UDENYCA®
pegfilgrastim-cbqv
Injection 6 mg/0.6 mL

AccordCares® Enrollment Form

HCP attestation (Section 6) required to complete enrollment

*Denotes **REQUIRED** Information

Call 1-844-483-3692
Monday to Friday | 8 AM to 8 PM ET
FAX 1-877-226-6370
AccordCares.com

Check for services requested:*

☐ Benefits Verification ☐ Co-Pay Savings Program ☐ Support for Claims, Prior Authorizations, and Appeals

Please choose the UDENYCA presentation that will be used:*

■ Prefilled Syringe ■ Prefilled Autoinjector ■ ONBODY®

1 PATIENT INFORMATION

Patient's Name:*

Gender at Birth:* ■ Male ■ Female DOB:* (MM/DD/YYYY) / /

Patient's Address:*

City:* State:* ZIP:*

Patient's Phone #:* ■ Home ■ Cell Email:

Alternate Contact Name: Phone #:

OK to leave a message? ■ Yes ■ No Best Time to Call ■ Morning ■ Afternoon ■ Evening

2 INSURANCE INFORMATION

(Please attach a copy of both sides of the patient's insurance card(s). If not available, please complete the information below.)

Is the Patient Insured?*† ■ Yes ■ No

Insurance Type:* ■ Commercial ■ Medicare ■ Medicaid ■ Other

Benefit Verification Preference:* ■ Medical ■ Pharmacy ■ Both

PLEASE COMPLETE THE SECTION(S) THAT CORRESPOND TO THE PREFERRED BENEFIT VERIFICATION.

	PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE (if applicable)
Insurance Name*		
Phone Number*		
Policy ID Number*		
Group Number*		
Policyholder's Name*		
Policyholder's DOB*	/ /	/ /
Policyholder's Relationship to Patient*		
Medicare Beneficiary ID Number*		

†If the patient is uninsured, AccordCares can provide information about independent foundations that may be able to help. Call 1-844-483-3692 for additional information.

Please see **page 2** for **HCP Attestation** and **Required Signature**

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3 PHARMACY BENEFIT PLAN (If Applicable)

Insurance Name: Phone Number:

ID Number: Group Number:

BIN: PCN:

Policyholder's Name: Policyholder's DOB: / /

4 CLINICAL INFORMATION

Drug Name: **UDENYCA** Primary Diagnosis/ICD-10 Code (REQUIRED):*

Secondary Diagnosis

Site of Care:* ☐ Freestanding Infusion Center ☐ Physician Office
☐ Hospital Outpatient Clinic ☐ Hospital Inpatient ☐ Home ☐ Other

Anticipated Start Date:* / /

5 PRESCRIBER INFORMATION

Prescriber's Name:*

Practice/Facility Name:*

Organization Tax ID Number:* Organization NPI Number:*

Individual NPI Number:* Provider PTAN:*

Mailing Address:* City:* State:* ZIP:*

Office Contact's Name:* Fax Number:*

Office Contact's Phone Number:* Email:*

6 HEALTHCARE PROFESSIONAL ATTESTATION*

I, _____ (Print Name) attest that, where required by applicable law, regulation, or other applicable authority, I have obtained patient, parent, or guardian consent, permission and/or a HIPAA authorization ("Legal Permission") permitting me to use and disclose my patients' health, demographic, and other individually identifiable information, including insurance and financial information, to Accord BioPharma, Inc., its affiliates, its program administrator, and their respective agents, service providers and field reimbursement professionals for the purpose of providing patient support programs, co-pay assistance or reimbursement support as part of the patient's treatment with UDENYCA. I maintain records of such Legal Permission consistent with applicable law. I further certify that (a) any reimbursement investigation support provided to patients through AccordCares is not made in exchange, directly or indirectly, for my recommendation, prescription, or use of the above therapy or any other product or service for or from anyone, and (b) my decision to prescribe the above therapy was based solely on my determination of medical necessity. For insured patients, I understand that the AccordCares program does not provide free drug in the instance of an administrative error or a coverage restriction. I attest that UDENYCA is being prescribed consistent with the approved prescribing information or I believe it is medically necessary based on the patient's diagnosis.

Healthcare Professional Signature (Required):* **Date:*** / /

AccordCares® Enrollment Form

†Patient consent may be required if requested by provider

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Patient Name: _____

7 PATIENT CONSENT (Patient consent may be required if requested by provider)†

I authorize my physician(s) and their staff and my health insurance plan to disclose my personal information, which may include health, demographic, and other individually identifiable information, including insurance and financial information to Accord BioPharma, Inc., its affiliates, partners, assignees, or acquirers, its program administrator, and their respective agents, service providers and field reimbursement professionals for the purpose of:

- Verifying or coordinating insurance coverage or otherwise obtaining payment for my treatment with the prescribed drug
- Coordinating my receipt of the prescribed drug
- Determining eligibility and managing the AccordCares Co-Pay Savings and Patient Assistance Programs
- Providing me with information about the prescribed drug
- Providing me with information on external resources that might be available to me
- Assisting me or my provider with co-pay support for the prescribed drug
- Assisting me or my provider with insurance coverage and reimbursement support services, including benefits verification checks, prior authorizations, claim reviews and denials, or searching for alternative funding from charitable foundations

I understand that Accord will disclose my health information to my pharmacies, health insurer(s), healthcare providers, caregivers, and other third parties for the purposes described above, and as otherwise permitted by law, and Accord may contact me directly. I understand that once my Protected Health Information is disclosed as permitted by this authorization it may be redisclosed by Accord and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal privacy laws. I understand that I may refuse to sign this authorization. I may also revoke (withdraw) this authorization at any time in the future by contacting my Prescriber, or AccordCares at 1-844-483-3692. My refusal or future revocation will not affect the commencement or continuation of my treatment by my Prescriber; however, if I do not sign or I revoke this authorization, I will no longer be eligible to participate in the AccordCares Co-Pay and Patient Assistance Programs. If I revoke this authorization, my revocation will not affect Protected Heath Information previously disclosed in reliance upon this authorization. I understand and agree that this authorization will remain valid for 5 years after the date of my signature, unless I revoke it earlier. I understand that I may receive a copy of this authorization.

I certify that the personal information that I provide to AccordCares is true and complete. I agree that, at any time during my participation in AccordCares, additional documentation to verify my personal information may be requested, if there is missing information or I do not respond to requests for additional documents, my participation may be delayed, or I may no longer be able to participate.

If I qualify for, and receive, co-pay assistance, I agree to comply with Accord's program rules and I will not get reimbursed for the assistance I receive from anyone else, including from an insurance program, another charity, or from a health savings, flexible spending, or other health reimbursement account. I understand that the AccordCares programs may be discontinued or the rules for participation may change at any time, without notice.

Please see next page for PATIENT SIGNATURE

AccordCares® Enrollment Form

†Patient consent may be required if requested by provider

‡Denotes **REQUIRED** Information

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AccordCares.com

Patient Name:

7 PATIENT CONSENT (continued)

ACCORD PATIENT CONSENT & PRIVACY NOTICE (Required)†

☐ I consent to the collection, use, and disclosure of my personal health data by Accord BioPharma, Inc. as described in the ACCORD PATIENT CONSENT section above. My consent is required to process personal data under certain privacy laws, and I have the right to withdraw my consent by calling AccordCares at 1-844-483-3692 or by writing to PO Box 7613, Overland Park, Kansas 66207.

PATIENT TEXT MESSAGE (Optional Consent)

☐ Accord may use automatic dialing machines or artificial or prerecorded messages to contact me and may leave a voicemail or SMS/text message. Accord may send automated and recurring text messages from AccordCares or Accord, including service updates, marketing messages, refill reminders, and other notifications (standard text messaging rates may apply). SMS/text messages from AccordCares will be sent to the mobile phone number provided. Reply HELP for help or STOP to cancel. I understand that I am not required to provide this consent as a condition of purchasing any goods or services.

MARKETING (Optional Consent)

☐ I consent to the collection, use, and disclosure of my health-related personal data to receive communications from AccordCares or Accord, regarding its products, programs, services, scientific research and other research opportunities. My consent is required to process personal data under certain privacy laws, and I have the right to withdraw my consent by calling AccordCares at 1-844-483-3692 or by writing to PO Box 7613, Overland Park, Kansas 66207.

Signature:‡ **Date:‡** / /

Patient or Patient Representative Name:‡ **Relationship to Patient:‡**

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