AccordCares™
PHONE: 1-866-258-7151 | FAX: 1-855-558-6304
PO BOX 221643, Charlotte, NC 28222
Monday–Friday 8AM–8PM ET

CAMCEVI™ (leuprolide) 42 mg injection emulsion

AccordCares™ Prescription and Enrollment Form

To get started, please complete and fax this form to 1-855-558-6304, or complete and electronically sign at www.accordcaresportal.com. For assistance, please call AccordCares at 1-866-258-7151.

SELECT ALL REQUESTED SERVICES:

- ❑ Benefits Verification and Co-Pay Program
- ❑ Prior Authorization Support and/or Appeal Support
- ❑ Specialty Pharmacy Referral Triage
- ❑ Patient Assistance Program (PAP) (For Uninsured Patients)

SECTION 1: PATIENT INFORMATION *INDICATES A REQUIRED FIELD

SEX ❑ M ❑ F

* PATIENT NAME (FIRST, MI, LAST)

* STREET ADDRESS | * CITY | * STATE | * ZIP

* DATE OF BIRTH (MM/DD/YY) | * PRIMARY PHONE | ALTERNATE PHONE | ❑ OKAY TO LEAVE MESSAGE

LANGUAGE PREFERENCE | CAREGIVER NAME | RELATIONSHIP TO PATIENT | CAREGIVER PHONE

SECTION 2: INSURANCE INFORMATION PLEASE INCLUDE A COPY OF EACH INSURANCE CARD *INDICATES A REQUIRED FIELD

❑ PATIENT HAS NO INSURANCE (SKIP TO SECTION 3 BELOW)

	PRIMARY INSURANCE	SECONDARY INSURANCE	PRESCRIPTION INSURANCE
* INSURANCE/PAYER NAME			
INSURANCE PLAN NAME			
* POLICYHOLDER NAME			
* POLICYHOLDER DOB			
* RELATIONSHIP TO POLICYHOLDER			
* POLICY ID NUMBER			
GROUP NUMBER			
INSURANCE PHONE NUMBER			
RX BIN	Not Applicable	Not Applicable	
PCN	Not Applicable	Not Applicable	

SECTION 3: FINANCIAL INFORMATION REQUIRED IF REQUESTING THE PATIENT ASSISTANCE PROGRAM

REQUESTS FOR PATIENT ASSISTANCE PROGRAM ONLY: Uninsured patients who are prescribed CAMCEVI™ may be eligible for the AccordCares Patient Assistance Program. To help determine if the patient qualifies, please fill in the information below:

Annual Pretax Household Income: $

Number Living in the Household (Including members under 18 years):

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SECTION 4: PATIENT CONSENT AND AUTHORIZATION TO BE COMPLETED BY THE PATIENT OR THEIR AUTHORIZED REPRESENTATIVE

By signing below, the patient acknowledges and authorizes that his/her healthcare providers and staff, his/her health insurer, health plan or programs that provide me healthcare benefits (together, "Health Insurers"), and any specialty pharmacies that dispense his/her medication to disclose to Accord BioPharma and their affiliates and agents health information about the patient, including information related to his/her medical condition and treatment, health insurance coverage and claims, prescription (including fill/refill information), and referral to and enrollment in the program ("My Information") for the purposes of enrolling the patient in and providing certain services, that may include

- Determining his/hers health care plan coverage and benefits for CAMCEVI™ treatments prescribed by his/her doctor and other procedures as part of his/her therapy on CAMCEVI treatments
- Identifying and informing the patient of alternative sources of funding, including third-party non-profit organizations and other patient support programs
- Tracking his/her ongoing use of prescribed CAMCEVI treatments
- Contacting him/her to collect any additional information needed to provide these services or for purposes of market research about CAMCEVI and AccordCares
- Measuring or tracking the quality of services provided to him/her by the program
- And as required or permitted by law

The patient understands that once his/her healthcare providers, health plans, pharmacies, or others who have his/her personal and health information disclose his/her health information, it may no longer be protected under federal or state privacy law (for example, HIPAA) from further disclosure. However, the patient understands that Accord BioPharma agrees to protect his/hers information by using and disclosing it only for the purposes allowed by him/her in this Authorization or as otherwise allowed by law.

The patient understands that his/her authorization is voluntary and his/her healthcare providers, health plans and pharmacies may not condition his/her treatment, payment for treatment, enrollment or eligibility for benefits on whether the patient sign this authorization. However, if the patient does not sign this authorization, it may affect his/her ability to enroll in AccordCares.

The patient understands that this authorization will remain valid for 3 year(s) after the date of his/her signature or such earlier date as required by applicable law, unless the patient revokes it earlier by cancelling his/her enrollment, which the patient may do by calling, mailing or faxing a request to AccordCares by phone at 1-866-258-7151, by mail to PO Box 221643, Charlotte, NC 28222 or by fax to 1-855-558-6304. The patient understands that his/her cancellation will not apply to any use or disclosure of his/her health information by his/her healthcare providers, health plans or pharmacies before they receive notice of his/her cancellation.

By signing below, the patient consents to these services and certifies that the patient is at least eighteen (18) years of age.

The patient also understands that the services may be revised, changed, or terminated at any time.

The patient understands and agrees that his/her healthcare providers, health plans, and/or specialty pharmacy(ies) may receive remuneration from Accord BioPharma in exchange for disclosing his/her information to AccordCares and/or for providing him/her with support services in connection with the program.

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PATIENT NAME: **PATIENT DOB:**

SECTION 4: PATIENT CONSENT AND AUTHORIZATION (CONTINUED) TO BE COMPLETED BY THE PATIENT OR THEIR AUTHORIZED REPRESENTATIVE

ACCORDCARES COPAY ASSISTANCE PROGRAM TERMS AND CONDITIONS:

By signing below, the patient acknowledges that he/she will comply with the following:

- The AccordCares Co-Pay Program for CAMCEVI™ can be used to reduce the amount of an eligible patient's out-of-pocket expenses for CAMCEVI. With this program, eligible patients may pay as little as $0 co-pay per CAMCEVI treatment, subject to a maximum benefit of $25,000 per calendar year for out-of-pocket expenses for CAMCEVI including co-pays or coinsurances.
- This program is not valid for patients who are enrolled in a state or federally funded insurance program, including but not limited to Medicare, Medicaid, TRICARE, Veterans Affairs health care, a state prescription drug assistance program, or the Government Health Insurance Plan available in Puerto Rico (formerly known as "La Reforma de Salud").
- Program offer is not valid for cash-paying patients and the patients are responsible for any out-of-pocket costs for CAMCEVI that exceed the annual maximum.
- The program does not cover or provide support for supplies, procedures, or any physician-related service associated with CAMCEVI.
- To be eligible, the patient must have private insurance with coverage of CAMCEVI.
- This offer is not valid when the entire cost of his/her prescription drug is eligible to be reimbursed by his/her private insurance plans or other private health or pharmacy benefit programs.
- The patient must deduct the value of this assistance from any reimbursement request submitted to his/her private insurance plan, either directly by the patient or on his/her behalf.
- The patient is responsible for reporting use of the program to any private insurer, health plan, or other third party who pays for or reimburses any part of the prescription filled using the program, as may be required.
- The patient should not use the program if his/her insurer or health plan prohibits use of manufacturer co-pay assistance programs.
- The patient must be 18 years of age or older to be eligible for this Co-pay Program.
- This program is not considered health insurance. This program is not valid where prohibited by law. This program cannot be combined with any other savings, free trial or similar offer for the specified prescription. Valid prescription is required.
- Accord BioPharma reserves the right to rescind, revoke or amend this program without notice. This offer is not conditioned on any past, present, or future purchase, including refills. The program terms and offer will expire at the end of each calendar year.

ACCORDCARES PATIENT ASSISTANCE PROGRAM AND FAIR CREDIT REPORTING ACT (FCRA) AUTHORIZATION:

By signing and checking the optional box below, the patient acknowledges that he/she will comply with the following:

- The AccordCares Patient Assistance Program is available to patients that do not have insurance, or their medicine is not covered.
- To qualify for the AccordCares Patient Assistance Program, the patient understands that the he/she must meet certain income and other eligibility requirements. Some patients with Medicare Prescription Drug Coverage (Part D) who cannot afford their medicines and who meet certain financial criteria may also be eligible for assistance. AccordCares may ask for proof of income at any time for the purpose of audit/verification. If requested, the patient agrees to provide proof of income within 30 days of the request. Continuation in the program is conditioned upon timely verification of income.
- In addition, the patient agrees to notify AccordCares promptly if his/her insurance situation changes.
- The patient also agrees that Accord BioPharma may verify his/her eligibility for the AccordCares Program, and the patient understands that such verification may include contacting him/her or his/her healthcare provider for additional information and/or reviewing additional financial, insurance, and medical information.
- The patient authorizes Accord BioPharma to use his/her demographic information to access reports on his/her individual credit history from consumer reporting agencies for the purposes of determining his/her income eligibility. The patient understands that, upon request, Accord BioPharma will tell him/her whether an individual consumer report was requested and the name and address of the agency that furnished it. The patient further understands and authorizes Accord BioPharma to use any consumer reports about him/her and information collected from him/her, along with other information they obtain from public and other sources, to estimate his/her income in conjunction with the AccordCares Patient Assistance Program eligibility determination process.
- If the patient completed Section 3, the he/she confirms his/her agreement with the conditions set forth in Section 3 and certifies that the information he/she has set forth in Section 3, including the number of people in his/her household and his/her household income, are true and accurate to the best of his/her knowledge.

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SECTION 4: PATIENT CONSENT AND AUTHORIZATION (CONTINUED) TO BE COMPLETED BY THE PATIENT OR THEIR AUTHORIZED REPRESENTATIVE

- The patient further certifies that he/she will not seek reimbursement or credit for this prescription requested under the AccordCares Patient Assistance Program from any insurer, health plan, or government program, and if he/she is a member of a Medicare Part D plan, he/she will not seek to have this prescription, or any cost associated with it, counted as part of his/her out-of-pocket cost for prescription drugs.
- The patient understands that any drugs provided under the AccordCares Patient Assistance Program shall not be sold, traded, bartered, or transferred.
- The patient understands he/she must be a permanent resident of the U.S. or U.S. Territory (including Guam, Puerto Rico, and the Virgin Islands).
- The patient understands that any program assistance provided by AccordCares will terminate if the program becomes aware of any fraud or if this medication is no longer prescribed for me.
- The patient certifies that he/she cannot afford this medication.
- The patient understands that completing this application does not ensure that he/she will qualify for this program. In order to qualify for the program, he/she must live in the United States, or a U.S. Territory and he/she is being treated by a U.S. licensed doctor.
- Accord BioPharma reserves the right to rescind, revoke or amend this program without notice.

WHICH BEST DESCRIBES YOU? ❑ **I AM A PATIENT** ❑ **I AM A LEGALLY AUTHORIZED REPRESENTATIVE**

* **PRINT NAME OF PATIENT**

* **PRINT NAME OF LEGALLY AUTHORIZED REPRESENTATIVE**

* **LEGALLY AUTHORIZED REPRESENTATIVE'S RELATIONSHIP TO PATIENT**

* **SIGNATURE OF PATIENT (OR PATIENT'S AUTHORIZED REPRESENTATIVE)**

* **SIGNATURE DATE (MM/DD/YYYY)**

❑ (optional) I have read and agree to the Terms and Conditions for participation in the AccordCares Patient Assistance Program and provide my authorization for the Fair Credit Reporting Act Authorization on Pages 3-4.

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PATIENT NAME: **PATIENT DOB:**

SECTION 5: PRESCRIBER CERTIFICATION TO BE COMPLETED BY THE HEALTHCARE PROVIDER

By signing below, I represent and warrant the following:

- This Enrollment Form has been prepared exclusively by the healthcare provider or healthcare provider office identified in this Enrollment Form.
- By signing below, I represent and warrant that I am authorized pursuant to the laws of my state of license to prescribe CAMCEVI™.
- I, or others in my healthcare provider practice group, ("my Practice") have obtained written authorization from the patient named in this Enrollment Form that complies with the requirements of the HIPAA Privacy Rule, 45 C.F.R. § 164.508, and authorizes me and the Practice, as well as the patient's health insurance plan(s), to disclose the patient's personal health information ("PHI"), including information relating to the patient's medical condition and prescription medications and the information disclosed in this Enrollment Form to AccordCares, the AccordCares Patient Assistance Program ("PAP") and the AccordCares Co-Pay Program (collectively, "the Programs") and authorizes the Programs (together with their respective administrators, contractors, or other affiliates) to use and disclose the PHI for purposes of benefits investigation and reimbursement support.
- I certify that I, or a healthcare provider in my Practice, have determined that the prescribed product is medically appropriate for the patient identified above and that I, or a healthcare provider in my Practice, will be supervising the patient's treatment.
- I have read and agree to the Terms and Conditions of the AccordCares Co-Pay Program. I certify that, to the best of my knowledge, the patient meets the criteria set forth in the Terms and Conditions, and that the information I am providing on this form is true and correct.
- I certify that I/my office will not consider the fact that the patient may receive a benefit from the AccordCares Co-Pay Program when determining the amount of any charge(s) to the patient.
- I certify that I/my office will not charge the patient any fee to complete this form and I/my office will not advertise or otherwise use the AccordCares Co-Pay Program as means of promoting my services or CAMCEVI.
- I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient.
- If the patient receives free product through the AccordCares Patient Assistance Program, neither I nor my Practice will seek reimbursement for such product administered to the patient from any source.
- Neither I nor my Practice will receive any reimbursement from AccordCares, whether for administration fees or otherwise.
- I understand that I am/my office is responsible for reporting receipt of AccordCares Co-Pay Program benefits to any insurer, health plan, or other third party that pays for or reimburses any part of the medication cost paid for by the AccordCares Co-Pay Program, as may be required.
- I understand and agree that the certifications I am providing in this Healthcare Provider Certification apply to the patient indicated on this form and to any other patient enrolled in the AccordCares Co-Pay Program who I treat with CAMCEVI and any claim I submit/my office submits for AccordCares Co-Pay Program benefits on the patient's behalf.
- I hereby certify that, for any insured patient seeking co-pay assistance under the AccordCares Co-Pay Program, in the absence of financial support from such program, any applicable copay, coinsurance, or other out-of-pocket cost for CAMCEVI would be collected from the patient upon treatment.
- I understand that I may be asked to sign a new Healthcare Provider Certification if the Terms and Conditions of the AccordCares Co-Pay Program for CAMCEVI change.
- I understand that information concerning Program participants may be summarized for statistical or other purposes and provided to AccordCares and/or the Programs only for use in an aggregated, de-identified format.
- I and my Practice grant the Programs the right to conduct periodic audits of my Practice's records to verify the information provided herein, excluding patient-identifiable data (unless the auditor enters into an appropriate agreement with my Practice to protect an individual's medical privacy).
- I consent to receive communications related to the Programs by phone, email, and fax.
- I understand that AccordCares its affiliates and vendors reserve the right to modify or discontinue this program at this facility/practice or terminate assistance at any time and without notice.
- I certify that the information provided above is true and that CAMCEVI is being prescribed for the patient listed above.
- I appoint AccordCares, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law.

* PRINT NAME OF HEALTHCARE PROVIDER	* HEALTHCARE PROVIDER SIGNATURE	* SIGNATURE DATE (MM/DD/YYYY)

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PATIENT NAME: **PATIENT DOB:**

SECTION 6: PRESCRIBER INFORMATION TO BE COMPLETED BY THE HEALTHCARE PROVIDER * *INDICATES A REQUIRED FIELD*

* PRESCRIBER NAME (FIRST, MI, LAST)
* PRACTICE / INSTITUTION NAME
* STREET ADDRESS
* CITY
* STATE
* ZIP
* OFFICE PHONE
* OFFICE FAX
* OFFICE CONTACT
* OFFICE CONTACT PHONE NUMBER
* GROUP TAX ID
* NPI NUMBER
* STATE LICENSE NUMBER

SECTION 7 : PRESCRIPTION INFORMATION TO BE COMPLETED BY THE HEALTHCARE PROVIDER

PRESCRIPTION: CAMCEVI™

Prescribers in all states must comply with the prescription requirements of their state. For prescribers in states with official prescription form requirements, such as New York, please submit prescriptions on an official state prescription form, in addition to this enrollment form. Prescribers may need to submit an electronic prescription to the Specialty Pharmacy.

* PATIENT NAME (FIRST, MI, LAST)
* PATIENT DOB (MM/DD/YYYY)
* PRIMARY DIAGNOSIS CODE:
SECONDARY DIAGNOSIS CODE:

DRUG ALLERGIES ❑ NO KNOWN DRUGS ALLERGIES
CONCURRENT MEDICATIONS ❑ NO KNOWN CONCURRENT MEDICATIONS

❑ PRE-FILLED SYRINGE CONTAINING 42 MG CAMCEVI (LEUPROLIDE INJECTABLE EMULSION): Inject 42mg subcutaneously once every 6 months # OF REFILLS: 0

❑ OTHER

IF 'OTHER' IS CHECKED, PLEASE PROVIDE WRITTEN INSTRUCTIONS IN THE BOX BELOW (I.E. ORDER, STRENGTH, DOSING INSTRUCTIONS, ETC.)

ORDER, STRENGTH, DOSING INSTRUCTIONS

* PRESCRIBER SIGNATURE (NO STAMPS)
* PRESCRIBER SIGNATURE DATE
* PRINTED NAME OF PRESCRIBER
COLLABORATIVE PHYSICIAN NAME (IF APPLICABLE)