Enrollment Form

For Use by Administering Providers Only

Aliqopa™ (copanlisib) for Injection

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

The provider or patient may fax or mail a **completed** ARC Enrollment Form to **1-833-4ARC FAX** (1-833-427-2329) or **PO Box 220694, Charlotte, NC 28222**. Call us at **1-833-ALIQOPA** (1-833-254-7672) to request insurance benefit verification, discuss other resources and services, or both. Access Counselors are available from 9:00 AM to 7:00 PM ET (M-F).

ARC 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 ARC for Aliqopa Patient Support Program services. Patient signature not required for a benefit verification (BV) only.

Administering Provider Information

Administering Provider Name: ____________________

Specialty: __________ NPI#: __________ Tax ID#: __________ Provider Medicaid #: __________

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: __________

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: __________ OK to Contact? ☐ Y ☐ N

ICD-10 Primary dx: ____________________

Primary Insurance: __________ Policy #: __________ Phone: __________

Secondary Insurance: __________ Policy #: __________ Phone: __________

Patient Support Program Services

ARC 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.

If you would like to enroll in one or more of the patient support services, please select the services you would like to enroll in from the list below. Your signature is required for enrollment.

☐ Financial Assistance for Aliqopa Co-Pay ☐ Travel Assistance

☐ Patient Assistance Program ☐ Additional education and information about Aliqopa treatment

By enrolling in Aliqopa Patient Support Program(s) you are agreeing to be contacted by ARC and / or Bayer.

Please sign to confirm your selection. Patient Signature: ____________________

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 ARC 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.

Healthcare Provider Signature: ____________________ Date: __________

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PP-860-US-0180 08/17