Access Services by Bayer™

Helping Your Patients Get Their Bayer Medications Through Access Services by Bayer™

Instructions for completing the Access Services by Bayer™ Patient Support Request Form (SRF).

STEP 1 ADMINISTERING PROVIDER INFORMATION

Administering Provider Name: _____
Specialty: _____ NPI#: _____ Tax ID#: _____
Facility Name: _____
Facility Address: _____ City/State/Zip Code: _____
Facility Type (check box): ❒ Hospital Outpatient ❒ Freestanding Clinic/Physician Office ❒ Other

Administering Site Contact(s)
Benefit Verification Contact: _____
Title: _____ Phone: _____ Fax: _____
Claims Filing & Appeals Contact: _____
Title: _____ Phone: _____ Fax: _____

COMPLETE STEPS 1 THROUGH 3

STEP 2 PATIENT INFORMATION (Insurance information must be provided for benefit verification. Please provide copies of both sides of the patient's insurance card[s])

Patient Name: _____ Patient DOB: _____
Patient Address: _____ City/State/Zip Code: _____
Patient Phone: _____ Patient Email: _____
ICD-10 Primary dx: _____
Primary Insurance: _____ Policy #: _____ Phone: _____
Secondary Insurance: _____ Policy #: _____ Phone: _____

STEP 3 PATIENT SUPPORT PROGRAM SERVICES

ASB may be able to assist you in identifying financial assistance or travel assistance related to your Aliqopa treatment. Patients with no insurance for Aliqopa may also receive assistance from the Patient Assistance Program. Please note that assistance is not guaranteed and is dependent upon eligibility and availability of funds. You may be referred to a third-party and/or be required to provide additional documentation to assess eligibility.

By enrolling in Access Services by Bayer™ (ASB) you are agreeing to be contacted by ASB and/or Bayer.

COMPLETE ALL REQUIRED FIELDS INCLUDING PATIENT SIGNATURES TO AVOID DELAYS IN TREATMENT

PATIENT TO SIGN — **Patient Signature:** _____

PRESCRIBER TO COMPLETE STEP 4 AND SIGN, DATE AND FAX COMPLETED FORM TO 1-800-390-1826

STEP 4 HEALTHCARE PROVIDER DECLARATION

I verify that the information contained in this order form is complete and accurate to the best of my knowledge. I understand that Bayer reserves the right to modify or terminate ASB at any time and without notice. I understand that Bayer is not responsible for filing claims and that all final decisions on diagnosis, the need for treatment, and the appropriateness of Aliqopa for a particular patient rest with me as the patient's healthcare provider.

PRESCRIBER TO SIGN, DATE, AND FAX TO 1-800-390-1826 — **Healthcare Provider Signature:** _____ **Date:** _____

STEP 5 HIPAA AUTHORIZATION

PATIENT HIPAA AUTHORIZATION

PATIENT TO SIGN AND DATE — **Patient name (print)*:** _____
Patient signature: _____ **Date (mm/dd/yyyy):** _____

PATIENT TO SIGN AND DATE HIPAA AUTHORIZATION

If signed by a legal representative:
Print Name: _____
Relationship to patient: _____

STEP 6 BAYER US PATIENT ASSISTANCE FOUNDATION

Bayer offers a patient assistance program for patients who have limited or no prescription coverage.
If you are eligible, Aliqopa® (copanlisib) 60 mg vial for injection may be available for free.

How many people live in your household and are dependent on your household income (include yourself)? _____
For example: you (1) + your spouse (1) + your children (2) + your parents (2) = 6

What is your total household income? $ _____
This includes all income made by you and your relatives living in your household. Please include income earned by work wages, Social Security retirement benefit, Social Security disability benefit, unemployment, any pensions, and any other income including alimony and child support. Adding all of these numbers together gives your total household income.

You may be required to submit proof of income, which includes any of the following:

- Recent 1040 or 1040EZ Federal tax return
- 1099 tax form
- Proof of non-filing letter if you did not file a federal tax return
- Wage/tax statements (W2)

COMPLETE STEP 6 FOR ADDITIONAL FINANCIAL ASSISTANCE

Patient Last Name*: _____ Patient First Name*: _____ Date of Birth*: _____ Gender: ❒ M ❒ F
Street*: _____ City*: _____ State*: _____ ZIP*: _____
List or attach other current medications prescribed: _____
Known drug allergies: ❒ No ❒ Yes List: _____

PRESCRIBER TO SIGN AND DATE — **Dispense as written:** _____ **Date (mm/dd/yyyy):** _____

PATIENT ASSISTANCE APPLICATION REQUIRES BOTH PRESCRIBER AND PATIENT SIGNATURES

PATIENT TO SIGN AND DATE — **Patient signature:** _____ **Date (mm/dd/yyyy):** _____

If signed by a legal representative —
Print Name: _____ **Relationship to patient:** _____

*Results of Benefit Investigation are not a guarantee of coverage and should be verified by dispensing provider.

BAYER

Access Services by Bayer™ | Aliqopa (copanlisib) 60 mg vial for injection

ENROLLMENT FORM

For Use by Administering Providers Only – Aliqopa™ (copanlisib) for Injection

Phone: 1.800.288.8374
Fax: 1.800.390.1826

Access Services by Bayer™ (ASB) is a comprehensive program that offers access and reimbursement support for Aliqopa.

The provider or patient may fax or mail a **completed** ASB Enrollment Form to **1-800-390-1826** or **PO Box 29097, Phoenix, AZ 85038-9097**. Call us at **1-800-288-8374** to request insurance benefit verification, discuss other resources and services, or both. Access Counselors are available from 9:00 AM to 6:00 PM ET (M-F).

ASB will call the payer(s) to verify coverage for the patient, including any prior authorization requirements. An Access Counselor will call the healthcare provider to discuss the results within 24 to 48 hours and fax you a summary of insurance benefits for this patient. The patient may use this form to enroll in Access Services by Bayer™. Patient signature not required for a benefit verification (BV) only.

STEP 1 ADMINISTERING PROVIDER INFORMATION

Administering Provider Name: _____

Specialty: _____ NPI#: _____ Tax ID#: _____

Facility Name: _____

Facility Address: _____ City/State/Zip Code: _____

Facility Type (check box): ❒ Hospital Outpatient ❒ Freestanding Clinic/Physician Office ❒ Other

Administering Site Contact(s)

Benefit Verification Contact: _____

Title: _____ Phone: _____ Fax: _____

Claims Filing & Appeals Contact: _____

Title: _____ Phone: _____ Fax: _____

STEP 2 PATIENT INFORMATION (Insurance information must be provided for benefit verification. Please provide copies of both sides of the patient's insurance card[s])

Patient Name: _____ Patient DOB: _____

Patient Address: _____ City/State/Zip Code: _____

Patient Phone: _____ Patient Email: _____

ICD-10 Primary dx: _____

Primary Insurance: _____ Policy #: _____ Phone: _____

Secondary Insurance: _____ Policy #: _____ Phone: _____

STEP 3 PATIENT SUPPORT PROGRAM SERVICES

ASB may be able to assist you in identifying financial assistance or travel assistance related to your Aliqopa treatment. Patients with no insurance for Aliqopa may also receive assistance from the Patient Assistance Program. Please note that assistance is not guaranteed and is dependent upon eligibility and availability of funds. You may be referred to a third-party and/or be required to provide additional documentation to assess eligibility.

By enrolling in Access Services by Bayer™ (ASB) you are agreeing to be contacted by ASB and/or Bayer.

PATIENT TO SIGN **Patient Signature:** _____

STEP 4 HEALTHCARE PROVIDER DECLARATION

I verify that the information contained in this order form is complete and accurate to the best of my knowledge. I understand that Bayer reserves the right to modify or terminate ASB at any time and without notice. I understand that Bayer is not responsible for filing claims and that all final decisions on diagnosis, the need for treatment, and the appropriateness of Aliqopa for a particular patient rest with me as the patient's healthcare provider.

PRESCRIBER TO SIGN, DATE, AND FAX TO 1-800-390-1826

Healthcare Provider Signature: _____ **Date:** _____

STEP 5 HIPAA AUTHORIZATION

PATIENT HIPAA AUTHORIZATION

I voluntarily provide this authorization for the use and disclosure of my Protected Health Information ("PHI"), as such term is defined by the Health Insurance Portability and Accountability Act of 1996 (as amended, "HIPAA"). I understand that PHI is health information that identifies me or that could reasonably be used to identify me.

I authorize my healthcare provider, including my physician and pharmacy, and my health plan, to disclose to Bayer and its contracted agents my name, address, telephone number, health insurance status and coverage and such medical information as may be necessary for me to enroll in Access Services by Bayer™ (ASB). I understand this disclosure(s) will contain PHI, including information about my current medical condition, treatment, coordination of treatment and receipt of medication. I allow the use and disclosure of my PHI to Bayer its contracted agents for the following purposes:

- To verify my insurance information and coverage
- To ensure the accuracy and completeness of the Access Services by Bayer™ (ASB) Enrollment Form
- To help with my insurance coverage questions for Bayer medications
- To determine if I qualify for other Bayer patient support programs
- To determine my eligibility for other sources of prescription medication financial assistance
- To provide education, training, and ongoing support on the use of my Bayer medication
- To send me information on Bayer products and services related to my treatment
- To send me refill reminders for my Bayer prescription medication and to encourage its appropriate use
- To communicate with me, my healthcare providers and health plan about my medical care and treatment
- To contact me for market research feedback, sales support purposes, and as necessary to comply with applicable laws

I understand that:

- This Authorization will remain in effect until the end of my participation in Access Services by Bayer™ (ASB) or 5 years from the date of my signature on this Authorization, whichever occurs later.
- I may cancel this Authorization at any time by writing to: **Access Services by Bayer, PO Box 29097, Phoenix, AZ 85038-9097**.
- If I cancel this Authorization my healthcare provider and health plan will stop sharing my PHI with Bayer and its contracted agents. However, the revocation will not affect prior use or disclosure of my PHI in reliance on this Authorization.
- That entities that receive my PHI in accordance with this Authorization may not be required by law to keep the information private and that it will no longer be protected by the HIPAA privacy law. It may become available in the public domain.
- I do not need to sign this Authorization to receive (i) medical treatment or medication or (ii) coverage, payment, enrollment in or eligibility for benefits from my health plan. However, if I do not sign this Authorization, I may not participate in Access Services by Bayer™ (ASB) or be eligible for other Bayer patient support programs.
- I understand that some of my health care providers, such as my pharmacies, may receive payment from Bayer in return for services that require use or disclosure of my PHI to Bayer and its contracted agents.

I have read and understand the terms of this Authorization and have had an opportunity to ask questions about the uses and disclosures of PHI. I understand that I am entitled to receive a signed copy of this Authorization and I can also get a copy by contacting Access Services by Bayer™ (ASB) at **1-800-288-8374**.

PATIENT TO SIGN AND DATE

Patient name (print)*: _____

Patient signature: _____ **Date (mm/dd/yyyy):** _____

If signed by a legal representative:

Print Name: _____

Relationship to patient: _____

*Results of Benefit Investigation are not a guarantee of coverage and should be verified by dispensing provider.

PATIENT SUPPORT REQUEST FORM

Phone: 1-866-2BUSPAF (1-866-228-7723)
Fax: 1-866-575-6568

Bayer US Patient Assistance Foundation

Complete Step 6 for additional financial assistance

STEP 6 BAYER US PATIENT ASSISTANCE FOUNDATION

Bayer offers a patient assistance program for patients who have limited or no prescription coverage. If you are eligible, Aliqopa® (copanlisib) 60 mg vial for injection may be available for free.

How many people live in your household and are dependent on your household income (include yourself)? _____
For example: you (1) + your spouse (1) + your children (2) + your parents (2) = 6

What is your total household income? $ _____
This includes all income made by you and your relatives living in your household. Please include income earned by work wages, Social Security retirement benefit, Social Security disability benefit, unemployment, any pensions, and any other income including alimony and child support. Adding all of these numbers together gives your total household income.

You may be required to submit proof of income, which includes any of the following:

- Recent 1040 or 1040EZ federal tax return
- 1099 tax form
- Proof of non-filing letter if you did not file a federal tax return
- Wage/tax statements (W2)

Patient Last Name*: _____ **Patient First Name*:** _____ **Date of Birth*:** _____ **Gender:** ❒ M ❒ F

Street*: _____ **City*:** _____ **State*:** _____ **ZIP*:** _____

List or attach other current medications prescribed: _____

Known drug allergies: ❒ No ❒ Yes **List:** _____

Healthcare Professional Authorization

I certify that I am the healthcare professional who prescribed the medication requested in this application for the sole benefit of the named patient, and that my decision to prescribe was based on my independent professional judgment. I authorize the Bayer US Patient Assistance Foundation free drug program (the "Program"), and agents acting on its behalf to use my provider information, including National Provider ID, in the eligibility assessment process, and to forward this prescription, as necessary, to a dispensing pharmacy. In addition to the above, my signature below certifies the following: (i) I will not charge patients any fee for, or related to, their application, enrollment in the Program, any co-payment, or other cost-sharing amount related to free drug provided under the Program; (ii) no claim for payment for any product provided through the Program may be submitted to any third-party payer, including private insurers, Medicaid or Medicare; (iii) this medication provided by the Program will only be utilized by the patient named on this form, and will not be offered for sale, trade, barter, or returned for credit; (iv) the patient applying for assistance through the Program is being treated in an outpatient setting; (v) to the best of my knowledge, the information provided on this form is current, complete and accurate.

I understand and acknowledge that (i) submission of the application does not guarantee the patient's eligibility in the Program; (ii) the Program has the right to discontinue the Program at any time; and (iii) medication provided through the Program for enrolled patients is not contingent on any past, present or future prescriptions for this or any other Bayer product.

PRESCRIBER TO SIGN AND DATE

Dispense as written: _____ **Date (mm/dd/yyyy):** _____

PATIENT SUPPORT REQUEST FORM

Phone: 1-866-2BUSPAF (1-866-228-7723)
Fax: 1-866-575-6568

Bayer US Patient Assistance Foundation

PROGRAM RULES AND INCOME VERIFICATION CONSENT

By applying for the Bayer US Patient Assistance Foundation free drug program, I understand and agree that: **(i)** there is no charge to participate and my participation in the program is not contingent on any requirement to purchase or use any Bayer product; **(ii)** completing and signing the program application does not guarantee my eligibility; **(iii)** the program may change or end at any time; **(iv)** I will not sell or trade any medicine that I get through this program; **(v)** I will notify the program within thirty (30) days if there is any change in my income, health insurance, eligibility to enroll in Medicare Part D, or any other reason that may affect my eligibility; **(vi)** I will not seek to be reimbursed or receive credit from my insurance provider, including Medicare Part D plans, for medicine I receive through the program; **(vii)** I will not seek credit for medicine from the program toward my true out-of-pocket expenses under Medicare Part D; and **(viii)** the information I provided in this application is correct and complete.

I am providing 'written instructions' under the Fair Credit Reporting Act to the Bayer US Patient Assistance Foundation (the "Foundation"), including its agents, administrators, and service providers, authorizing the Foundation to obtain information from my credit profile and/or other information from Experian Health. I authorize the Foundation, including its agents, administrators, and service providers, to obtain such information solely to determine my eligibility to participate in the Foundation's free drug program.

PATIENT TO INITIAL HERE

Patient initial here _____ to confirm you and understand and consent to the above rules and instructions.

PATIENT HIPAA AUTHORIZATION

I agree to allow my healthcare providers and health insurers to use and disclose my Protected Health Information ("PHI"), as such term is defined by the Health Insurance Portability and Accountability Act of 1996 (as amended, "HIPAA"), to the Bayer US Patient Assistance Foundation (the "Foundation"), Bayer and their agents for the following purposes: (1) to verify my insurance information and coverage; (2) to ensure the accuracy and completeness of my application to the Foundation's free drug program (the "Program"); (3) to determine if I am eligible for the Program and, if so, provide me with my prescribed Bayer medicine at no cost; (4) to contact me for feedback on the quality of customer service for the Program and to improve Program operations and administration; and (5) as required or permitted under applicable law. I understand that PHI is health information that will identify me, or that could reasonably be used to identify me, and will include my name, address, telephone number, health insurance status, medical condition(s), diagnosis and treatments.

My application to the Foundation is entirely voluntary. I understand that I do not need to sign this consent form to receive medical treatment or medication from my healthcare providers. However, if I do not sign this form, I will not be eligible to apply for free medicine through the Foundation's Program. This consent to share my PHI will continue until I am no longer enrolled in the Program or until I choose to cancel my consent, which I may do at any time. I (or my representative) can cancel my consent at any time by writing to the Bayer US Patient Assistance Foundation, PO Box 5670, Louisville, KY 40255. If I (or my representative) cancel (revoke) this consent, my healthcare provider and health plan will stop sharing my PHI with Bayer and its contracted agents. However, cancelling my consent will not have any effect on prior use or disclosure of my PHI in reliance on this consent. I understand that entities that receive my PHI in accordance with this consent may not be required by law to keep the information private and that it will no longer be protected by the HIPAA privacy law.

I (or my representative) have read and understand the terms of this consent form and have had an opportunity to ask questions about the uses and disclosure of my PHI. All of my questions have been answered to my satisfaction.
I understand that I am entitled to receive a signed copy of this consent and I can also get a copy by contacting the Program at 1-866-2BUSPAF (1-866-228-7723).

PATIENT TO SIGN AND DATE

Patient signature: _____ **Date (mm/dd/yyyy):** _____

If signed by a legal representative —

Print Name: _____ **Relationship to patient:** _____

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