Aliqopa™ Resource Connections

Bayer US Patient Assistance Foundation

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 Bayer US Patient Assistance Foundation (BUSPAF), which provides Aliqopa at no cost to eligible uninsured and under-insured patients.

The provider or patient may fax or mail a **completed** BUSPAF Enrollment Form for Aliqopa™, **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 BUSPAF 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 verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Aliqopa based on my professional judgment of medical necessity. I certify that the patient is being treated in an outpatient setting and that, to the best of my knowledge, the patient does not have any other insurance coverage for Aliqopa. I authorize the Bayer US Patient Assistance Foundation ("BUSPAF"), including its agents, administrators, and service providers to forward this prescription to a dispensing pharmacy on behalf of myself and my patient.

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

By providing my signature below, I authorize the Bayer US Patient Assistance Foundation ("BUSPAF"), including its agents, administrators, and service providers to use and disclose the information on this form to permit BUSPAF to assess my eligibility for this program and contact me. I verify that the information provided in this application form is current, complete, and accurate, and understand that it will be reviewed and relied upon to determine my eligibility for product assistance under BUSPAF. I understand that I may not, and agree that I will not, seek reimbursement from any private insurance or public assistance program for any Aliqopa made available to me under BUSPAF. I understand that any product assistance is contingent upon my ability to meet the eligibility criteria, and BUSPAF reserves the right to make an independent determination of financial and medical need. I also understand that BUSPAF reserves the right at any time, and without notice, to modify or discontinue this program with respect to any patient, or in its entirety. I authorize BUSPAF to use and obtain information from my healthcare provider, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this application in order to provide assistance. If I experience an adverse event or a product technical complaint, I understand that it will be shared with Bayer Pharmacovigilance, and that Bayer may contact my healthcare provider or myself to learn more about the event. I acknowledge that I am a legal resident of the United States.

I am providing 'written instructions' under the Fair Credit Reporting Act to BUSPAF, including its agents, administrators, and service providers, authorizing BUSPAF to obtain information from my credit profile and/or other information from Experian Health. I authorize BUSPAF, including its agents, administrators, and service providers, to obtain such information solely to determine my eligibility for BUSPAF and its Products.

I may refuse to sign this authorization without any effect on my care or treatment from my healthcare provider. However, if I refuse to sign this form, I will not be eligible to receive free product through BUSPAF. I can cancel this authorization at any time by mailing a written request to PO Box 5670, Louisville, KY 40255 or by calling 1-866-2BUSPAF. This cancellation will not effect any use or disclosure of my information made prior to receiving notice of cancellation.

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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