ALIQOPA® (COPANLISIB) SPOILAGE REPLACEMENT REQUEST FORM

Please read instructions carefully before completing the form:

This form may only be used if the healthcare provider is requesting an exception to the Aliqopa returns policy. Exceptions will only be approved for one vial per patient. Submitting a request is not a guarantee of approval. Bayer reserves the right to limit, modify or discontinue the Aliqopa returns policy (including allowance for exceptions) at any time.

In order for your request to be considered, follow the steps below:

- Complete and submit form via email to:
  MPS.bayer@bayer.com
- Submit a copy of proof of purchase with this form

HealthCare Provider to Complete Sections Below:

Prescriber Information:

Prescriber's Name:_____ Prescriber NPI #: _____

Facility Name (where product was shipped): _____

Facility Address: _____

City:_____ State:_____ Zip: _____

Office Contact Name:_____ Phone: (____)_____ Fax: (____)_____

Patient Information:

Patient Name:_____ Patient DOB:_____/_____/_____

Patient Address:_____ City:_____ State:_____ Zip: _____

Product Information:

Was the Aliqopa vial reconstituted? Select one: □ Yes □ No

Was Aliqopa administered in part or in whole to the patient? Select one: □ Yes □ No

Reason for return exception request: _____

Order Information:

Specialty Distributor (where product was purchased from): _____

Specialty Distributor Address: _____

City:_____ State:_____ Zip:_____

Account #:_____ Invoice #:_____ PO #:_____

Date of Purchase:_____/_____/_____ Batch: _____

Prescriber Attestation

I certify the information provided above is accurate to the best of my knowledge and hereby attest that the Aliqopa vial at issue: (i) has been reconstituted but not administered to any patient; (ii) will be appropriately discarded pursuant to OSHA requirements and not administered to any future patient; and (iii) will not be billed in whole or part to any third-party payer or resold or offered for sale, trade, or barter.

Prescriber Signature:_____ Date:_____/_____/ _____

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