Aliqopa™ Resource Connections

Patient Assistance Program

Aliqopa™ (copanlisib) for Injection

Aliqopa™ Resource Connections (ARC) is a comprehensive program that offers access and reimbursement support for Aliqopa.

This form may be used to request eligibility assessment for the ARC Patient Assistance Program (PAP), which provides Aliqopa at no cost to eligible uninsured and under-insured patients.

The provider or patient may fax or mail a **completed** ARC Patient Assistance Program Enrollment Form, **including the signed Patient Authorization** (page 2 of this form), to **1-833-4ARC FAX** (1-833-427-2329) or **PO Box 220694, Charlotte, NC 28222**. Should you have any questions about the services offered through ARC, please contact us. Access Counselors are available at **1-833-ALIQOPA** (1-833-254-7672) from 9:00 AM to 7:00 PM ET (M-F). You will be contacted by ARC regarding the outcome of your enrollment.

Please make sure both the patient and healthcare provider sign and date the application.

Administering Provider Information

Administering Provider Name: _____

Facility Name: _____ Facility Address: _____

City/State/Zip Code: _____

Primary Contact Name: _____ Title: _____

Phone: _____ Extension: _____ Fax: _____

Tax ID #: _____ NPI #: _____ State License #: _____ Expiration: _____

Direct to Healthcare Provider Distribution (Complete only if the shipping address is different from the Administering Provider section)

Site: _____ Contact Name for Shipment: _____

Address: _____

City/State/Zip Code: _____

Business Hours: _____ Phone: _____ Fax: _____

Prescription

☐ Aliqopa™ (copanlisib) for injection

Patient Name: _____ Patient DOB: _____

Patient Address: _____

City/State/Zip Code: _____

ICD-10 Code: _____ Strength/Dosage: _____ Sig: _____

Quantity (max. 1): _____ Days Supply (max. 1): _____ Number of Refills (max. 8): _____

Healthcare Provider Signature: _____ Date: _____

If you are requesting Aliqopa and you are a New York State Prescriber: Attach order for Aliqopa on your NYS official prescription form.

Healthcare Provider Certification

I certify that the information I have provided in the healthcare provider sections is accurate to the best of my knowledge. I understand that Bayer reserves the right to modify or terminate ARC at any time and without notice. My signature certifies that Aliqopa, provided for patient assistance, will not be billed to any third-party payer; resold or offered for sale, trade, or barter; and will not be returned for credit. 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. I agree to abide by this certification throughout my participation in ARC.

Healthcare Provider Signature: _____ Date: _____

Aliqopa™ (copanlisib) 60 mg vial for injection

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Patient must sign authorization below and submit with the rest of the application. If approved, patient's Aliqopa will be sent to the treating facility.

Patient Information

Patient Name:_____ Patient DOB: _____

Patient Address: _____

City/State/Zip Code: _____

Patient Phone: _____ Patient Email: _____ OK to Contact? ☐ Y ☐ N

Insurance Status: ☐ Uninsured ☐ Insured If insured, please provide reason for this application: _____

Primary Insurance: _____ Policy #: _____ Phone: _____

Patient Financial Information (To be provided by the patient)

Annual household income: $_____ Number in household dependent on income:_____

Income documentation will be required to assess Aliqopa Patient Assistance Program eligibility for uninsured patients. Acceptable forms of documentation include the most recent copy of US federal tax return, Social Security income statements, recent pay stubs, etc. Income documentation is not required for commercially insured patients applying for co-pay assistance.

Patient Authorization for ARC

I authorize the use and disclosure of my Protected Health Information ("PHI") as defined by the Health Insurance Portability and Accountability Act of 1996, which was amended by the Health Information Technology for Economic and Clinical Health Act (as amended, "HIPAA"). I understand that PHI is health information that identifies me or that could reasonably be used to identify me and that this authorization to release my information is voluntary.

I authorize my healthcare provider, including my physician and my health plan, to disclose my name, address, and telephone number, along with certain medical information, including my treatment, my eligibility for assistance, the coordination of my treatment, the receipt of my medication and my participation in the Patient Support Program, ARC, to Bayer and its agents. I understand that certain healthcare providers may receive payment from Bayer in connection with the use and disclosure of my PHI as described in this authorization.

I allow the use and disclosure of my PHI for the following purposes: (1) To verify my insurance information; (2) to ensure the accuracy and completeness of the ARC enrollment form; (3) to help with reimbursement questions; (4) to see if I qualify for patient assistance; (5) to determine my eligibility for other sources of funding; (6) to provide education, training, and ongoing support regarding my treatment; (7) to send me information on related products and services related to my treatment; (8) to send me reminders regarding my treatment and to encourage appropriate use; (9) to communicate with me, my healthcare providers and health plan insurers about my medical care and treatment; (10) to contact me for market research feedback; (11) for sales purposes; and (12) to comply with applicable law.

This authorization expires at the end of my participation of the program or three (3) years after I sign it. I can revoke at any time. I understand that if I revoke this authorization, it will not have any effect on any actions taken by my healthcare providers before receiving the revocation. I can revoke this authorization by writing to: ARC: PO Box 220694, Charlotte, NC 28222.

I also understand that under this authorization, entities that receive my PHI may not be required by law to keep the information private and it may become available in the public domain. I understand that I do not need to sign this form to receive medical treatment or medication.

I have read and understand this authorization and had an opportunity to ask questions about the uses and disclosures of PHI described above. All of my questions have been answered to my satisfaction. I authorize the use and disclosure of my information as described in this form, and I am entitled to receive a signed copy of this authorization.

I certify that the information provided in this application, and any supporting documentation provided at a later date, is complete and accurate. By enrolling in the Aliqopa Patient Assistance Program, I am providing permission to share my PHI with Bayer. If I experience an adverse event, Bayer may contact me or my treating provider to learn more about the event. I understand that Bayer reserves the right at any time and without notice to modify or discontinue ARC and the related eligibility criteria (including any assistance provided to me). I have read, understand, and agree to all of the above.

Print Patient's or Patient Representative's Name:_____

Patient or Patient Representative's Signature:_____ Date: _____ / _____ / _____

_____

If signed by the Patient's Representative, include a description of the Representative's relationship to the Patient and such person's authority to act for the Patient (eg, parent, guardian, etc)

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