other state or federal medical or pharmaceutical benefit program or pharmaceutical assistance program, including any state pharmaceutical assistance programs (collectively, "Government Programs"). Patients who move from commercial insurance to Government Programs will no longer be eligible to participate in the Copay Assistance Program and agree to notify the Copay Assistance Program of any such change. If the patient lives in Massachusetts, the Copay Assistance Program expires on the earlier of: (i) the Expiration Date set forth below; (ii) the date an AB-rated generic equivalent becomes available for the Program Product; or (iii) January 31, 2026, absent a change in Massachusetts state law. If the patient lives in California, the Copay Assistance Program expires on the earlier of: (i) the Expiration Date set forth below; or (ii) the date an FDA approved therapeutically equivalent for the Program Product or over the counter product with the same active ingredients becomes available.
- Patients must have an out-of-pocket cost for the Program Product prior to the Expiration Date of the Copay Assistance Program set forth below.
- The benefit available under the Copay Assistance Program is limited to the amount the patient's private health insurance company indicates that the patient is obligated to pay for up to a per syringe/annual maximum.
- The Program may apply to patient out-of-pocket costs incurred for Program Product subject to per syringe/annual maximums based on Program Product administration date After reaching the maximum Copay Assistance Program benefit, the patient will be responsible for all remaining out-of-pocket expenses. The patient or provider may contact the KabiCare Patient
  Support Program for more information.
- This Copay Assistance Program benefit is for commercially insured patients only. Uninsured and cash paying patients may be eligible for other types of support not part of the Copay Assistance Program.
- The Patient and participating pharmacy or healthcare professional agree not to seek reimbursement for all, or any part, of the benefit received by the patient through the Copay Assistance Program. Participating patients and pharmacies or health care professionals are responsible for reporting receipt of Copay Assistance Program benefits as may be required by law.
- Patient must be a resident of the United States or the Commonwealth of Puerto Rico. Product must originate and be administered to patient in the United States or the Commonwealth of Puerto Rico.
- All information applicable to the Copay Assistance Program requested on the KabiCare.US site must be provided, and all certifications must be provided. No other purchase is necessary.
- The Copay Assistance Program is not insurance.
- It is illegal to sell, purchase, trade, counterfeit, or duplicate, or offer to sell, purchase, trade counterfeit, or duplicate the Copay Assistance Program card. Void if reproduced.
- The Copay Assistance Program is intended to comply with all applicable laws and regulations, including, without limitation, the federal Anti-Kickback Statute, its implementing regulations, and related guidance interpreting the federal Anti-Kickback Statute.
- The Copay Assistance Program is void where prohibited by law, taxed, or restricted. The Copay Assistance Program is not transferable. No substitutions are permitted.
- The Copay Assistance Program benefit has no cash value and cannot be combined with any other Copay Assistance Program, free trial, discount, rebate, prescription savings card, or other offer.
- The full value of the Copay Assistance Program benefit is intended to pass entirely to the patient. No other individual or entity is entitled to receive any discount or other amount in connection with the Copay Assistance Program.
- This offer is not conditioned on any past, present, or future purchase obligation, and the Copay Assistance Program does not obligate the use of any specific product or provider.
- To the extent applicable, this offer will be accepted only at participating pharmacies, to the extent applicable.
- KabiCare reserves the right to rescind, revoke, terminate, or amend the Copay Assistance Program at any time without notice.
- Data related to patient's receipt of Copay Assistance Program benefits may be collected, analyzed, and shared with KabiCare, for market research and other purposes related to assessing Copay Assistance Programs. Data shared with KabiCare will be aggregated and de-identified, meaning it will be combined with data related to other Copay Assistance Program redemptions and will not identify patient.
- The Terms and Conditions of the Copay Assistance Program are valid for Program Product only, and Fresenius Kabi reserves the right to rescind, revoke, or amend the Program without notice.

Section 4: Bridge to Commercial Coverage – Patient Attestation

KabiCare provides a limited and temporary supply of free product through the KabiCare Commercial Bridge Program ("Commercial Bridge Program") for eligible commercially insured patients when a prior authorization request has been pending with the payer for an extended period of time, as determined by Fresenius Kabi in its sole discretion. You may contact the KabiCare Patient Support Program for specific information about the duration of supply for the Program Product you have been prescribed, and when other program eligibility criteria have been satisfied.

The patient and participating providers may not seek reimbursement for any free product provided under the Commercial Bridge Program nor does the Commercial Bridge Program include payment for product administration fees.

By signing above, the patient hereby certifies to the following: I certify that I am not enrolled in any Federal health care program (such as Medicare, Medicaid, Veteran Affairs health care programs, Department of Defense health care programs, TRICARE, or CHAMPUS) If I am enrolled in the Commercial Bridge Program, I certify that all information provided herein is correct and complete, to the best of my knowledge. I acknowledge that any product provided through the Commercial Bridge Program is provided on a complimentary basis. I certify that I will not submit or cause to be submitted any claims for payment or reimbursement for such products to any third party payor, including any Federal health care programs. If I am or become in possession of such product, I understand that such product is only for me and I will not give such product to anyone else. I agree that I will not sell, trade, or distribute or otherwise transfer such product.

I understand that if I am enrolled in the Commercial Bridge Program, any future changes to prescription drug coverage, or insurance coverage may affect whether I can continue to participate in the Commercial Bridge Program. I agree to contact KabiCare at 1-833-KABICARE (1-833-522-4227) and tell them about any changes to my prescription drug coverage, or insurance coverage. I understand there is no purchase requirement associated with assistance through by or through the Commercial Bridge Program. I understand that completing this form does not guarantee that assistance will be provided.

Section 5: Fair Credit Reporting Act (FCRA) - Patient Authorization

The information I have provided is complete and accurate and will be used to decide if I am eligible to participate in the KabiCare Patient Assistance Program (the "PAP"). I agree that submitting my application is not a guarantee that I am entitled to participate in the PAP or that the PAP is obligated to provide me with any assistance. I understand that the PAP can revise, change, or terminate the program at any time. I authorize my healthcare providers and my health plan or insurers to give my medical and financial information to KabiCare, and including any third parties responsible for the administration of the KabiCare Patient Support Program, including without limitation, its HUB provider, and, any other third party responsible for assessing my income and ability to pay. I authorize KabiCare and its service providers to obtain credit reports about me from one or more credit reporting agencies in order to verify my information and determine my eligibility to participate in the PAP. I authorize KabiCare and Experian to review my medical and financial information and to use it only to determine if I am eligible to participate in the PAP, to operate the PAP, or as otherwise required or permitted by law. I understand and agree that KabiCare and Experian may contact me directly to verify the information I have submitted or to ask for additional information or documentation to process my application.

Section 6: Prescriber Certification and Statement of Medical Necessity

Prescriber Declaration: My signature certifies that the person named on this form is my patient, I will be supervising this patient's treatment, and the information that has been provided is complete and accurate to the best of my knowledge.

I also certify that I have made the clinical judgement that any products provided through KabiCare Patient Support Program(s), including KabiCare's Patient Assistance Program (the "PAP") are medically necessary and appropriate for the patient named on this form and will be used only by that patient. I will not use any such product or prescribe, provider, furnish, or dispense any portion thereof to any other person or patient. If I am or become in possession of such medications, I will not sell, resell, offer for sale, trade, or barter such products.

In addition, I certify that no claim for payment or reimbursement for any product furnished through KabiCare Patient Support Program(s), including the PAP, will be submitted to any third-party payer, including any Federal health care program (such as Medicare, Medicaid, Veteran Affairs health care programs, Department of Defense health care programs, TRICARE, or CHAMPUS), any other health care benefit plan, payer or patient, or returned for credit.

I further certify that (a) any reimbursement investigation support or assistance provided to patients through KabiCare Patient Support Program is not made in exchange, directly or indirectly, for any past, present, or future recommendation, prescription, purchase, or use of the above therapy or any other product or service for or from anyone and (b) my decision to prescribe product was based solely on my determination of medical necessity as set forth herein. I understand that completing this form does not guarantee that assistance will be provided to my patient.

Prescriber Acknowledgement: Where required by applicable law, regulation, or other applicable authority, I have obtained appropriate written authorization from the patient ("Legal Permission") permitting me to use and disclose my patients' health, demographic, and other individually identifiable information, including insurance and financial information, to Fresenius Kabi, its affiliates, its program administrator, and their respective agents, service providers and field reimbursement professionals for the purpose of assessing the patient's insurance coverage and eligibility for participation in the KabiCare Patient Support Program(s), providing patient support programs, copay assistance, patient assistance, and/or reimbursement support in connection with the patient's treatment with product. I maintain records of such Legal Permission consistent with applicable law.

I appoint KabiCare on my behalf, to convey this prescription to the appropriate dispensing entity, to the extent permitted under applicable state law. Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form.

Section 7: Patient Assistance Program - Patient Attestation

I certify that all information provided herein is correct and complete, to the best of my knowledge. To the extent I receive any free product through programs offered by or through the KabiCare Patient Support Programs, including the KabiCare Patient Assistance Program ("PAP"), I acknowledge that such product is provided on a complimentary basis. I certify that I will not submit or cause to be submitted any claims for payment or reimbursement for such products to any third-party payor, including any Federal health care programs (such as Medicare, Medicaid, Veteran Affairs health care programs, Department of Defense health care programs, TRICARE, or CHAMPUS). If I am or become in possession of such product, I understand that such product is only for me, and I will not give such product to anyone else. I agree that I will not sell, resell, offer for sale, trade, barter, distribute or otherwise transfer such product. I understand that if I am enrolled in a Medicare Part D Plan (including a Medicare Advantage Prescription Drug Plan) or other Federal health care program, I may not apply any assistance I receive to my "True Out of Pocket" ("TrOOP") expenditures, and that it is my responsibility to notify such Federal health care program(s) of any assistance I may receive, including my enrollment in the PAP. I understand that if I am enrolled in the PAP, any future changes to my income, prescription drug coverage, or insurance coverage may affect whether I can continue to participate in the PAP. I agree to contact KabiCare at 1-833-KABICARE (1-833-522-4227) and inform them about any changes to my income, prescription drug coverage, or insurance coverage. I understand there is no purchase requirement associated with assistance through by or through any KabiCare Patient Support Program(s), including the PAP. I understand that completing this form does not guarantee that assistance will be provided.

I understand that Fresenius Kabi reserves the right at any time and without notice to me to modify and/or discontinue any or all support offered by or through KabiCare Patient Support Programs, including modification of eligibility criteria, covered medications and immediate termination of assistance provided through the PAP.