A Message from

2019-2020 ACCC PRESIDENT
Ali McBride, PharmD, MS, BCOP

ACCC is proud to publish its 9th print edition of the Patient Assistance & Reimbursement Guide for 2020. This guide is a resource that truly reflects my ACCC President’s Theme of “Collaborate. Educate. Compensate: A Prescription for Sustainable Cancer Care Delivery.” Ten years ago, nurse navigators, advanced practice providers, financial advocates, and molecular pathologists were not part of the common vernacular describing members of the cancer care team. As oncology engages in value-based reimbursement, new payment models, and precision medicine, oncology pharmacists and pharmacy staff have also become integral members of the cancer care team who help deliver quality, cost-effective care.

While this Patient Assistance & Reimbursement Guide is not a product of the ACCC Financial Advocacy Network—and actually pre-dates this important ACCC initiative—it does align closely with the network’s basic principles. It helps further ACCC’s commitment to continue building the confidence of financial advocates and navigators by connecting them with solutions and ultimately improving the patient experience. The guide is a clear product of this commitment by providing the most up-to-date content with accurate links and directions for applying to patient assistance, reimbursement, and/or foundation programs.

Similar to what the ACCC Financial Advocacy Network has done for financial advocates and navigators, the ACCC Oncology Pharmacy Education Network (OPEN) has brought pharmacists and pharmacy staff to the forefront of ACCC membership, highlighting the key role they play in ACCC education and advocacy efforts. OPEN offers pharmacists and other allied and administrative team members the knowledge and know-how to navigate the accelerating course of change in oncology—clinically, operationally, fiscally, and programmatically.

Today, financial navigators and pharmacy staff take part in very specific, yet essential roles that—if effectively integrated—can help reduce financial toxicity and improve patient quality of life. Based on feedback from both of these important member disciplines, we have made updates to the 2020 Patient Assistance & Reimbursement Guide that will improve this resource and help streamline operations and improve the patient and user experience. Specifically, in addition to listing oncology-related medications by both manufacturer (page 2) and brand and generic names (page 3-4), this year we have included a third table of contents that lists medications by oral administration and parenteral administration to better help users find affordable treatment options for patients.

The escalating pace of approval and addition of novel agents mandates continual education and learning. To help in this effort, the ACCC Patient Assistance & Reimbursement Guide is updated on a quarterly basis with the most up-to-date information on cancer drug assistance and reimbursement programs, including directions on how to apply and links to enrollment forms. And you can help! As you use this guide throughout the year, if you know of any changes, updates, and/or corrections to the information within, please let us know. We also want to hear your feedback on how you are using this guide and if you have ideas for how we can improve this critical resource. Please direct all comments, questions, and feedback to Maddelynne Parker, Content Coordinator, at mparker@accc-cancer.org.
### Pharmaceutical Company Patient Assistance & Reimbursement Programs

<table>
<thead>
<tr>
<th>Company</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>AbbVie, Inc.</td>
<td>13</td>
</tr>
<tr>
<td>Amgen, Inc.</td>
<td>14</td>
</tr>
<tr>
<td>Astellas Pharma U.S., Inc.</td>
<td>16</td>
</tr>
<tr>
<td>AstraZeneca</td>
<td>19</td>
</tr>
<tr>
<td>Bayer HealthCare Pharmaceuticals, Inc.</td>
<td>21</td>
</tr>
<tr>
<td>Beigene</td>
<td>25</td>
</tr>
<tr>
<td>Boehringer Ingelheim Pharmaceuticals, Inc.</td>
<td>27</td>
</tr>
<tr>
<td>Bristol-Myers Squibb</td>
<td>29</td>
</tr>
<tr>
<td>Celgene Oncology</td>
<td>31</td>
</tr>
<tr>
<td>Coherus BioSciences</td>
<td>33</td>
</tr>
<tr>
<td>Eisai Co., Ltd.</td>
<td>35</td>
</tr>
<tr>
<td>Eli Lilly and Company</td>
<td>37</td>
</tr>
<tr>
<td>EMD Serono, Inc.</td>
<td>39</td>
</tr>
<tr>
<td>Exelixis, Inc.</td>
<td>41</td>
</tr>
<tr>
<td>Genentech, Inc.</td>
<td>43</td>
</tr>
<tr>
<td>Incyte Corporation</td>
<td>45</td>
</tr>
<tr>
<td>Ipsen Biopharmaceuticals, Inc.</td>
<td>47</td>
</tr>
<tr>
<td>Janssen Biotech, Inc.</td>
<td>49</td>
</tr>
<tr>
<td>Karyopharm Therapeutics</td>
<td>51</td>
</tr>
<tr>
<td>Kite Pharma</td>
<td>53</td>
</tr>
<tr>
<td>Merck</td>
<td>54</td>
</tr>
<tr>
<td>Mylan</td>
<td>56</td>
</tr>
<tr>
<td>Novartis Pharmaceuticals Corporation</td>
<td>58</td>
</tr>
<tr>
<td>Pfizer, Inc.</td>
<td>60</td>
</tr>
<tr>
<td>Pharmacyclics, LLC</td>
<td>62</td>
</tr>
<tr>
<td>Puma Biotechnology</td>
<td>64</td>
</tr>
<tr>
<td>Regeneron Pharmaceuticals, Inc. and Sanofi Genzyme</td>
<td>66</td>
</tr>
<tr>
<td>Seattle Genetics</td>
<td>69</td>
</tr>
<tr>
<td>Sun Pharmaceutical Industries, Inc.</td>
<td>70</td>
</tr>
<tr>
<td>Taiho Oncology</td>
<td>72</td>
</tr>
<tr>
<td>Takeda Oncology</td>
<td>74</td>
</tr>
<tr>
<td>TerSera Therapeutics</td>
<td>76</td>
</tr>
<tr>
<td>Teva Oncology</td>
<td>77</td>
</tr>
<tr>
<td>Verastem Oncology</td>
<td>78</td>
</tr>
</tbody>
</table>

### Medical Device & Testing Patient Assistance & Reimbursement Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Biotechnologies</td>
<td>79</td>
</tr>
<tr>
<td>Foundation Medicine</td>
<td>80</td>
</tr>
</tbody>
</table>

### Other Patient Assistance Programs & Resources

<table>
<thead>
<tr>
<th>Program</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agingcare.com®</td>
<td>87</td>
</tr>
<tr>
<td>BenefitsCheckUp®</td>
<td>87</td>
</tr>
<tr>
<td>CancerCare®</td>
<td>87</td>
</tr>
<tr>
<td>CancerCare® Co-payment Assistance Foundation</td>
<td>88</td>
</tr>
<tr>
<td>Cancer Financial Assistance Coalition</td>
<td>88</td>
</tr>
<tr>
<td>Co-Pay Relief</td>
<td>88</td>
</tr>
<tr>
<td>FamilyWize®</td>
<td>89</td>
</tr>
<tr>
<td>Good Days®</td>
<td>89</td>
</tr>
<tr>
<td>HealthWell Foundation®</td>
<td>90</td>
</tr>
<tr>
<td>The Leukemia &amp; Lymphoma Society</td>
<td>90</td>
</tr>
<tr>
<td>Medicine Assistance Tool</td>
<td>91</td>
</tr>
<tr>
<td>NeedyMeds</td>
<td>91</td>
</tr>
<tr>
<td>Patient Access Network Foundation</td>
<td>92</td>
</tr>
<tr>
<td>Patient Advocate Foundation</td>
<td>92</td>
</tr>
<tr>
<td>RxAssist</td>
<td>93</td>
</tr>
<tr>
<td>RxHope™</td>
<td>93</td>
</tr>
<tr>
<td>Rx Outreach®</td>
<td>94</td>
</tr>
</tbody>
</table>

### Quick Reference Guide

<table>
<thead>
<tr>
<th>Guide</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quick Reference Guide</td>
<td>96</td>
</tr>
</tbody>
</table>

The ACCC Patient Assistance & Reimbursement Guide was printed in January 2020. This publication is updated four times a year. Visit [accc-cancer.org/PatientAssistanceGuide](accc-cancer.org/PatientAssistanceGuide) to download and print the most up-to-date information on cancer drug assistance and reimbursement programs.
## Patient Assistance & Reimbursement Assistance Programs

### by drug or product

<table>
<thead>
<tr>
<th>Drug/Product Name</th>
<th>Assistance Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abraxane® (paclitaxel protein-bound particles for injectable suspension) (albumin-bound)</td>
<td>31</td>
</tr>
<tr>
<td>Adakveo® (crizanlizumab-tmca) for IV infusion</td>
<td>58</td>
</tr>
<tr>
<td>Adcetris® (brentuximab vedotin) for injection</td>
<td>69</td>
</tr>
<tr>
<td>Afinitor® (everolimus) tablets</td>
<td>58</td>
</tr>
<tr>
<td>Alecensa® (alecinitib) capsules</td>
<td>43</td>
</tr>
<tr>
<td>Alimta® (pemetrexed) for injection</td>
<td>37</td>
</tr>
<tr>
<td>Aliqopa™ (copanlisib) for injection</td>
<td>21</td>
</tr>
<tr>
<td>Alunbrig® (brigatinib)</td>
<td>74</td>
</tr>
<tr>
<td>Aranesp® (darbepoetin alfa) injection</td>
<td>14</td>
</tr>
<tr>
<td>Aromasin® (exemestane) for injection</td>
<td>60</td>
</tr>
<tr>
<td>Arzerra® (ofatumumab) injection</td>
<td>58</td>
</tr>
<tr>
<td>Avastin® (bevacizumab) for injection</td>
<td>43</td>
</tr>
<tr>
<td>Balversa™ (erdafitinib) tablets</td>
<td>49</td>
</tr>
<tr>
<td>Bavencio® (avelumab) for injection</td>
<td>39</td>
</tr>
<tr>
<td>Bendeka® (bendamustine hydrochloride) for injection</td>
<td>77</td>
</tr>
<tr>
<td>Besponsa® (inotuzumab ozogamicin) for injection</td>
<td>60</td>
</tr>
<tr>
<td>Blincyto® (blinatumomab) for injection</td>
<td>14</td>
</tr>
<tr>
<td>Bosulif® (bosutinib) tablets</td>
<td>60</td>
</tr>
<tr>
<td>Brukinsa™ (Zanubrutinib) capsules</td>
<td>25</td>
</tr>
<tr>
<td>Cabometyx® (cabozantinib) tablets</td>
<td>41</td>
</tr>
<tr>
<td>Calquence® (acalabrutinib) capsules</td>
<td>19</td>
</tr>
<tr>
<td>Camptosar® (irinotecan hydrochloride) injection</td>
<td>60</td>
</tr>
<tr>
<td>Cometriq™ (cabozantinib) capsules</td>
<td>41</td>
</tr>
<tr>
<td>Coteli® (cobimetinib) tablets</td>
<td>43</td>
</tr>
<tr>
<td>Cyramza® (ramucirumab) for injection</td>
<td>37</td>
</tr>
<tr>
<td>Darzalex® (daratumumab) injection</td>
<td>49</td>
</tr>
<tr>
<td>Daurismo™ (gladegib) tablets</td>
<td>60</td>
</tr>
<tr>
<td>Doxil® (doxorubicin hydrochloride liposome injection)</td>
<td>49</td>
</tr>
<tr>
<td>Elitke® (rasburicase) IV infusion</td>
<td>66</td>
</tr>
<tr>
<td>Ellence® (epirubicin hydrochloride injection)</td>
<td>60</td>
</tr>
<tr>
<td>Emend® (aprepitant) for injection</td>
<td>54</td>
</tr>
<tr>
<td>Emend® (fosaprepitant) for injection</td>
<td>54</td>
</tr>
<tr>
<td>Empliciti® (elotuzumab) for injection</td>
<td>29</td>
</tr>
<tr>
<td>Erbitux® (cetuximab) injection</td>
<td>37</td>
</tr>
<tr>
<td>Erleada® (apalutamide) tablets</td>
<td>49</td>
</tr>
<tr>
<td>Erivedge® (vismodegib) capsules</td>
<td>43</td>
</tr>
<tr>
<td>Exjade® (deferiprone) tablets</td>
<td>58</td>
</tr>
<tr>
<td>Farydak® (panobinostat) capsules</td>
<td>58</td>
</tr>
<tr>
<td>Faslodex® (fulvestrant) injection</td>
<td>19</td>
</tr>
<tr>
<td>Femara® (letrozole) tablets</td>
<td>58</td>
</tr>
<tr>
<td>Fulphila® (pegfilgrastim-jmdb) injection</td>
<td>56</td>
</tr>
<tr>
<td>Gardasil®9 (Human Papillomavirus 9-valent Vaccine, Recombinant)</td>
<td>54</td>
</tr>
<tr>
<td>Gazyva® (obinutuzumab) injection</td>
<td>43</td>
</tr>
<tr>
<td>Gilotrif® (afatinib) tablets</td>
<td>27</td>
</tr>
<tr>
<td>Gleevec® (imatinib mesylate) tablets</td>
<td>58</td>
</tr>
<tr>
<td>Granix® (tbo-filgrastim) for injection</td>
<td>77</td>
</tr>
<tr>
<td>Halaven® (eribulin mesylate) injection</td>
<td>35</td>
</tr>
<tr>
<td>Herceptin® (trastuzumab)</td>
<td>43</td>
</tr>
<tr>
<td>Herceptin Hyllecta™ (trastuzumab and hyaluronidase-oyesk)</td>
<td>43</td>
</tr>
<tr>
<td>Ibrance® (palbociclib) capsules</td>
<td>39</td>
</tr>
<tr>
<td>Iclusig® (ponatinib) tablets</td>
<td>74</td>
</tr>
<tr>
<td>Idamycin PFS® (idarubicin hydrochloride) for injection</td>
<td>60</td>
</tr>
<tr>
<td>Idhifa® (enasidenib)</td>
<td>31</td>
</tr>
<tr>
<td>Imbruvica® (ibrutinib) capsules</td>
<td>62</td>
</tr>
<tr>
<td>Imfinzi® (durvalumab) injection</td>
<td>19</td>
</tr>
<tr>
<td>Imlygic® (talimogene laherparepvec) suspension for injection</td>
<td>14</td>
</tr>
<tr>
<td>Inlyta® (axitinib) tablets</td>
<td>60</td>
</tr>
<tr>
<td>Intron® A (interferon alfa-2b, recombinant) for injection</td>
<td>54</td>
</tr>
<tr>
<td>Iressa® (gefitinib)</td>
<td>19</td>
</tr>
<tr>
<td>Istodax® (romidepsin) for injection</td>
<td>31</td>
</tr>
<tr>
<td>Jadenu® (deferasirox)</td>
<td>58</td>
</tr>
<tr>
<td>Jakafi® (ruxolitinib) tablets</td>
<td>45</td>
</tr>
<tr>
<td>Kadcyla® (ado-trastuzumab emtansine)</td>
<td>43</td>
</tr>
<tr>
<td>Kanjinti™ (trastuzumab-anns) for injection</td>
<td>14</td>
</tr>
<tr>
<td>Keytruda® (pembrolizumab) injection</td>
<td>54</td>
</tr>
<tr>
<td>Kisqali® (ribociclib) tablets</td>
<td>58</td>
</tr>
<tr>
<td>Kymriah® (tisagenlecleucel) suspension for IV infusion</td>
<td>58</td>
</tr>
<tr>
<td>Kyprolis® (carfilzomib) for injection</td>
<td>14</td>
</tr>
<tr>
<td>Lenvima® (lenvatinib) capsules</td>
<td>35</td>
</tr>
<tr>
<td>Libtayo® (cemiplimab-rwlc) injection</td>
<td>66</td>
</tr>
<tr>
<td>Lonsurf® (trifluridine and tipiracil) tablets</td>
<td>72</td>
</tr>
<tr>
<td>Lorbrena® (lorlatinib)</td>
<td>58</td>
</tr>
<tr>
<td>Lumoxiti™ (moxetumomab pasudotox-tdfk) for injection</td>
<td>19</td>
</tr>
<tr>
<td>Lupon Depot® (leuprolide acetate for depot suspension)</td>
<td>13</td>
</tr>
<tr>
<td>Lynparza® (olaparib)</td>
<td>19</td>
</tr>
<tr>
<td>Mekinist® (trametinib) tablets</td>
<td>58</td>
</tr>
<tr>
<td>Mylotarg® (gemtuzumab ozogamicin) for injection</td>
<td>60</td>
</tr>
</tbody>
</table>
Patient Assistance & Reimbursement Assistance Programs

by drug or product (continued)

Nerlynx® (neratinib) tablets 64
Neulasta® (pegfilgrastim) injection 14
Neulasta® Onpro® (pegfilgrastim) injection kit 14
Neupogen® (filgrastim) 14
Nexavar® (sorafenib) tablets 21
Ninlaro® (ixazomib) capsules 74
Nivestym™ (filgrastim-aafi) injection 60
Nplate® (romiplostim) injection 14
Nubeqa® (darolutamide) tablets 21
Odomzo® (sonidegib) capsules 70
Onivyde® (irinotecan liposome injection) 47
Opdivo® (nivolumab) injection 29
Padcev™ (enfortumab vedotin-ejfv) injection 16
Perjeta® (pertuzumab) for injection 43
Piqray® (alpelisib) tablets 58
Polivy™ (polatuzumab vedotin-piiq) injection 43
Pomalyst® (pomalidomide) 31
Portrazza® (necitumumab) injection 37
Procrit® (epoetin alfa) 49
Prolixa® (denosumab) injection 14
Promacta® (eflotrombopag) tablets 58
Reblozyl® (luspatercept-aamt) for injection 31
Revlimid® (lenalidomide) capsules 31
Rituxan® (rituximab) 43
Rituxan Hycela® (rituximab/hyaluronidase human) for injection 43
Rozlytrek™ (entrectinib) 43
Ruxience™ (rituximab-pvvr) 60
Rydapt® (midostaurin) 58
Sandostatin® (octreotide acetate) for injection 58
Sandostatin® LAR Depot (octreotide acetate) for injectable suspension 58
Sensipar® (cinacalcet) tablets 14
Somatuline® Depot (lanreotide) for injection 47
Sprycel® (dasatinib) tablets 29
Stivarga® (regorafenib) tablets 21
Sutent® (sunitinib malate) capsules 60
Sylatron™ (peginterferon alfa-2b) for injection 54
Synribo® (omacetaxine mepesuccinate) for injection 77
Tafinlar® (dabrafenib) capsules 58
Tafrecto® (sorafenib) tablets 58
Talzenna™ (talazoparib) capsules 60
Tarceva® (erlotinib) tablets 43
Tasigna® (nilotinib) capsules 58
Tecentriq® (atezolizumab) for injection 43
Thalomid® (thalidomide) 31
Torisel® (temsirolimus) injection 60
Treanda® (bendamustine hydrochloride) for injection 77
Trisenox® (arsenic trioxide) injection 77
Tykerb® (lapatinib) tablets 58
Udenyca® (pegfilgrastim-cbqv) 33
Varubi® (rolapitant) tablets 76
Vectibix® (panitumumab) for injection 14
Venclexta® (venetoclax) tablets 43
Verzenio® (abemaciclib) tablets 37
Vidaza® (azacitidine for injection) 31
Vitrakvi® (larotrectinib) 21
Vizimpro® (dacomitinib) tablets 60
Votrient® (pazopanib) tablets 58
Xalkori® (crizotinib) capsules 60
Xgeva® (denosumab) injection 14
Xofiprog® (radium Ra 223 dichloride) injection 21
Xospata® (gilteritinib) tablets 16
Xpovio® (selinexor) tablets 51
Xtandi® (enzalutamide) capsules 16
Yervoy® (ipilimumab) 29
Yescarta® (axicabtagene ciloleucel) suspension for infusion 53
Yondelis® (trabectedin) 49
Yonsa® (abiraterone acetate) tablets 70
Zelboraf® (vemurafenib) tablets 43
Zincacid® (dextrazoxane) for injection 60
Zoladek® (goserelin acetate implant) 76
Zolinza® (vorinostat) 54
Zometa® (zoledronic acid) for injection 58
Zytiga® (abiraterone acetate) tablets 49
## Patient Assistance & Reimbursement Assistance Programs

by parenteral administration and oral administration

<table>
<thead>
<tr>
<th>Parenteral Administration</th>
<th>Oral Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abraxane® (paclitaxel protein-bound particles for injectable suspension) (albumin-bound)</td>
<td>Keytruda® (pembrolizumab) injection</td>
</tr>
<tr>
<td>Adakveo® (crizanlizumab-tmca) for IV infusion</td>
<td>54</td>
</tr>
<tr>
<td>Ad cetris® (brentuximab vedotin) for injection</td>
<td>Kymriah® (tisagenlecleucel) suspension for IV infusion</td>
</tr>
<tr>
<td>Alimta® (pemetrexed) for injection</td>
<td>58</td>
</tr>
<tr>
<td>Al jop a® (copanlisib) for injection</td>
<td>Kyprolis® (carfilzomib) for injection</td>
</tr>
<tr>
<td>Aranesp® (darbepoetin alfa) injection</td>
<td>14</td>
</tr>
<tr>
<td>Arzerra® (ofatumumab) injection</td>
<td>Libtayo® (cemiplimab-rwlc) injection</td>
</tr>
<tr>
<td>Avastin® (bevacizumab) injection</td>
<td>66</td>
</tr>
<tr>
<td>Bavencio® (avelumab) injection</td>
<td>Lumoxiti® (moxetumomab pasudotox-tdfk) for injection</td>
</tr>
<tr>
<td>Bendeka® (bendamustine hydrochloride) for injection</td>
<td>19</td>
</tr>
<tr>
<td>Besponsa® (inotuzumab ozogamicin) for injection</td>
<td>Lupon Depot® (leuprolide acetate for depot suspension)</td>
</tr>
<tr>
<td>Blin cyto® (blinatumomab) for injection</td>
<td>13</td>
</tr>
<tr>
<td>Camptosar® (irinotecan hydrochloride) injection</td>
<td>Mylotarg® (gemtuzumab ozogamicin) for injection</td>
</tr>
<tr>
<td>Cyramza® (ramucirumab) injection</td>
<td>60</td>
</tr>
<tr>
<td>Dar zalex® (daratumumab) injection</td>
<td>Neulasta® (pegfilgrastim) injection</td>
</tr>
<tr>
<td>Doxi l® (doxorubicin hydrochloride liposome injection)</td>
<td>14</td>
</tr>
<tr>
<td>El leite® (rasburicase) IV infusion</td>
<td>Neulasta® Onpro® (pegfilgrastim) injection kit</td>
</tr>
<tr>
<td>Ellence® (epirubicin hydrochloride injection)</td>
<td>Neupogen® (filgrastim)</td>
</tr>
<tr>
<td>Emend® (fosaprepitant) for injection</td>
<td>Nivestym® (filgrastim-aafi) injection</td>
</tr>
<tr>
<td>Erbitux® (cetuximab) injection</td>
<td>Nplate® (romiplostim) injection</td>
</tr>
<tr>
<td>Fas lo dex® (fulvestrant) injection</td>
<td>Onivyde® (irinotecan liposome injection)</td>
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<td>Ful phila® (pegfilgrastim-jmdb) injection</td>
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<td>Prolia® (denosumab) injection</td>
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<td>Rituxan® (rituximab)</td>
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<td>Velcade® (bortezomib) for injection</td>
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## Patient Assistance & Reimbursement Assistance Programs

### by parenteral administration and oral administration (continued)

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<tr>
<th>Drug Name</th>
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<td>Xofigo® (radium Ra 223 dichloride) injection</td>
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<td>Yescarta® (axicabtagene ciloleucel) suspension</td>
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<td>Alunbrig® (brigatinib)</td>
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<td>Zytiga® (abiraterone acetate) tablets</td>
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I was honored to facilitate this Pre-Conference with my fellow Advisory Committee Member, Lori Schneider. We had a full day of engaging conversations, and it was very exciting to have speakers from different organizations come together to share the innovations and strategies that have made them successful in financial navigation. My top takeaways from the day are:

1. **There exists a continuing interest and quest for additional knowledge in financial navigation.** Although ACCC has covered this topic in various meeting sessions for the past five years, members place value in a Pre-Conference devoted exclusively to this content.
2. **Cancer programs continue to have a need for resources to support the growth of this service line.** ACCC released its newest tool, “Making the Business Case for Hiring a Financial Navigator,” authored by Lori Schneider and Christina Fuller, to great fanfare. I am hoping over the next two years to see hospitals and practices putting the business case study into play by adding financial navigation to their list of services. Access it online at accc-cancer.org/docs/projects/financial-advocacy/ufo-2019-fan-navigator-tool.pdf.

3. **ACCC members are asking for financial navigation certification.** This is a complicated endeavor, but I would love if ACCC can find a way to move this idea forward. In the past two years, as chair of the Financial Advocacy Network, I have often been asked if there is going to be a certification for financial navigation—beyond the existing Boot Camp.

4. **Technological tools are evolving and can be a big help to financial navigation programs.** A wide variety of technology tools and vendors are stepping up to facilitate financial navigation, specifically identifying ways to help with financial navigation workload and prioritization. Non-profit organizations are contributing with their own tools and ideas.

5. **As a field, financial navigation continues to innovate to better meet our patients’ needs.** A common theme throughout the Pre-Conference was our quest to help cancer patients and support the financial health of our cancer programs. The energy and engagement from speakers and the audience was invigorating and revitalizing.

I always say one of the best tools a financial navigator can have is a network of colleagues who share their passion. This Pre-Conference afforded an excellent networking opportunity.

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**Lori Schneider’s Top Five Takeaways**

**ACCC Financial Advocacy Network Advisory Committee Chair 2020**

I was honored to help plan this hugely successful Pre-Conference. We featured speakers from health systems that have had financial navigation programs for more than 10 years, as well as those that are just now developing programs. While many valuable tips and tools were shared, my top five takeaways from the day included:

1. **Financial toxicity continues to be a rising concern for patients and their families.** Many of the day’s speakers gave examples of what they are doing to help fight financial toxicity. Some included data points showing that even patients with insurance or those who receive co-pay assistance still face significant financial concerns. Out-of-pocket costs and insurance premiums continue to be a financial burden, especially when added to current household bills and a reduction of income due to an inability to work. Insurance optimization and coverage—along with foundation and patient assistance programs—are key factors to helping patients and families.

2. **Financial navigators need more tools and resources to help optimize their programs.** Live polling allowed attendees to ask questions that were then reviewed and answered at the end of each presentation. Financial navigators were shown a wide variety tools—both commercial (proprietary) and homegrown solutions. For example, Advisory Committee Member, Angie Santiago, CRCS-I, Thomas Jefferson University Health System, Sidney Kimmel Cancer Center, presented spreadsheets and tools that she created to help with tracking and productivity, as well as a tool that is used to help patients compare insurance plans. The latter allows patients to choose a plan that best meets their individual and family needs.
3. **There is an identified need for data and metrics reporting.** Attendees received an overview of the ACCC Financial Advocacy Boot Camp module “Measuring and Reporting,” which showcased the importance of measuring and tracking patient data. Recommended items to track included Medicare-only patients, uninsured patients, patients who are receiving co-pay and/or foundation assistance, and patients that are receiving medication from pharmaceutical patient assistance programs. It is also important to track the number of patients each navigator works with and how much time is spent with patients in order to determine an average. These data can then be presented to management to help determine staffing needs.

4. **Networking and learning from others are key because of the ever-changing landscape of financial navigation.** There is always something new to learn by networking with our peers—whether it be processes, tools, or resources. With the landscape of oncology constantly changing, it is difficult to stay on top of all updates. Attendees agreed that the ACCC Financial Advocacy Boot Camp is one of the best training tools for financial navigators. Another important resource: the ACCC Financial Advocacy Network Guidelines. Our Pre-Conference ended with an ACCC Financial Advocacy Town Hall where subject matter experts and attendees benefited alike from an engaged Q&A and brainstorming session.

5. **Financial navigation programs are not a one-size-fits-all.** Throughout the day, speakers demonstrated that health systems create financial navigation programs that are tailor made to fit their organization. For example, Vanderbilt-Ingram Cancer Center highlighted its optimization project that resulted from one of the ACCC’s Financial Advocacy Learning Labs. Access online at: accc-cancer.org/FANLearningLabs. More, financial navigation programs originate out of a variety of departments in a cancer center, including pharmacy, social work, or revenue cycle/billing. Finally, there is also a variety of focus points across the financial navigation landscape due to how these programs grow within the healthcare system. Focus areas for these programs include insurance optimization, foundation and/or co-pay assistance, pharmaceutical patient assistance for oral and/or IV medications, and the completion of authorizations, as well as programs that include a mix of these.

The knowledge shared, friendships made, and follow-up conversations that continued throughout the conference were a highlight of this Pre-Conference. I know that together we can all help make a difference in the fight against financial toxicity. ●

The ACCC Financial Advocacy Network is supported by:

- **Gold Partners**
  - Janssen
  - Johnson & Johnson
  - Pfizer

The **Association of Community Cancer Centers (ACCC)** is the leading education and advocacy organization for the cancer care community. Founded in 1974, ACCC is a powerful network of 25,000 multidisciplinary practitioners from 2,100 hospitals and practices nationwide. As advances in cancer screening and diagnosis, treatment options, and care delivery models continue to evolve—so has ACCC—adapting its resources to meet the changing needs of the entire oncology care team. For more information, visit accc-cancer.org or call 301.984.9496. Join our social media communities; read our blog, ACCCBuzz; and tune in to our podcast, CANCER BUZZ.

The **ACCC Financial Advocacy Network** is the leader in providing professional development training, tools, and resources that will empower providers to proactively integrate financial health into the cancer care continuum and help patients gain access to high quality care for a better quality of life.

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STEP 1. Provider writes chemotherapy order for patient.

STEP 2. Chemotherapy order is sent to finance staff.

STEP 3. Staff identifies the patient’s financial status and follows the appropriate flowchart below.

**Flowchart**

- **No Insurance**
  - Verify benefits.
  - Verify drugs are indicated for diagnosis.
  - Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.
  - Identify patient’s responsibility.

- **Medicaid Program**
  - Verify benefits.
  - Verify drugs are indicated for diagnosis.
  - Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.
  - Identify patient’s responsibility.

- **Medicare Only**
  - Verify benefits.
  - Verify drugs are indicated for diagnosis.
  - Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.
  - Identify patient’s responsibility.

- **Medicare & Supplemental**
  - Verify benefits.
  - Verify drugs are indicated for diagnosis.
  - Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.
  - Identify patient’s responsibility.

- **Medicare & Secondary**
  - Verify benefits.
  - Verify drugs are indicated for diagnosis.
  - Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.
  - Identify patient’s responsibility.

- **Medicare Advantage**
  - Verify benefits.
  - Verify drugs are indicated for diagnosis.
  - Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.
  - Identify patient’s responsibility.

- **Other Government Programs**
  - Verify benefits.
  - Verify drugs are indicated for diagnosis.
  - Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.
  - Identify patient’s responsibility.

- **Managed Care**

- **Commercial & Insurance Exchanges**
<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify if patient qualifies for charity care within the clinic or institution and complete paperwork.</td>
</tr>
<tr>
<td>2</td>
<td>Create payment plan for any balance (if available) or collect balance.</td>
</tr>
<tr>
<td>3</td>
<td>Collect out-of-pocket costs.</td>
</tr>
<tr>
<td>4</td>
<td>Fill out forms for foundation funding that is available.</td>
</tr>
<tr>
<td>5</td>
<td>Identify if patient qualifies for charity care within the clinic or institution and complete paperwork.</td>
</tr>
<tr>
<td>6</td>
<td>Create payment plan for any balance (if available) or collect balance.</td>
</tr>
<tr>
<td>7</td>
<td>Identify if foundation assistance is available.</td>
</tr>
<tr>
<td>8</td>
<td>If patient qualifies, send in EOB and/or anything else to help verify amount for foundation to pay.</td>
</tr>
<tr>
<td>9</td>
<td>Fill out forms for foundation funding that is available.</td>
</tr>
<tr>
<td>10</td>
<td>If any balance, create payment plan for any balance (if available) or collect balance.</td>
</tr>
<tr>
<td>11</td>
<td>Identify if foundation assistance is available.</td>
</tr>
<tr>
<td>12</td>
<td>If patient qualifies, send in EOB and/or anything else to help verify amount for foundation to pay.</td>
</tr>
<tr>
<td>13</td>
<td>Fill out forms for foundation funding that is available.</td>
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<tr>
<td>14</td>
<td>If any balance, create payment plan for any balance (if available) or collect balance.</td>
</tr>
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<td>15</td>
<td>Identify if foundation assistance is available.</td>
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<td>If patient qualifies, send in EOB and/or anything else to help verify amount for foundation to pay.</td>
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<tr>
<td>17</td>
<td>Fill out forms for foundation funding that is available.</td>
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<td>18</td>
<td>If any balance, create payment plan for any balance (if available) or collect balance.</td>
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<td>19</td>
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<td>If patient qualifies, send in EOB and/or anything else to help verify amount for foundation to pay.</td>
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<td>21</td>
<td>Fill out forms for foundation funding that is available.</td>
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<td>22</td>
<td>If any balance, create payment plan for any balance (if available) or collect balance.</td>
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<tr>
<td>23</td>
<td>Identify if manufacturer assistance is available and fill out forms if applicable.</td>
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<tr>
<td>24</td>
<td>If no manufacturer assistance, then identify if foundation assistance is available.</td>
</tr>
<tr>
<td>25</td>
<td>Fill out forms for foundation funding that is available.</td>
</tr>
<tr>
<td>26</td>
<td>If patient qualifies for manufacturer or foundation assistance, send in EOB and/or anything else to help verify amount owed. Process payment using co-pay card or whatever form of payment the program has.</td>
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Supporting Patients Through Their Journey on Jakafi® (ruxolitinib)

IncyteCARES (Connecting to Access, Reimbursement, Education and Support) provides a single point of contact through a registered nurse, OCN®, to assist eligible patients and healthcare providers in obtaining access to Jakafi® (ruxolitinib) and to connect them with continuing support and resources. The program offers:

**REIMBURSEMENT SUPPORT**
- Insurance benefit verification
- Information about prior authorizations
- Guidance with appealing insurance denials or coverage restrictions

**ACCESS ASSISTANCE**
- Copay/Coinsurance assistance
- Free medication program
- Temporary access for insurance coverage delays
- Referrals to independent nonprofit organizations and foundations

**EDUCATION & SUPPORT**
- Access to a registered nurse, OCN®
- Educational information for your patients about their condition and Jakafi
- Patient Welcome Kit

**CONNECTION TO SUPPORT SERVICES**
- Referrals for transportation assistance
- Access to patient advocacy organizations for counseling and emotional support resources

**Connect with IncyteCARES**
For full program terms and eligibility, visit IncyteCARES.com or call 1-855-4-Jakafi (1-855-452-5234).
Oncology-related products: Lupron Depot® (leuprolide acetate for depot suspension)

**MyAbbVie Assist**

**Patient Assistance**

We believe that people who need our medicines should be able to get them. MyAbbVie Assist provides free medicines to qualifying patients. MyAbbVie Assist reviews all applications on a case-by-case basis. Participation in the program is free; the program does not collect any fees from people seeking its assistance. Patients may be eligible to receive free Lupron Depot if they:

- Have been prescribed Lupron Depot
- Have limited or no health insurance coverage
- Live in the United States
- Are being treated by a licensed U.S. health care provider on an outpatient basis
- Demonstrate qualifying financial need.

Note: Financial need requirements vary, and are based on the patient’s insurance coverage, household income, and projected out-of-pocket medical expenses.

If you apply, patients should work with their healthcare provider to submit a program application. Download the application (abbvie.com/content/dam/abbvie-dotcom/uploads/PDFs/pap/Lupron-Application-approved.pdf), follow the instructions on the first page, and submit all requested information via fax to 1.866.483.1305. For more information, call 1.800.222.6885, Monday through Friday.

This program is part of the AbbVie Patient Assistance Foundation, a separate legal entity from AbbVie.
Oncology-related products: Aranesp® (darbepoetin alfa) injection, Blincyto® (blinatumomab) for injection, Imlygic® (talimogene laherparepvec) suspension for injection, Kanjinti™ (trastuzumab-anns) for injection, Kyprolis® (carfilzomib) for injection, Neulasta® (pegfilgrastim) injection, Neulasta® Onpro® (pegfilgrastim) injection kit, Neupogen® (filgrastim), Nplate® (romiplostim) injection, Prolia® (denosumab) injection, Sensipar® (cinacalcet) tablets, Vectibix® (panitumumab) for injection, Xgeva® (denosumab) injection

Patient and Reimbursement Assistance Websites

amgenassist360.com
amgenfirststep.com

PATIENT ASSISTANCE

Amgen Assist 360™
Amgen Assist 360™ Whatever type of insurance patients have—even if they have none—their Amgen Reimbursement Counselor can help them understand how their Amgen medicine may be covered, and refer them to programs that may be able to help you afford it, such as Amgen FIRST STEP. When patients enroll in Amgen Assist 360, their Amgen Nurse Ambassador serves as a single point of contact to help them find resources that are most important to them. Nurse Ambassadors are only available to patients that are prescribed certain products. Nurse Ambassadors are there to support, not replace, your treatment plan and do not provide medical advice or case management services. Nurse Ambassadors can:
• Connect patients to reimbursement specialists to help with insurance benefit verification and put them in touch with programs that may help them afford their medication, such as Amgen FIRST STEP.
• Refer patients to independent nonprofit organizations that may provide counseling, community resources, and assistance with treatment-related travel costs, such as gas, tolls, parking, airfare, and lodging.
• If patients have questions about their Amgen medication, they can help them get the answers they need.

For more information and enrollment forms by specific drugs, visit https://www.amgenassist360.com/hcp/ or call 1.888.4ASSIST (1.888.427.7478), Monday through Friday, 9:00 am to 8:00 pm ET.

Amgen FIRST STEP™ Program

Amgen offers this program for Blincyto, Imlygic, Kanjinti, Kyprolis, Neulasta, Neulasta Onpro, Neupogen, Nplate, Prolia, Vectibix, and Xgeva to help eligible patients who are commercially insured pay for their out-of-pocket prescription costs, including deductible, co-insurance, and co-payment. There is no income eligibility requirement.

Patient eligibility requirements:
• Patients must be prescribed one of the drugs listed above.
• Patients must have private commercial health insurance that covers medication costs for the drugs listed above.
• Patients must not participate in any federal, state, or government-funded healthcare program, such as Medicare, Medicare Advantage, Medicare Part D, Medicaid, Medigap, VA, DoD, or TRICARE.
• Patients may not seek reimbursement for value received from the Amgen FIRST STEP Program from any third-party payers, including flexible spending accounts or healthcare savings accounts.

Other restrictions apply. Amgen reserves the right to revise or terminate this program, in whole or in part, without notice at any time.

To confirm patient eligibility and enroll in one of these programs, call 1.888.65.STEP1 (1.888.657.8371) or visit amgenfirststep.com.
Amgen First Step coverage limits and maximums:

• Program covers out-of-pocket medication costs for the Amgen product only. Program does not cover any other costs related to office visit or administration of the Amgen product.

• No out-of-pocket cost for first dose or cycle; $5 out-of-pocket cost for subsequent dose or cycle. Maximum benefit of $10,000 per patient per calendar year. (For Kyprolis and Kanjinti: maximum benefit of $20,000 per patient per calendar year; for Prolia: $25 out-of-pocket cost for subsequent dose or cycle, maximum benefit of $1,500 per patient per calendar year.) Patient is responsible for costs above these amounts.

Learn more at the Amgen FIRST STEP Health Care Healthcare Provider and Specialty Pharmacy Portal: amgenfirststep.com/login. For questions call 1.888.65.STEP1 (1.888.657.8371) Monday through Friday, 9:00 am to 8:00 pm ET.

Uninsured Patients

Patients may be able to receive Amgen medications at no cost from Amgen Safety Net Foundation (amgensafetynetfoundation.com) if they meet the following requirements:

• Have lived in the U.S. or its territories for six months or longer
• Satisfy income eligibility requirements
• Are uninsured or their insurance plan excludes the Amgen or its generic/biosimilar.

Certain Medicare Part D patients with product coverage who cannot afford their out of pocket costs may be eligible. It is required that they are able to demonstrate:

• Inability to afford the medicine
• Ineligibility for Medicaid or Medicare’s low-income subsidy (Extra Help)
• Have satisfied all payer guidelines and Prior Authorization (PA) requirements prior to applying for assistance
• Do not have any other financial support options.

To apply, visit amgensafetynetfoundation.com/how-to-apply.html, select the appropriate medication, complete the Patient Application, and fax the completed application along with its prescribing physician and facility information to 1.866.549.7239.

Once a completed application and any requested supporting documents have been received and processed, the patient and provider will be notified of the enrollment decision. Missing information or an incomplete application will delay an enrollment decision. Eligible patients are enrolled for a period up to 12 months. To re-enroll in Amgen Safety Net Foundation, patients must submit a new application.

For questions, call 1.888.762.6436, Monday through Friday, 9:00 am to 8:00 pm ET.

REIMBURSEMENT ASSISTANCE

Amgen Assist 360™

Connect with an Amgen Reimbursement Counselor by phone or schedule a visit with a Field Reimbursement Specialist to receive assistance with the following:

• Insurance benefit verification
• Prior authorizations
• Billing and claims support.

Visit amgenassist360.com/hcp/patient-support/amgen-access-specialist for more information.

Amgen Reimbursement Counselors can assist with submitting, storing, and retrieving benefit verifications for anyone currently on an Amgen product. The Benefit Verification Center offers the tools, information, and support that make a difference to providers and patients. Visit amgenassistonline.com and select the specific drug to get started.

For more information, call 1.888.4ASSIST (1.888.427.7478), Monday through Friday, 9:00 am to 8:00 pm ET.
**PATIENT ASSISTANCE**

**Astellas Pharma Support Solutions™**

Astellas Pharma Support Solutions offers access and reimbursement support to help patients overcome challenges to accessing Astellas products. To enroll in either Xospata Support Solutions or Xtandi Support Solutions, visit [astellaspharmasupportsolutions.com](http://astellaspharmasupportsolutions.com), select the appropriate medication, and follow the patient enrollment process.

**Xospata Support Solutions™**

Xospata Support Solutions ([astellaspharmasupportsolutions.com/products/xospata/index.aspx](http://astellaspharmasupportsolutions.com/products/xospata/index.aspx)) offers access and reimbursement support to help patients access Xospata. It provides information regarding patient healthcare coverage options and financial assistance information that may be available to help patients with financial needs. To speak with a dedicated access specialist, call 1.844.632.9272, Monday through Friday, 8:30 am to 8:00 pm ET.

**Xospata Quick Start+® Program**

The Xospata Quick Start+ Program provides a one-time, 7-day supply of Xospata at no cost to eligible patients who experience an insurance-related delay. Overnight shipping is offered directly to the patient. To be eligible, patients must:
- Have prescription drug insurance
- Be new to Xospata therapy
- Have been prescribed Xospata for an FDA-approved indication
- Have experienced an insurance-related access delay.

To enroll, fill out the appropriate section during the Xospata Support Solutions enrollment process.

**Xospata Copay Card Program**

The Xospata Copay Card Program is for eligible patients who have commercial prescription insurance. The Program parameters are as follows:
- Patients pay as little as $0 per prescription
- A patient will be enrolled in the program for a 12-month period
- The program benefit covers up to a maximum of $25,000 per calendar year
- There are no income requirements.

Xospata Support Solutions can evaluate eligibility and enroll patients in the Xospata Copay Card Program, or the preferred network specialty pharmacy can be contacted to determine eligibility and enroll the patient in the program.

**Xtandi Support Solutions™**

Xtandi Support Solutions ([astellaspharmasupportsolutions.com/products/xtandi/index.aspx](http://astellaspharmasupportsolutions.com/products/xtandi/index.aspx)) offers access and reimbursement support to help patients overcome challenges to accessing Xtandi. It provides information regarding patient healthcare coverage options and financial assistance options that may be available to help patients with financial needs. To speak with a dedicated access specialist, please call 1.855.8XTANDI (1.855.898.2634), Monday through Friday, 8:00 am to 8:00 pm ET.

**Xtandi Quick Start+® Program**

The Xtendi Quick Start+ Program provides a one-time, 14-day supply of Xtandi at no cost to new patients who experience a delay in insurance coverage. Overnight shipping is offered directly to the patient. To be eligible, patients must:
- Have prescription drug insurance
- Be new to Xtandi therapy
- Have been prescribed Xtandi for an FDA-approved indication
- Meet other eligibility criteria.

The program is not valid for patients whose prescription claims are reimbursed, in whole or in part, by any state or federal government program, including, but not limited to Medicaid, Medicare, Medigap, Department of Defense (DoD), Veterans Affairs (VA), TRICARE, Puerto Rico Government Insurance, or any state patient or pharmaceutical assistance program. This offer is not valid for cash-paying patients.
Offered directly to the patient. Patient eligibility for the for the Quick Start+ program, includes:

- Have prescription drug insurance
- Be new to Xtandi therapy
- Have experienced an insurance-related access delay
- Have been prescribed Xtandi for an FDA-approved indication.

To enroll, fill out the appropriate section during the Xtandi Support Solutions enrollment process.

**Xtandi Patient Savings Program**

The Xtandi Patient Savings Program is for eligible patients who have commercial prescription insurance. The program parameters are as follows:

- Patients can pay as little as $0 per prescription
- Patients will be enrolled in the program for a 12-month period
- The program covers up to a maximum of $25,000 per calendar year
- There are no income requirements.

Patients must provide their Savings Card ID number to the specialty pharmacy when they fill their prescription. There are 2 ways patients can receive the Savings Card: by contacting their specialty pharmacy or by applying for the Savings Card at activatethecard.com/xtandi.

The program is not available to patients whose prescription claims are reimbursed, in whole or in part, by any state or federal government program, including but not limited to Medicaid, Medicare, Medigap, DoD, VA, TRICARE, Puerto Rico Government Insurance, or any state patient or pharmaceutical assistance program.

**PADCEV Support Solutions℠**

PADCEV Support Solutions (astellaspharmasupportsolutions.com/products/padcev/index.aspx), a component of Astellas Pharma Support Solutions℠, offers access and reimbursement support to help patients access Padcev. It provides information regarding patient healthcare coverage, financial assistance information that may be available to help patients with financial needs, and coding and billing information for Padcev.

Patients can enroll in PADCEV Support Solutions by completing the Patient Enrollment Form, including signatures, and fax it to 1.877.747.6843, enroll via the Prescriber Portal (padcev.aspnp programs.com/), or enroll by phone. To speak with a dedicated access specialist, please call us at 1.888.402.0627, Monday through Friday, 8:30 am to 8:00 pm ET.

**PADCEV Copay Assistance Program**

The PADCEV Copay Assistance Program is for eligible patients who have private commercial health insurance and are not insured by any federal or state healthcare program, including, but not limited to, Medicare, Medicaid, TRICARE, or Veterans Affairs (VA). Under this Program:

- Patients pay as little as $5 per dose
- A patient will be enrolled in the Program for a 12-month period
- Patients may save up to a maximum of $25,000 per calendar year
- There are no income requirements.

This offer is not valid for cash-paying patients. PADCEV Support Solutions can evaluate eligibility and enroll patients in the PADCEV Copay Assistance Program, or patients can enroll through the Padcev Patient Enrollment Process. For more information, contact PADCEV Support Solutions at 1.888.402.0627, Monday through Friday, 8:30 am to 8:00 pm ET.

**Astellas Patient Assistance Program**

The Astellas Patient Assistance Program provides Xtandi, Xospata, or Padcev at no cost to patients who meet the program eligibility requirements. The patient may be eligible if they meet the following criteria:

- Patient is uninsured or has insurance that excludes coverage for Xtandi, Xospata, or Padcev
- Patient has a verifiable shipping address in the United States
- Patient has been prescribed Xtandi, Xospata, or Padcev for an FDA-approved indication
- Patient meets program financial eligibility requirements.

To enroll a patient in the Astellas Patient Assistance Program, complete the Xtandi, Xospata, or Padcev Support Solutions enrollment process and complete the PAP application to upload through the portal or fax the form to the number on the form. If the patient is eligible, the patient and provider will be notified, and the prescription will be shipped directly to the patient’s home.

**REIMBURSEMENT ASSISTANCE**

**Astellas Pharma Support Solutions℠ Benefits Verification**

Astellas Pharma Support Solutions offers benefits verification assistance to evaluate a patient’s insurance coverage for Xtandi, Xospata, or Padcev. After performing a benefits verification, a summary of benefits
will be provided that includes:
• The patient’s insurance coverage requirements for the medication
• Requirements for prior authorization, step edit, or other coverage restrictions, if any
• Cost-sharing responsibility, including deductibles, coinsurance or copayment, and out-of-pocket maximums
• A list of specialty pharmacies that participate in your patient’s insurance coverage.

Upon completion of the specific drug’s patient enrollment process, the benefits verification process begins. Once it is complete, a summary of benefits will be sent.

Prior Authorization
Astellas Pharma Support Solutions can provide prior authorization (PA) assistance when a patient’s insurer requires PA approval. Prior authorizations will be communicated to the patient and provider and the prescription will be sent to a specialty pharmacy. Xtandi, Xospata, or Padcev Support Solutions will follow up with the specialty pharmacy to confirm receipt, check status, and notify of the outcome.

If the patient’s insurance denies a prior authorization request, Xtandi or Xospata Support Solutions can assist the healthcare provider with an appeal for a denied prior authorization request. Xtandi, Xospata, or Padcev Support Solutions will determine if any additional documentation is required by the patient’s insurer, inform the healthcare provider of what information is needed and how to provide it to the insurer, and track and inform the healthcare provider of the appeal status.
AstraZeneca

Oncology-related products: Calquence® (acalabrutinib) capsules, Faslodex® (fulvestrant) injection, Imfinzi® (durvalumab) injection, Iressa® (gefitinib) tablets, Lumoxiti™ (moxetumomab pasudotox-tdfk) for injection, Lynparza® (olaparib), Tagrisso® (osimertinib) tablets

Patient and Reimbursement Assistance Websites
astrazenecaspecialtysavings.com
MyAccess360.com

PATIENT ASSISTANCE

Patient Savings Programs
The goal of the Patients Savings Programs is to assist eligible patients with their out-of-pocket costs. Patients may pay $0 per supply or infusion, dependent on the specific medication, and subject to annual maximums. There are no income requirements to participate in these programs.

Patients are ineligible if prescriptions are paid by any state or other federally funded programs, including, but not limited to, Medicare Part B, Medicare Part D, Medicaid, Medigap, VA or TRICARE, or where prohibited by law. Eligibility rules apply. Additional restrictions may apply.

How the Programs Work:
1. Your patient may have an out-of-pocket cost for an AstraZeneca specialty product.
2. If the patient meets the eligibility requirements, you can enroll him or her into the Patient Savings Program via the online enrollment portal. The links to the portal for each product can be found at astrazenecaspecialtysavings.com.
3. A Patient Savings Program account will be created for the eligible patient. Once enrolled, patient-specific account information will be presented in the portal for immediate use.
4. The patient will pay a set amount of his or her out-of-pocket costs, based on the product. The pharmacy or provider will use the Patient Savings Program to cover the balance, up to the program maximum.

For more information about eligibility and details on these programs, please visit astrazenecaspecialtysavings.com or call AstraZeneca Access 360 at 1.844.ASK.A360 (1.844.275.2360).

The AstraZeneca Access 360™ program provides personal support to connect patients to affordability programs and streamline access and reimbursement for AstraZeneca’s medicines. Access 360 provides:
• Assistance with understanding patient insurance coverage and pharmacy options
• Reimbursement assistance
• Eligibility requirements and enrollment assistance for specialty Patient Savings Programs
• Referrals to patient assistance programs
• Referrals to nurse assistance or educational support programs, if applicable.

To learn more about the AstraZeneca Access 360 program, call 1.844.ASK.A360 (1.844.275.2360), Monday through Friday, 8:00 am to 8:00 pm ET or visit www.MyAccess360.com.

The AZ&Me™ Prescriptions Savings Programs
The AZ&Me™ Prescriptions Savings Programs are designed to help qualifying people without insurance and those in Medicare Part D who are still having trouble affording their AstraZeneca medications. There are two programs:
• AZ&Me Prescription Savings program for people without insurance
• AZ&Me Prescription Savings program for people with Medicare Part D.
There is a shared application process for the AZ&Me Prescription Savings Program for people without insurance and the AZ&Me Prescription Savings Program for people with Medicare Part D, and the same application is used for both programs. To apply for the program you may either call 1.800.AZandMe (1.800.292.6363) or visit azandmeapp.com to download an application. For an updated list of the medications available through the AZ&Me Prescription Savings Program, please visit azandmeapp.com.

Eligibility Requirements:
- Patient must be a resident of the United States, or have a Work Visa or Green Card.
- Patient must not be currently receiving prescription drug coverage under a private insurance or government program, or receiving any other assistance to help pay for medicine.
- Patient annual income must be at or below a certain level.

If the patient is a Medicare Beneficiary, they must not be eligible for or enrolled in Low Income Subsidy (LIS) for Medicare Part D, and they must have spend at least three percent of their annual household income on prescription medicines in the current year.

If a patient has experienced a life changing event in the past year, and their financial documentation does not accurately reflect their current situation, AstraZeneca encourages them to apply for the AZ&Me Prescription Savings Program. They may still meet the criteria to enroll.

Application Checklist
The following items must be submitted in order to complete patient application:
- A completed application, signed and dated by the patient and prescriber
- A completed prescription (included on page 3 of the application)
- If the patient is a Medicare enrollee, please also include a copy of their Medicare Part B and/or Medicare Part D Prescription Drug statement, or a summary document from the pharmacy indicating the amount spent on prescriptions in the current calendar year.

Please note that faxed applications must be sent from a physician’s office in order for their prescription to be processed.

For more information, please visit azandmeapp.com or call 1.800.AZandME (1.800.292.6363).

REIMBURSEMENT ASSISTANCE

AstraZeneca Access 360™
The Access 360 program provides personal support to connect patients to affordability programs and streamline access and reimbursement for AstraZeneca medicine. Access 360 provides:
- Assistance with understanding patient insurance coverage and pharmacy options
- Prior authorization support
- Claims and appeal process support.

For more information, call 1.844.ASK.A360 (1.844.275.2360), Monday through Friday, 8:00 am to 8:00 pm ET or visit myaccess360.com.
Oncology-related products: Aliqopa™ (copanlisib) for injection, Nexavar® (sorafenib) tablets, Nubeqa® (darolutamide) tablets, Stivarga® (regorafenib) tablets, Vitrakvi® (larotrectinib), Xofigo® (radium Ra 223 dichloride) injection

Patient and Reimbursement Assistance Websites
nubeqa-us.com
hcp.xofigo-us.com/patient-financial-assistance
zerocopaysupport.com
hcp.aliqopa-us.com/access-and-reimbursement/arc-program/
hcp.vitrakvi-us.com/access/

PATIENT ASSISTANCE

Xofigo Access Services

Xofigo Patient Assistance Program
Xofigo Access Services may provide Xofigo free of charge for eligible patients who are uninsured or who are insured but do not have coverage for Xofigo. Eligibility criteria include:
• Financial criteria based on adjusted gross household income (documentation of income is required)
• Residency in the United States, including the District of Columbia, Puerto Rico, Guam, or the U.S. Virgin Islands.

Complete the Xofigo Access Services Patient Assistance Application (hcp.xofigo-us.com/coordinate-patient-care/getting-patients-started/patient-financial-assistance) and fax the completed form including the signed patient authorization, to 1.855.963.4463. Call an Access Counselor at 1.855.6XOFIGO (1.855.696-3446), Monday through Friday, 9:00 am to 7:00 pm ET, if you have any questions or to obtain more information.

Registered providers can also submit an application for patient assistance via the secure Xofigo Access Services Provider Portal: xofigoaccessonline.com.

$0 Commercial Copay Assistance Program
Your patient may be eligible for copayment/coinsurance assistance if your patient has a private commercial plan that covers Xofigo. Patients approved for assistance will not have to pay anything to access Xofigo. Eligibility criteria include:
• Patient has private commercial insurance
• Residency in the United States, including the District of Columbia, Puerto Rico, Guam, or the U.S. Virgin Islands.


Independent Copay/Coinsurance Assistance Foundations
Medicare beneficiaries and patients with other government insurance who need help paying for treatment with Xofigo are not eligible for copay assistance through the Xofigo Access Services commercial copay/coinsurance assistance program. If your patient needs assistance with cost-share requirements, they may be eligible for copay or coinsurance assistance through an independent copay/coinsurance assistance foundation. Xofigo Access Services

Bayer HealthCare Pharmaceuticals, Inc.
Access Counselors can verify your patients’ coverage for Xofigo and provide information about any available foundation. The foundations determine your patient’s eligibility for copay or coinsurance assistance based on their own criteria.

**REACH®**

Patients taking Stivarga or Nexavar can enroll in REACH® (Resources for Expert Assistance and Care Helpline). This free program is here to support patients and caregivers with information about therapy and financial assistance options. The REACH program offers Nurse Counselors to answer medical questions and provide educational and support materials, as well as guidance on side effects, and Financial Access Counselors to provide help with:

- Benefit verification and specialty pharmacy provider (SPP) identification
- Patient Assistance Program (PAP) for the uninsured or underinsured
- Prior authorizations and denial/appeal information
- Co-pay assistance for eligible commercially insured patients not previously enrolled in the REACH Commercial Co-Pay Assistance Program
- Referral to independent organizations that may assist eligible patients with their out-of-pocket expenses.

Enroll online at zerocopaysupport.com by clicking on the specific medication. For questions about the co-pay program, call the $0 co-pay program support at 1.866.581.4992.

**Independent Charitable Organizations**

REACH can help patients who are government insured (e.g., Medicare, Medicaid, Military) by giving information on Part D prescription drug plans. Financial advice may be available through independent charitable organizations.

Call 1.866.639.2827, 9:00 am to 5:00 pm ET, to speak with a reimbursement counselor.

**Patient Assistance Program**

Patients who are uninsured or underinsured may be eligible to receive free medication for up to 12 months. Eligibility requirements apply. Financial assistance may also be available through independent charitable organizations. Call 1.866.639.2827, 9:00 am to 5:00 pm ET, to speak with a reimbursement counselor.

For more information, visit hcp.aliqopa-us.com/access-and-reimbursement/arc-program/ or call an Access Counselor at 833.ALIQOPA (833.254.7672), Monday through Friday, 9:00 am to 7:00 pm.

**DUDE Access Services™**

DUDE (Darolutamide User Drug Experience) Access Services provides a range of services and resources for Nubeqa patients, including:

- Two months of free treatment for
To provide these savings to your patients and benefit from the advantages of DUDE Access Services, complete and fax the Patient Service Request form (https://www.nubeqahcp.com/sites/g/files/kmftyce1081/files/2019-07/Nubeqa_PatientServiceRequestForm_4.pdf) to 1-844-NUBEQA3 (1.844.682.3723). You can also call 833-337-DUDE (1.833.387.3833), Monday through Friday, 9:00 am to 7:00 pm ET.

Nubeqa Free Trial Program
The Nubeqa free trial program provides two months’ supply of Nubeqa at no cost to patients who meet the program eligibility requirements and agree to the terms and conditions. To be eligible, the patient must reside in the United States or Puerto Rico, and be a new patient not currently using Nubeqa or who previously received Nubeqa through the free trial program. For more information please call, 1.833.337.DUDE (1.833.337.3833).

$0 Co-Pay Program
Commercially insured patients qualify for $0 co-pay. The Nubeqa $0 co-pay program benefit has a maximum amount of $25,000 per year, per patient. The Nubeqa co-pay program is for commercially insured patients using Nubeqa for an approved FDA indication, being treated in the U.S., including, Puerto Rico, Guam, and U.S. territories. Patients who are enrolled in any type of government insurance or reimbursement programs are not eligible. For questions about the Nubeqa $0 Co-pay Program, please call us at 1.833.337.DUDE (1.833.337.3833).

TRAK Assist™
TRAK Assist provides several options to help patients access their Vitrakvi treatment.
- TRAK Assist $0 Co-Pay Program is for eligible patients with commercial or private insurance. Patients who are enrolled in any type of government insurance or reimbursement programs are not eligible.
- Vitrakvi Bridge Program is for commercially insured patients whose coverage is delayed or who experience a temporary lapse in coverage. This program provides free Vitrakvi for a limited period of time while a patient is without coverage.
- Referrals to independent assistance foundations are for publicly insured patients who need help with out-of-pocket costs related to their treatment. TRAK Assist offers referrals to third-party assistance programs; eligibility criteria apply.
- Bayer U.S. Patient Assistance Foundation is for qualified uninsured or underinsured patients.

TRAK Assist also provides a dedicated phone line that provides patients direct access to a nurse or pharmacist who can answer questions about treatment with Vitrakvi. To enroll patients in TRAK Assist, download the Vitrakvi patient support service request form and prescription (hcp.vitrakvi-us.com/resources) and fax the completed form, along with copies of the patient's pharmacy insurance card(s) (front and back), to 1.888.506.TRACK (1.888.506.8725). For more information, please call 1.844.634.TRACK (1.844.634.8725), Monday through Friday, 9:00 am to 7:00 pm ET.

Vitrakvi Commitment Program™
Bayer will provide full or partial refunds (for up to 60 days) to patients (through the Bayer In-Network Specialty Pharmacy) for patients who do not receive clinical benefit within 90 days of initiation on Vitrakvi. Program rules apply. For more information, visit hcp.vitrakvi-us.com/access or call 1.844.634.TRACK (1.844.634.8725).

REIMBURSEMENT ASSISTANCE

Xofigo Access Services
Xofigo Access Services provides a variety of services to support access to Xofigo, including:
- Insurance and benefits verification
- Prior authorization support
- Claims appeal research and information
- Claims tracking
- Billing and coding guidance
- Payer policy information.

To access these services, call 1.855.6XOFIGO (1.855.696.3446) 9:00 am to 7:00 pm ET, Monday through Friday. You can also access these services online 24/7 through the Xofigo Access Services Provider Portal: xofigoaccessonline.com.

REACH®
Some insurance plans require patients to obtain approval for coverage before starting therapy (known as Prior Authorization), which can take time and delay the start of therapy. REACH may be able to provide temporary assistance for patients to start therapy right away while waiting for their Prior Authorization approval.

The REACH program Financial Access Counselors to provide help with benefit verification and specialty pharmacy provider (SPP) identification. Call a REACH counselor 1.866.639.2827 for more information.

**Aliqopa Resource Connections**
The ARC patient support program offers comprehensive access, reimbursement support, and patient assistance services, including:

- Insurance benefit verifications
- Prior authorization information (physician office must submit prior authorization)
- Claims appeal information
- Claims status
- Billing and coding information
- Payer policy information.

For more information, call 833.ALIQOPA (833.254.7672), Monday through Friday, 9:00 am to 7:00 pm ET, or visit hcp.aliqopa-us.com/access-and-reimbursement/arc-program/.

**DUDE Access Services™**
A range of support services are available for your Nubeqa patients, including:

- Benefits verification
- Prior authorization assistance
- Appeal support.

To provide these savings to patients and benefit from the advantages of DUDE Access Services, complete and fax the Patient Service Request form (https://www.nubeqahcp.com/sites/g/files/kmftyc1081/files/2019-07/Nubeqa_PatientServiceRequestForm_4.pdf) to 1.844.NUBEQA3 (1.844.682.3723). You can also call 1.833.337.DUDE (1.833.337.3833), Monday through Friday, 9:00 am to 7:00 pm ET.

**TRAK Assist™**
TRAK Assist provides access support and coverage assistance. Patient coverage support, includes:

- Insurance benefit investigation
- Prior authorization and appeals support
- Sample documentation
- Payer policy information.

For more information, please call 1.844.634.TRAK (1.844.634.87250), Monday through Friday, 9:00 am to 7:00 pm ET.
Oncology-related products: Brukinsa™ (Zanubrutinib) capsules

PATIENT ASSISTANCE

myBeiGene™ PATIENT SUPPORT
The myBeiGene program is a comprehensive patient support program designed to provide appropriate information and assistance to patients. Dedicated oncology nurse advocates provide personalized support for each patient’s needs.

myBeiGene Patient Support simplifies access by:
- Assisting with insurance verification and prior authorization support
- Co-pay/co-insurance assistance for commercially insured patients
- Bridge supply for insurance coverage delays
- Free product for uninsured and underinsured patients (note: certain financial and eligibility criteria apply).

myBeiGene Patient Support can also help provide information to patients about their disease and treatment with Brukinsa, provide patient and caregiver follow up support, and has dedicated oncology nurse advocates for practices, patients, and caregivers.

To enroll in myBeiGene Patient Support, call myBeiGene at 1.833.234.4363 and speak to an oncology nurse advocate, fill out and submit the online form found at brukinsa.com/patient-support, or download, complete and fax the enrollment form (brukinsa.com/enrollment-form.pdf) to 1.877.828.5593.

Co-Pay/Co-Insurance Assistance
Eligible commercially insured patients may have a co-pay as little as $0 per prescription. There is no patient income requirement. The program is subject to an annual benefit limit of $25,000. Patients are ineligible if prescriptions are payable by any state or federally funded programs, including, but not limited to, Medicare, Medicaid, VA, or TRICARE, or where prohibited by law. Eligibility criteria and restrictions apply.

Bridge Supply
Eligible patients may receive a 15-day supply of medication (for on-label use only) in cases of a coverage delay lasting longer than 5 days. Eligibility criteria and restrictions apply.

For more information and questions, oncology nurse advocates are available Monday through Friday, 8:00 am to 8:00 pm ET at 1.833.BeiGene (1.833.234.4363).

REIMBURSEMENT ASSISTANCE

myBeiGene™ PATIENT SUPPORT
The myBeiGene program is a comprehensive patient support program designed to provide appropriate information and assistance to patients, including assistance with:
- Insurance verification
- Prior authorization support.

To enroll in myBeiGene Patient Support for co-pay/co-insurance assistance, call myBeiGene at 1.833.234.4363 and speak to an oncology nurse advocate, fill out and submit the online form found at brukinsa.com/patient-support, or download, complete and fax the enrollment form (brukinsa.com/enrollment-form.pdf) to 1.877.828.5593.

For more information, oncology nurse advocates are available Monday through Friday, 8:00 am to 8:00 pm ET at 1.833.BeiGene (1.833.234.4363).
oncology nurse advocate, or fill out and submit the online form found at brukinsa.com/patient-support, or download, complete and fax the enrollment form (brukinsa.com/enrollment-form.pdf) to 1.877.828.5593.

For more information, oncology nurse advocates are available Monday through Friday, 8:00 am to 8:00 pm ET at 1.833.BeiGene (1.833.234.4363).
PATIENT ASSISTANCE

Boehringer Ingelheim Pharmaceuticals, Inc.

Oncology-related product: Gilotrif® (afatinib) tablets

PATIENT ASSISTANCE

Gilotrif Patient Services
Boehringer Ingelheim’s Gilotrif Patient Services includes a range of programs and services offered through the company's Solutions Plus program. This program provides support, education, and reimbursement services to patients who are prescribed Gilotrif, as well as to their providers.

Gilotrif can be prescribed for non-dispensing accounts by calling 1.844.569.2836 or by downloading the prescription and enrollment form at patientservices.gilotrifhcp.com/sites/default/files/accredo_prescription_and_enrollment_form.pdf. Fax the completed form to Accredo at 1.888.454.8488.

Once Gilotrif prescription enrollment is complete, patients will receive a welcome call, confirming enrollment and insurance benefits. The first delivery often arrives within four days. Upon receiving the prescription and enrollment form, Accredo will fill the prescription and call the patient to schedule their delivery.

For more information, call contact Accredo at 1.844.569.2836.

Co-pay Assistance Program
Eligible commercially insured patients 18 years or older could pay as little as $0 a month with a maximum savings up to $5,500 monthly and a maximum annual program benefit of $25,000. No income eligibility or additional paperwork is required.

Bridge Program
Eligible patients experiencing more than a 5-day payer approval delay can receive a 15-day supply of Gilotrif at no cost to the patient for the FDA-approved indications. For commercial and Medicare Part D insured people treated with Gilotrif. This program allows patients to start therapy and avoid a prolonged delay.

Gilotrif Dose Exchange™
Gilotrif Dose Exchange facilitates the transition to a new dose at no cost while eliminating an additional Gilotrif co-pay in a given month for eligible patients. Eligible patients receive a new dose of Gilotrif with convenient packaging to return unused tablets.

Gilotrif Dose Exchange covers up to 2 dose modifications for patients serviced through Accredo or the Gilotrif Dispensing Network who have 9 or more tablets to exchange. Call 1.844.569.2836 to learn more.

The Boehringer Ingelheim Cares Foundation Patient Assistance Program
The program helps those in need obtain Boehringer Ingelheim medications including Gilotrif free of charge. Patients prescribed Gilotrif who apply must meet program eligibility requirements including income and prescription coverage criteria in order to be enrolled. The program requires a completed application form signed by patient and healthcare provider and supporting documentation. This program is for patients who are uninsured or underinsured.

To submit an application, complete the Patient Assistance Program Application for Gilotrif form (boehringer-ingelheim.us/sites/us/files/files/gilotrif_pap_application-fillable.pdf) and fax the complete application to 1.855.297.5905. For more information, visit boehringer-ingelheim.us/our-responsibility/patient-assistance-program or call 1.855.297.5904, Monday through Friday, 8:30 am to 6:00 pm ET.
**REIMBURSEMENT ASSISTANCE**

**Gilotrif Patient Services**
Reimbursement Specialists personally work with providers and patients to resolve any issues they may have with benefits verification, prior authorization, or denials and appeal of claims.

Enroll patients by downloading and completing the Prescription and Enrollment Form (gilotrifthcp.com/sites/default/files/Accredo%20Updated%20GILOTRIF%20Enrollment%20Form%20042719.pdf). Fax the complete form to Accredo at 1.888.454.8488. For more information, call contact Accredo at 1.844.569.2836.

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**Communication Skills 101**

Effective communication is a two-way process involving listening and speaking. It is a learned skill that requires practice. Listening and speaking are equally important to the process. To listen effectively, you must resist formulating your response while the other person is still speaking. The better option: allow a thoughtful pause while you both digest what has been said.

**Tips for Effective Speaking**

- Pay attention—not just to your words, but also to your non-verbal message(s).
- Putting a desk between you and the patient and family can foster a perception of distance. If possible, position yourself at a 35 to 45 degree angle towards the patient and keep your arms relaxed and open towards their body.
- Try not to look tense or stressed, instead adopt a relaxed and calm demeanor. Look up frequently to maintain eye contact.
- **DO** smile, sit, or stand comfortably.
- Have at least 2 to 3 minutes of discussion with the patient and family before you begin to take notes. Never “doodle.” Shuffle papers as little as possible. The patient must feel that your focus is on him or her and what they are saying.
- Allow patients and families to see your notes before the end of your visit. Remember: transparency builds trust.

Source: ACCC Financial Advocacy Network. accc-cancer.org/FAN
Bristol-Myers Squibb

Oncology-related products: Empliciti® (elotuzumab) for injection, Opdivo® (nivolumab) injection, Sprycel® (dasatinib) tablets, Yervoy® (ipilimumab)

PATIENT ASSISTANCE

BMS Access Support®
Bristol-Myers Squibb (BMS) is committed to helping appropriate patients get access to our medications by providing access and reimbursement support services. The appropriate program will depend on the patient’s coverage.

BMS Oncology Co-Pay Assistance Program
This program is designed to assist with out-of-pocket deductibles, co-pay, or co-insurance costs for eligible commercially insured patients who have been prescribed certain BMS products. Patients participating in any state or federal healthcare program including Medicaid, Medicare, Medigap, CHAMPUS, TriCare, VA, or DoD, or any state, patient, or pharmaceutical assistance program are not eligible for this co-pay program. The patient must live in the United States or Puerto Rico. Enrolled patients pay the first $25 of the co-pay for each dose of a BMS medication covered by this program. This program will cover the remainder of the co-pay, up to a maximum of $25,000 per BMS medication during a calendar year. If a patient is prescribed two BMS medications in combination, the maximum is $50,000. Other restrictions may apply. Final determination of program eligibility is based upon review of completed application.

Enrollment is simple. The provider completes the application through BMS Access Support in one of the following ways:
- Download the enrollment form on your computer (bmsaccesssupport.bmscustomerconnect.com/oncology/services/patient-financial-assistance/copay) and fax to 1.888.776.2370.
- Enroll online with our secure portal: https://www.mybmscases.com/app/login#.
- Call BMS Access Support at 1.800.861.0048. Monday through Friday, 8:00 am to 8:00 pm ET.

When completing the form, check the box for the BMS Oncology Co-Pay Program. BMS Access Support determines patient eligibility, including verifying commercial insurance coverage. BMS Access Support then notifies the provider and patient of the result and the appropriate next steps. For questions or to confirm receipt of the application, call the Support Center at 1.800.861.0048, 8:00 am to 8:00 pm ET, Monday through Friday.

Assistance for Uninsured Patients
For patients without prescription drug insurance, or for patients who are underinsured, BMS Access Support can make a referral to independent charitable foundations that may be able to provide financial support, including the Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF): bmspaf.org. This charitable organization may provide free medicine to eligible, uninsured patients who have an established financial hardship.

The BMSPAF accepts the BMS Access Support application. Patients may be eligible for assistance through the BMSPAF if they:
- Do not have insurance coverage for applicable medication
- Live in the United States, Puerto Rico, or U.S. Virgin Islands
- Are being treated by a U.S.-licensed prescriber
- Have a yearly income that is at or below 300% of the Federal Poverty Level. Medications that are
injected and certain cancer medications may be subject to higher limits.

Other eligibility criteria may apply. For more information about eligibility and to obtain an enrollment application, call the Bristol-Myers Squibb Patient Assistance Foundation at 1.800.736.0003.

Assistance for Patients with Federally-Funded Insurance Plans
Patients insured through Federal Healthcare Programs are not eligible for co-pay assistance programs sponsored by Bristol-Myers Squibb, but there are independent charitable foundations that can help. It is important to note that these foundations are independent from Bristol-Myers Squibb. Each foundation has its own eligibility criteria and evaluation process. Bristol-Myers Squibb cannot guarantee that a patient will receive assistance. For details, contact BMS Access Support at 1.800.861.0048.

REIMBURSEMENT ASSISTANCE

BMS Access Support
Benefits Reviews
BMS Access Support can conduct a benefits review. It will review patient coverage for BMS medication and reviews are typically completed within a median time of 24 hours. For enrolled patients, benefits may also be reverified.

Prior Authorization
BMS Access Support can assist by providing information about the prior authorization process. The Care Coordinator can conduct benefits review, obtain information about any prior authorization requirement, call the payer to obtain prior authorization detains, and fax summary of benefits to the provider.

Claims Appeals
If the patient’s insurer has denied coverage, BMS Access Support may be able to assist by providing information about the appeals process. It is important to review the insurer’s guidelines and to submit the required documents and information before the appeal deadline.

To start a benefits review or schedule a call with a Care Coordinator, visit bmsaccesssupport.bmscustomerconnect.com/overview-services.
Oncology-related products: Abraxane® (paclitaxel protein-bound particles for injectable suspension) (albumin-bound), Idhifa® (enasidenib) tablets, Inrebic® (fedratinib) capsules, Istodax® (romidepsin) for injection, Pomalyst® (pomalidomide), Reblozyl® (luspatercept-aamt) for injection, Revlimid® (lenalidomide) capsules, Thalomid® (thalidomide), Vidaza® (azacitidine for injection)

Patient and Reimbursement Assistance Website
celgenepatientsupport.com

PATIENT ASSISTANCE

Celgene Patient Support®
At Celgene Patient Support we care about making sure patients get the answers they need. That’s why our specialists are ready to help answer questions about the insurance approval process, and the financial help that may be available for your prescribed Celgene medicine. Celgene Patient Support can help patients understand the programs and services available.

To enroll, download the English or Spanish enrollment form at celgenepatientsupport.com/enrollment/email-or-fax and fax the completed form to 1.800.822.2496, or email it to patientsupport@celgene.com, or submit the form online. For more information, call 1.800.931.8691.

Celgene Commercial Co-Pay Program
This program is for eligible patients with commercial or private insurance. If patients are eligible, the co-pay program may help reduce co-pay responsibility to $25 or less, depending on the prescribed Celgene medication. This program provides up to $10,000 per calendar year.

Eligibility criteria for patients include:
• Commercial or private insurance that does not cover the full cost of the prescribed Celgene medication
• Residence in the United States or a U.S. territory
• Patients with government healthcare insurance (for example, Medicaid, Medicare [Parts B, C, and D], Medigap, and TRICARE) are not eligible
• Other eligibility requirements and restrictions apply. Please see full Terms and Conditions on the Celgene Patient Support® website (http://media.celgenepatientsupport.com/wp-content/uploads/CCCP_Full_Terms_and_Conditions.pdf)

Celgene Patient Assistance Program (PAP)
If patients do not have health insurance or enough coverage to pay for their medicine, the Celgene Patient Assistance Program may be able to provide them with the prescribed Celgene medicine at no cost. To qualify, patients must meet certain financial criteria. To find out more, call a Celgene Patient Support Specialist at 1.800.931.8691.

Independent Third-Party Organizations
For patients who are unable to afford their medication (including patients with Medicare, Medicaid, or other government-sponsored insurance), Celgene Patient Support® can provide you with information about independent third-party organizations that may be able to help patients with the cost of:
• Deductibles
• Co-payments/co-insurance
• Insurance premiums.

Transportation Assistance
A Specialist can provide information about independent third-party organizations that may be able to help with travel costs to and from the doctor’s office, including gas, tolls, parking, and taxi, bus, or train fare. Financial and medical eligibility requirements vary by organization.
REIMBURSEMENT ASSISTANCE

Celgene Patient Support®
Specialists are available to assist with each of the following steps in the insurance approval process for prescribed Celgene medications.

Benefits Investigation
• Initiate a benefits investigation to determine co-payment and other out-of-pocket costs
• Assess prior authorization or precertification requirements
• Educate patients about insurance coverage or other programs for which they may qualify.

Prior Authorization/ Precertification Assistance
• Assist with the prior authorization or precertification process by providing the necessary forms for completion
• Follow up with the insurance provider to determine the outcome
• Celgene provides a facilitation service and will not provide any medical input into a prior authorization.

Appeals Assistance
• Provide information about the appeals process after a denied prior authorization, precertification, and/or claim
• Supply a checklist of the required documentation for submission to the insurance company
• Submit the appeal to the insurance company at the request of the patient and follow up on the status until a decision is reached
• Celgene provides a facilitation service and will not provide any medical input into an appeal.

To enroll, download the English or Spanish enrollment form at celgenepatientsupport.com/enrollment/email-or-fax and fax the completed form to 1.800.822.2496, or email it to patientsupport@celgene.com, or submit the form online. For more information, call 1.800.931.8691.
**PATIENT ASSISTANCE**

**Coherus COMPLETE™**

Coherus COMPLETE provides a suite of patient support services and programs designed to assist with patient access.

**Coherus COMPLETE Co-Pay Assistance Program**

The Coherus COMPLETE Co-Pay Assistance Program provides for $0 out-of-pocket cost for each Udenyca dose. Our program can help eligible patients who are commercially insured with out-of-pocket costs for Udenyca. The maximum benefit per claim is up to $7,200 with a maximum annual benefit of $15,000 per 12-month enrollment period. Co-pay claim is processed like secondary insurance; no physical co-pay card is required.

To be eligible for the Co-Pay Assistance Program, patients:

- Must be prescribed Udenyca for a medically appropriate use
- Must have commercial health insurance that covers the medication costs of Udenyca
- Must not be covered by any federal, state, or government-funded healthcare program such as Medicare, Medicaid, Medicare Advantage, Medicare Part D, Veterans Affairs, the Department of Defense, or TRICARE
- Must not seek reimbursement amount received from Coherus from any third-party payers, including flexible spending accounts or healthcare savings accounts.

To enroll, visit copay.coheruscomplete.com and follow the instructions.

**Patient Assistance Program**

Udenyca can be provided at no cost to eligible uninsured and underinsured patients with financial hardship through the Patient Assistance Program (PAP). Eligibility criteria:

- Uninsured or functionally uninsured
- United States citizen or resident and must physically reside in the U.S. or a U.S. territory
- Be under the care of a U.S. licensed provider with an established practice located in the U.S.
- Patients who appear to be Medicaid eligible must have received a denial from Medicaid
- Diagnosis and dosing must be consistent with Udenyca’s FDA approved label
- Adjusted annual household income of ≤ 500% of Federal Poverty Level (FPL)
- Patient must agree to "soft" credit check if no required income documentation is provided.

To enroll, visit login.coheruscomplete.com and follow the instructions.

**INSURANCE BENEFIT VERIFICATION**

- Provides comprehensive product-specific coverage assessments
- Most benefit verification outcomes returned in one business day.
Comprehensive Prior Authorization (PA) Services
- Identification of payer PA requirements
- PA submissions
- PA tracking by following up with payers on PA determinations
- Sample letter of Medical Necessity
- Other Udencya specific information requested by the payer.

Coding and Billing Support
- Verify codes submitted
- Assists with claims submission questions.

For more information you can call 1.844.483.3692, or go to https://www.coheruscomplete.com/home.html
PATIENT ASSISTANCE

The Eisai Patient Assistance Program
Eisai has established the Patient Assistance Program for patients who need assistance paying for certain Eisai medications. This program provides medications at no cost to financially needy patients who meet program eligibility criteria.

To enroll for Lenvima, complete and submit the Lenvima Eisai Assistance Program Enrollment Form (http://www.eisaireimbursement.com/-/media/Files/XRay/Lenvima/LENVIMA-Eisai-Assistance-Program-Enrollment-Form.pdf) and fax the completed form to 1.855.246.5192, or call 1.866.61. EISAI (1.866.613.4724) for more information.

For Halaven, Eisai has created the Halaven Patient Assistance Program for customers who need assistance paying for Halaven. This program provides Halaven at no cost to patients who meet program eligibility criteria. Healthcare providers can call the program at 1.866.61. EISAI (1.866.613.4724), Monday through Friday, 8:00 am to 8:00 pm ET to determine eligibility.

Eisai reserves the right, at its sole discretion, to discontinue the Patient Assistance Program or change the qualifications at any time. All patient information remains confidential. Product supply for the program depends upon availability.

$0 Co-Pay Program
Commercially insured patients prescribed Halaven or Lenvima may be eligible for the $0 Co-Pay Program. Under this program, commercially insured patients pay a $0 co-pay on each prescription with an annual limit. Limits vary depending on the Eisai medication you have prescribed.

• For patients prescribed Halaven, the maximum benefit paid by Eisai Inc. will be $18,000 per year.
• For patients prescribed Lenvima, Eisai Inc. provides up to $40,000 per year to assist with out-of-pocket costs.

Enrollment in the $0 Co-Pay Program is automatic if the patient is receiving Lenvima from Accredo, Biologics, or CVS specialty. The Program is not available to patients eligible for state or federal healthcare programs, including Medicare, Medicaid, Medigap, VA, DoD, or TRICARE. Depending on the insurance plan, patients could have additional financial responsibility for any amounts over Eisai’s maximum liability.

Complete and submit the Lenvima Intake Form (http://www.eisaireimbursement.com/-/media/Files/XRay/Lenvima/LENVIMA-Pan-Tumor-Intake-Form.pdf) or call 1.866.61. EISAI (1.866.613.4724) for more information.

If you have prescribed Halaven there is a multi-step enrollment process, outlined below:

Step 1: Complete and submit an enrollment form (eisaireimbursement.com/-/media/Files/XRay/Halaven/Halaven-0Copay-Enrollment-Form.pdf) signed by both you and your patient.

Step 2: If the patient is determined to be eligible they will be sent a welcome letter and a card. This card should be given to the provider’s office so that it can be used to process the virtual debit card payment.

Step 3: Fax the Explanation of Benefits (EOB) or detailed Specialty Pharmacy receipt for the Halaven claim to 844.745.2350. The following information should be included:
• Patient’s information including full name
• Date of service
• Cost of the medication
• Amount covered by the insurance
• Patient’s financial responsibility: deductible; co-payment; and co-insurance.

Step 4: If the patient’s claim is approved, the appropriate funding based on the patient’s out-of-pocket costs will be loaded onto the patient’s card and a confirmation letter will be sent to you and your patient.

Restrictions and Conditions
Eligibility Criteria: Good toward the purchase of prescribed, eligible Eisai medication. No substitutions permitted. Not available to patients enrolled in state or federal healthcare programs, including Medicare, Medicaid, Medigap, VA, DoD, or TRICARE. May not be combined with any other coupon, discount, prescription savings card, free trial, or other offer. Federal law prohibits the selling, purchasing, trading, or counterfeiting of this card. Such activities may result in imprisonment of 10 years, fines up to $25,000, or both. Void outside the U.S. and where prohibited by law. Eisai Inc. reserves the right to rescind, revoke, or amend this offer at any time without notice. Patients and pharmacies are responsible for disclosing to insurance carriers the redemption and value of the card and complying with any other conditions imposed by insurance carriers or third-party payers. The value of this card is not contingent on any prior or future purchases.

The card is solely intended to provide savings on any purchase of the approved Eisai medication. Use of the card for any one purchase does not obligate the patient to make future purchases of the same Eisai medication or any other product. For patients prescribed Lenvima, this offer will expire March 31, 2020. For patients prescribed Halaven, this offer will expire November 20, 2021.

REIMBURSEMENT ASSISTANCE

The Eisai Assistance Program provides information to patients and healthcare professionals regarding the patient’s insurance benefits for coverage of certain Eisai medications.

For Halaven, specialists can provide information about coverage for Halaven, as well as information about programs that may help eligible patients afford their medication. Call 1.866.61.EISAI (1.866.613.4724) Monday through Friday, 8:00 am to 8:00 pm ET for all questions.

For Lenvima, specialists will complete a full benefit investigation to understand the patients’ insurance coverage. If needed, specialists can also discuss options for financial assistance to help patients access Lenvima. Contact 1.866.61.EISAI (1.866.613.4724) Monday through Friday, 8:00 am to 8:00 pm ET.
FOR PATIENTS

Lilly PatientOne
Lilly PatientOne (lillypatientone.com) strives to offer reliable and individualized treatment support for eligible patients prescribed a Lilly Oncology product. For those who qualify, help can be provided in the following ways:

• Evaluate financial assistance options, including co-pay programs and independent patient assistance foundations
• Provide reimbursement assistance (eligibility determination, benefits investigation, prior authorization assistance, appeals information).

Lilly PatientOne Co-Pay Program
With the Lilly PatientOne Co-Pay Program, eligible patients pay as little as $25 co-pay for certain prescribed Lilly oncology products up to a $25,000 annual maximum benefit for commercially insured patients. There are no income requirements.

Eligibility criteria:
• Patient must be treated with Alimta, Cyramza, Erbitux, or Portrazza for an FDA-approved indication
• Patients must be commercially insured.

Ineligible:
• Patients enrolled in Medicaid, Medicare, Medigap, CHAMPUS, DOD, VA, TRICARE, or any state, patient, or pharmaceutical assistance program
• Patients enrolled in any other financial support program, discount, discount card, or incentive program involving Alimta, Cyramza, Erbitux, or Portrazza
• Patients, pharmacists, and prescribers must not seek reimbursement from health insurance or any third party for any part of the benefit received by the patient through this program.

Patient Enrollment Steps:
1. Review program eligibility with your patient based upon the full criteria listed in the application
2. Apply online at lillypatientone.com or download an application (lillypatientone.com/assets/pdf/patient_assistance_program_application.pdf) to complete and fax with all required signatures to 1.877.366.0585
3. Your patient’s application will be reviewed to determine eligibility
4. The program may provide support for doses with a date of service that falls within 120 days before the date the application is received by the program.

After submitting the Lilly PatientOne Co-pay Program application, patients and providers will be informed of program enrollment status by Lilly PatientOne, indicating whether the patient meets eligibility requirements. Approved patients will receive a welcome letter and the co-pay card in the mail from Lilly PatientOne. Providers will be informed of patients’ enrollment status through a faxed letter with specific instructions on how claims can be filed. The physician’s office staff should remind patients to bring their co-pay card with them to their next appointment.

For questions or concerns, please call PatientOne 1.866.4PatOne, Monday through Friday, 9:00 am to 7:00 pm ET.
Lilly Cares Foundation
The Lilly Cares Foundation, Inc., a separate nonprofit organization, provides free Lilly medicines to qualifying patients. For more information about Lilly Cares, please visit LillyCares.com.

Independent Patient Assistance Program Foundations
There may be a way to help your underinsured patients get the treatment they need with less financial stress. If your patients can’t afford their co-pay or coinsurance, Lilly PatientOne provides information about a number of independent patient assistance programs that may be able to help eligible patients. These foundations are not affiliated with Eli Lilly and Company and have been established and are operated independently. Funding availability changes weekly, so contact a Lilly PatientOne representative at 1.866.4PatOne (1.866.472.8663) for the most recent updates.

Verzenio Continuous Care™ Program
The Verzenio Savings Card is available to eligible commercially insured patients who can pay as little as $0 a month with insurance provider coverage and a valid prescription for a 28-day supply of Verzenio. Digital cards can be downloaded online; preprinted physical cards are available from your Lilly Sales Specialist for distribution to patients. This offer is good for up to 12 months until December 31, 2021, with a $25,000 maximum annual cap.

This offer is invalid for patients without commercial drug insurance or those whose prescription claims are eligible to be reimbursed, in whole or in part, by any governmental program. Offer void where prohibited by law. Offer may be subject to monthly and annual cap of wholesale acquisition cost plus usual and customary pharmacy charges. Additional details and restrictions apply.

To download for the Verzenio Savings Card, visit verzenio.com/hcp/savings-support and follow the instructions there.

REIMBURSEMENT ASSISTANCE
Lilly PatientOne
If an insurance claim is denied, Lilly PatientOne can provide information to help you file an appeal on your patient’s behalf. Lilly PatientOne help you understand what documents and information you’ll need and the deadlines you’ll have to meet.

Lilly PatientOne also lists resources for coding, coverage, reimbursement, and appeals online at www.lilypatientone.com.

If you have questions about filing an appeal, please call at 1.866.4PatOne (1.866.472.8663).

Verzenio Continuous Care™ Program
The Verzenio Continuous Care Program provides an umbrella of support options tailored to a patient’s entire Verzenio treatment journey.

Once enrolled in the Verzenio Continuous Care Program, patients will have access to the following:
• Assistance with insurance and coverage
• MyFastRX Accelerated Initiation Program
• Dedicated support staff
• MyRightDose: a dose exchange program
• Verzenio Savings Card

Enrolling in the Verzenio Continuous Care Program will provide patients with assistance with insurance and coverage.

Through benefits investigation, patients understand their coverage options, locate the appropriate pharmacy, and identify their lowest possible out-of-pocket cost. A field reimbursement manager helps patients access prescribed Lilly FDA-approved medicines.

To enroll, download and complete the Verzenio Continuous Care Enrollment Form (verzenio.com/assets/pdf/HCP_Enrollment_Form.pdf) and fax all pages with prescriber and patient signature to 1.855.545.5957. Call 1.844.VERZENIO (1.844.837.9364) with additional questions or concerns.

MyRightDose Exchange Program
With MyRightDose, your patient can continue their Verzenio therapy at the proper dose for them without the hassle of delays and or additional co-pays. Medication is shipped to the patient as early as 48 hours after receipt of the enrollment form. Medication is available at no cost for up to three separate dose in a 12-month period. The quantity to be exchanged should be between 5 and 28 days per exchange. Additional terms and conditions apply.

To enroll, download and complete the MyRightDose Dose Exchange Program Enrollment Form (verzenio.com/assets/pdf/MyRightDose_Enrollment_Form.pdf) and fax the completed form to 1.833.665.6329. For more information, call 1.833.557.2417, Monday through Friday, 9:00 am to 6:00 pm ET, or visit verzenio.com.
PATIENT ASSISTANCE

CoverOne®
Patient Assistance Program

CoverOne includes a patient assistance program that provides Bavencio at no charge for patients who meet certain income, insurance (i.e., uninsured), and residency eligibility criteria. To determine patient eligibility, patients and providers should complete a CoverOne Enrollment Form on the CoverOne Enrollment Portal (coverone.com/en/portal/log-in.html) prior to treatment or fax the completed form to 1.800.214.7295 prior to treatment.

Patient assistance is not applied retroactively. A CoverOne representative will notify patients and providers as soon as possible with the patient’s eligibility determination.

NOTE: The CoverOne patient assistance program is a philanthropic program for patients in need, and is not contingent on any past or future commercial sale.

Co-Pay Assistance Program

CoverOne provides co-pay assistance for privately insured Bavencio® patients with co-pay/co-insurance responsibilities who meet the program eligibility criteria.

Healthcare professionals may submit an application for co-pay assistance for their privately-insured patients by submitting an enrollment form through the CoverOne Enrollment Portal (https://www.coverone.com/en/portal/log-in.html) or by faxing a completed Enrollment Form to 1-800-214-7295. The offer is not valid for medicines that are eligible to be reimbursed, in whole or in part, by Medicaid, Medicare, or other federal or state healthcare programs. Full terms and conditions for co-pay assistance can be found at coverone.com.

Enrolled patients may be eligible for a $0 co-pay for each treatment for Bavencio, up to a maximum of $30,000 per year. Once the annual co-pay assistance limit is reached, enrolled patients are responsible for paying all co-pays and any balance not covered by CoverOne.

Enrollment in the co-pay assistance program does not guarantee assistance. Whether an expense is eligible for the CoverOne Co-Pay assistance benefit will be determined at the time the benefit is paid. Eligible co-pay expenses must be in connection with a separately paid claim for Bavencio administered in an outpatient setting, which is otherwise covered by a private or commercial insurance plan.

The patient co-pay assistance program is not contingent on any past or commercial sale of Bavencio. The co-pay program does not assist with inpatient hospital claims or in any bundled payment arrangement where there is no separate patient co-pay for Bavencio, and does not assist with healthcare premiums or drug administration services.

When Bavencio is used in combination with axitinib, questions related to reimbursement and access for axitinib may be referred to Pfizer Oncology Together. Pfizer Oncology Together provides personalized support and financial assistance resources to help patients access their prescribed axitinib. To learn more, call 1.877.744.5675, Monday through Friday, 8:00 am to 8:00 pm ET or visit pfizeroncologytogether.com.

REIMBURSEMENT ASSISTANCE

CoverOne

CoverOne will help providers and patients understand the specific coverage and reimbursement guidelines for Bavencio. Reimbursement
support services include:
• Insurance benefit verification
• Prior authorization assistance
• Information on relevant billing codes for Bavencio (HCPCS, CPT, ICD-10-CM, NDC)
• Denied/underpaid claims assistance
• Payer research (non-patient specific)
  • Medicare, private payers, state Medicaid.

EMD Serono, Inc. and Pfizer, Inc. do not guarantee coverage and/or reimbursement for Bavencio. Coverage, coding, and reimbursement policies vary significantly by payer, patient, and setting of care. Actual coverage and reimbursement decisions are made by individual payers following the receipt of claims. Patients and healthcare professionals should always verify coverage, coding, and reimbursement guidelines on a payer and patient-specific basis.

Enroll through the CoverOne Enrollment Portal, https://www.coverone.com/en/portal/log-in.html or fax a completed CoverOne Enrollment Form to 1.800.214.7295 to request services.

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**Active Listening 101**

Active listening is a communication technique that requires the listener to feed back what is heard to the speaker by re-stating or paraphrasing what was heard in the listener’s own words. Active listening improves personal relationships, reduces misunderstanding and conflicts, strengthens cooperation, and fosters understanding. The skill is proactive, accountable, and professional.

Active listening is comprised of three primary elements: comprehension, retention, and response.

**Comprehension**—develop a shared meaning between parties through tone of voice, use of vocabulary and context, and speech pattern.

**Retention**—take notes if necessary.

**Response**—respond both verbally and non-verbally.

**Active Listening Tactics**

• Listen and hear rather than waiting to speak.
• Watch body language.
• Find common ground.
• Paraphrase the speaker’s words back to him or her as a question. (“I see/hear/feel like you are afraid of…”)
• Suspend your own frame of reference and judgments.
• Validate what the speaker is saying and feeling (“You seem to feel angry, is that because…?”)

**Barriers to Active Listening**

• Distractions
• Trigger words
• Vocabulary
• Limited attention span
• Emotions
• Noise and visual distraction
• Cultural differences
• Interrupting or influencing

Source. ACCC Financial Advocacy Network. accc-cancer.org/FAN
PATIENT ASSISTANCE

**Cabometyx Exelixis Access Services**

Exelixis Access Services (EASE) provides a variety of support to help patients get started on treatment as soon as possible. EASE can meet the unique needs of your patients and practice at each step along the access journey. EASE case managers are your single point of contact at EASE and can provide the status of your patients’ access journey, offer prompt support with payer coverage, financial assistance, and treatment coordination, and provide proactive follow-up.

- **The EASE $0 Co-Pay Program** ensures that eligible commercially insured patients pay $0 per month for a maximum benefit of $25,000 per year. Additional restrictions and eligibility rules apply. Visit activatethecard.com/7311 to enroll eligible patients.
- **The 15-Day Free Trial Program** provides free drug to help patients start treatment quickly. Limited to on-label indications. Additional restrictions and eligibility rules apply.
- **At your request, EASE can provide support with benefits investigation, prior authorization (PA) assistance, and appeals support and follow-up.**

To apply for these services, download and complete the EASE Enrollment Form (cabometyxhcp.com/downloads/CABOMETYX-EASEEnrollmentForm.pdf) and fax it to 1.844.901.EASE (1.844.901.3273). For more information, call 1.844.900.EASE (1.844.900.3273), Monday through Friday, 8:00 am to 8:00 pm ET.

**EASE Dose Exchange Program**

The EASE Dose Exchange Program can help ensure the continuity of your patient’s care by providing a lower dose when a dose adjustment is required. Patients receive a one-time supply of Cabometyx to help them transition to a lower dose; 15 days of free product are provided in the event a dose reduction is required. Additional restrictions and eligibility rules apply. To apply, complete the EASE Dose Exchange Form (cabometyxhcp.com/downloads/DoseExchangeForm.pdf) and fax it to 1.844.901.EASE (1.844.901.3273). For more information, call 1.844.900.EASE (1.844.900.3273), Monday through Friday, 8:00 am to 8:00 pm ET.

**Cometriq Exelixis Access Services**

EASE can provide healthcare professionals and patients with access and financial support. EASE Case Managers are available by phone to help with:

- Insurance-related issues
- Financial assistance.

If a patient cannot afford Cometriq medicine, EASE Case Managers are available to help with:

- **The EASE Co-Pay Program** provides eligible commercially

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**Patient and Reimbursement Assistance Websites**

- ease.us
- cometriq.com/hcp/access/
insured patients with Cometriq for $0 per month. The program covers the remaining out-of-pocket drug costs, up to a $25,000 yearly limit. Patients with government insurance are excluded. Additional restrictions and eligibility rules apply.

- The EASE Patient Assistance Program may provide Cometriq free of charge to patients who do not have insurance coverage, or insured but still cannot afford the medicine, and who meet eligibility requirements. Additional restrictions and eligibility rules apply.

For more information and to enroll in EASE for Cometriq, call 1.844.900.EASE (1.844.900.3273), Monday through Friday, 8:00 am to 8:00 pm ET.

REIMBURSEMENT ASSISTANCE

Cabometyx Exelixis Access Services

At your request, EASE can provide support with benefits investigation, prior authorization assistance, and appeals support and follow-up.

For more information, call 1.844.900.EASE (1.844.900.3273), Monday through Friday, 8:00 am to 8:00 pm ET.

This description of the Exelixis Access Services program is for informational purposes only. Exelixis makes no representation or guarantee concerning reimbursement or coverage for any service or item. Information provided through the Exelixis Access Services program does not constitute medical or legal advice and is not intended to be a substitute for a consultation with a licensed healthcare provider, legal counsel, or applicable third-party payer(s). Exelixis reserves the right to modify the program at any time without notice.

### Insurance Verification Form

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<td>Primary Insurance? Secondary? Tertiary?</td>
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<td>Specific Pharmacy Requirement:</td>
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<td>Co-insurance/Co-pay:</td>
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<td>Cap for drugs or diagnosis:</td>
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<td>Catastrophic Coverage or Stop-loss When?</td>
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<td>Part B</td>
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<td>Co-insurance?</td>
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<td>Prescription Drugs?</td>
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<td>Medicaid?</td>
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<tr>
<td>Spend Down?</td>
<td>Yes</td>
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<td>Share of Costs:</td>
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<tr>
<td>Spend Down Amount $:</td>
<td>____________________</td>
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</tbody>
</table>

Source: ACCC Financial Advocacy Network. accc-cancer.org/FAN
PATIENT ASSISTANCE

Genentech Access Solutions
The Genentech Patient Foundation

The Genentech Patient Foundation gives free Genentech medicine to people who don’t have insurance coverage or who have financial concerns. Patients will get free Genentech medicine if they:
- Do not have insurance or coverage for their Genentech medicine and their household makes less than $150,000 per year
- Have insurance, but can’t afford their out-of-pocket costs, have pursued other forms of financial assistance and meet certain income requirements (found online at https://www.gene.com/patients/patient-foundation/apply-for-help).

If one of these situations applies fax the completed Enrollment Form (gene.com/download/pdf/Genentech_Patient_Foun-
dation_Enrollment_Form.pdf) to 833.999.4363. You can expect to hear from a Foundation Specialist to let you know if the application was approved or if more information is needed. Once the application is approved, it will send the Genentech medicine to the patient or the health care provider’s office as directed on the form as quickly as possible.

For more information, call 888.941.3331, Monday through Friday, 6:00 am to 5:00 pm ET.

Genentech BioOncology® Co-pay Assistance Program

This co-pay assistance program helps eligible patients pay for prescription medication costs. Qualified patients must:
- Be covered by commercial or private insurance
- Receive a Genentech BioOncology product for an FDA-approved indication
- Not participate in a government-funded healthcare program, such as Medicare, Medicaid, Medigap, VA, DoD, or TRICARE
- Be 18 years of age and older
- Live in and receive treatment in the United States or U.S. Territories
- Not be receiving assistance through the Genentech Patient Foundation or any other co-pay charitable organization.
- There is no income requirement

Approved patients pay as little as $5 for their prescribed Genentech BioOncology products with an annual benefit limit of $25,000 per product. The $5 co-pay applies to FDA-approved Genentech combination products. Retroactive requests for assistance may be honored for qualifying patients if the infusion or prescription fill occurred within 120 days prior to enrollment and the patient meets all eligibility criteria at the time of infusion. No physical card is needed; patients simply need their Member ID.

To get started, visit copayassistantcenow.com. For questions about

Oncology-related products: Alecensa® (alectinib) capsules, Avastin® (bevacizumab) injection, Cotellic® (cobimetinib) tablets, Erivedge® (vismodegib) capsules, Gazyva® (obinutuzumab) injection, Herceptin® (trastuzumab), Herceptin Hyllecta™ (trastuzumab and hyaluronidase-oysk), Kadcyla® (ado-trastuzumab emtansine), Perjeta® (pertuzumab) for injection, Polivy® (polatuzumab vedotin-piqv) injection, Rituxan® (rituximab), Rituxan Hycrea® (rituximab and hyaluronidase human) for injection, Rozlytrek™ (entrectinib), Tarceva® (erlotinib) tablets (co-marketed with Astella Pharma US, Inc.), Tecentriq® (atezolizumab) for injection, Venclexta® (venetoclax) tablets, Zelboraf® (vemurafenib) tablets

Genentech, Inc.

Patient and Reimbursement Assistance Website
genentech-access.com
this program, call 855.MY.COPAY (855.692.6729), Monday through Friday, 9:00 am to 8:00 pm ET.

**Referrals to Co-pay Assistance Foundations**

If patients need help with their co-pay for Genentech medications, Genentech Access Solutions can refer them to an independent co-pay assistance foundation. An independent co-pay assistance foundation is a charitable organization that gives financial assistance for medicines.

Independent co-pay assistance foundations have their own rules for eligibility. Genentech cannot guarantee a foundation will help the patient, but can refer to a foundation that supports the disease state. This information is provided as a resource. Genentech does not endorse or show financial preference for any particular foundation. Listed foundations are not the only ones that might be able to help.

To get started, visit genentech-access.com, select a medication, and follow the directions for specific indications.

**REIMBURSEMENT ASSISTANCE**

**Genentech BioOncology Access Solutions**

**Benefits Investigation**

Genentech BioOncology Access Solutions can conduct a benefits investigation (BI) to help you determine if a Genentech medicine is covered, which specialty pharmacy (SP) the health insurance plan prefers, and if patient assistance might be needed. The potential outcomes of a BI are:
- Treatment is covered
- Prior authorization is required
- Treatment is denied.

Both the Prescriber Service Form and the Patient Consent Form must be received before Genentech BioOncology Access Solutions can begin helping your patient. Forms can be found by going to genentech-access.com, selecting the prescribed medication, and selecting the “Forms and Documents” section.

**Prior Authorization Assistance**

Access Solutions can help you identify if a prior authorization (PA) is necessary and offer resources as to obtain it. Both the Prescriber Service Form and the Patient Consent Form must be received before Genentech BioOncology Access Solutions can begin helping your patient.

If the request for a PA is not granted, your BioOncology Field Reimbursement Manager (BFRM) or Genentech BioOncology Access Solutions Specialist can work with the patient and provider to determine next steps.

**Appeals**

If the patient’s health insurance plan has issued a denial, a BFRM or Access Solutions Specialist can provide resources as the patient and provider prepare an appeal submission per the patient’s plan requirements.

If a plan issues a denial:
- The denial should be reviewed, along with the health insurance plan’s guidelines to determine what to include in your patient’s appeal submission
- The BFRM or Access Solutions Specialist has local payer coverage expertise and can help determine specific requirements for the patient.

Sample letters and additional considerations are available at genentech-access.com by selecting the prescribed medication and selecting the “Forms and Documents” section. Appeals cannot be completed or submitted by Genentech BioOncology Access Solutions Specialist on a provider’s behalf.

**My Patient Solutions™**

My Patient Solutions is an online tool to help you enroll patients in Genentech Access Solutions and manage your service requests.

Features of My Patient Solutions:
- Enroll and re-enroll patients
- Communicate with your Genentech Access Solutions Specialist
- See which service requests require action
- Co-pay assistance details
- View Benefits Investigation (BI) Reports
- Follow up on prior authorizations (PAs) or appeals
- Request benefits reverifications.

To register, visit genentech-access.com and follow the instructions. For assistance, call 866.422.2377, Monday through Friday, 6:00 am to 5:00 pm ET.
IncyteCARES

IncyteCARES (Connecting to Access, Reimbursement, Education and Support) is designed to help eligible patients gain access to Jakafi. IncyteCARES provides a single point of contact through a registered nurse. IncyteCARES nurses work one-on-one with patients to identify ongoing support, resources, and referrals to help meet their needs during treatment with Jakafi. Specifically, IncyteCARES nurses can help eligible patients with:
• Reimbursement support
• Delivery coordination
• Financial assistance options
• Temporary access for coverage delays
• Connection to support resources
• Ongoing education and support.

To enroll, patients and providers will need to complete either the online enrollment form (incytecares.com/enrollment.aspx) or hard-copy enrollment form (incytecares.com/pdf/jakafi-enrollment-form.pdf). Please note that once online enrollment has begun, the user will not be able to exit and return to it later as their information will not be saved.

Completed hard-copy forms should be faxed to 1.855.525.7207. Once the IncyteCARES program receives the completed enrollment form, the program will:
• Confirm the patient’s drug coverage for Jakafi
• Coordinate their Jakafi prescription with the appropriate specialty pharmacy
• Determine if the patient qualifies for any financial assistance
• Provide ongoing education and support.

For additional help, call an IncyteCARES registered nurse at 1.855.4.JAKAFI (1.855.452.5234), Monday through Friday, 8:00 am to 8:00 pm ET.

Patient Assistance Program

Patients who do not have prescription drug coverage for Jakafi may be eligible to receive the drug free of charge through the IncyteCARES Patient Assistance Program. This program helps people who do not have a prescription drug plan, as well as those whose plans have turned them down for Jakafi treatment. Certain conditions do apply for the free medication program. Patients may be eligible if they are a resident of the U.S. or Puerto Rico, and their household size and annual income meet certain criteria, including earning less than $125,000 a year or less than 600% of the Federal Poverty Level (FPL). In addition, patients insured through Medicare, Medicaid, TRICARE, and any state medical assistance program are not eligible. An IncyteCARES nurse can help determine if patients qualify for patient assistance. For additional help, call an IncyteCARES registered nurse at 1.855.4.JAKAFI (1.855.452.5234).

Co-pay/Coinsurance Assistance

Eligible patients may pay as little as $0 per month for Jakafi. Patients may be eligible for co-pay/coinsurance assistance if they are a resident of the U.S. or Puerto Rico, and they have a valid prescription for Jakafi for an FDA-approved treatment. Offer is not valid if patients are uninsured or paying cash for their prescription. Not valid for patients enrolled in state or federally-funded healthcare programs, such as Medicare, Medicaid, or TRICARE. Patients must have minimum out-of-pocket cost of $0.01 to redeem. Card is valid through December 31 of the year of activation. On January 1 of the following year, the card automatically resets and is subject to annual limits if the prescription
benefit remains the same. Amount of savings of the purchase of Jakafi will not exceed $11,977 per month and $25,000 per year. Limit one 30-day supply per 30 days. Massachusetts residents, this offer expires on January 1, 2020 absent a change in Massachusetts law.

**Temporary Access Program**
Eligible patients experiencing coverage delays can receive a free supply of Jakafi. To be eligible, patients must submit a proof of insurance claim verifying the delay. Free product is offered to eligible patients without any purchase contingency or other obligation. For more information, contact an IncyteCARES registered nurse at 1.855.4.JAKAFI (1.855.452.5234).

**Referral to an Independent Nonprofit Organization**
IncyteCARES can also provide information to patients about independent nonprofit organizations and foundations that may be able to help with copays and more. For more information, contact an IncyteCARES registered nurse at 1.855.4.JAKAFI (1.855.452.5234).

**REIMBURSEMENT ASSISTANCE**

**IncyteCARES**
IncyteCARES may be able to help eligible patients reduce concerns about their prescription drug coverage and cost for Jakafi. When patients are enrolled in IncyteCARES, they can talk one-on-one with a registered nurse to help you with questions about coverage.

**Benefit Verification**
An IncyteCARES registered nurse will be the single point of contact in working with the healthcare professional’s office and patients to help determine prescription drug coverage. An IncyteCARES registered nurse will find out if your insurance will cover Jakafi and the amount you may need to pay. IncyteCARES may help you receive Jakafi by eliminating possible barriers.

**Prior Authorizations and Insurance Appeals**
If needed, an IncyteCARES registered nurse will work with eligible patients and healthcare professionals to provide information about prescription drug plan requirements that must be met to get access to Jakafi. Some plans may require a prior authorization, which means they will ask for more information from your healthcare professional before deciding how much you will need to pay for your Jakafi. IncyteCARES will work with your healthcare professional’s office as the office responds to and provides this information to your plan.

In addition, if an insurance company says it will not pay for Jakafi, IncyteCARES can help you and your healthcare professional understand why coverage was denied and information about appealing the denial.
PATIENT ASSISTANCE

IPSEN CARES®
The IPSEN CARES® (Coverage, Access, Reimbursement & Education Support) serves as a central point of contact between patients, caregivers, doctors’ offices, insurance companies, and specialty pharmacies. Our Patient Access Specialists will check each patient’s pharmacy and medical benefits to determine if the drug is covered for the indication the treating physician has specified. If there are any restrictions, IPSEN CARES will inform the doctor about the additional information required by the insurance company for the doctor’s completion. Patients and providers can call 1.866.435.5677, Monday through Friday, 8:00 am to 8:00 pm ET, to begin the enrollment process. You can also enroll patients through the online provider portal at: ipsencaresportal.biologicsinc.com/Account/Login or download the drug-specific enrollment form from ipsencares.com and fax the signed and completed form to 1.888.525.2416. IPSEN CARES offers the following services for patients:
- Reimbursement assistance
- Copayment assistance
- Patient assistance program
- 360° communication.

Somatuline Depot Copay Assistance Program
Most eligible patients with private insurance pay no copay subject to a maximum annual benefit of $20,000. Program exhausts after 13 injections, or a maximum annual benefit of $20,000, whichever comes first. Cash-pay patients are eligible to participate. For cash-pay patients, the maximum copay benefit amount per prescription is $1,666.66, subject to the annual maximum of $20,000 in total. Patient pays any amount greater than the maximum copay savings amount per prescription. Patients must enroll every 12 months from date of acceptance to receive a continued benefit. Patients are not eligible for copay assistance through IPSEN CARES if they are enrolled in any state or federally funded programs for which drug prescriptions or coverage could be paid in part or in full, including, but not limited to, Medicare Part B, Medicare Part D, Medicaid, Medigap, VA, DoD, or TRICARE (collectively, “Government Programs”), or where prohibited by law. For patients with government-provided insurance, IPSEN CARES may be able to offer the contact information for independent nonprofit foundations that may be able to offer financial assistance. The maximum copay benefit per prescription for cash-paying patients is $1,666.66, subject to the $20,000 annual maximum. For more information, visit ipsencares.com/somatuline-patient-support or call 1.866.435.5677.

Onivyde Copay Program
Most eligible, commercially insured patients pay no copay ($0 copay), with an annual maximum benefit of $20,000. Cash-pay patients are eligible to participate. Patients are not eligible for copay assistance through IPSEN CARES if they are enrolled in any state or federally funded programs for which drug prescriptions or coverage could be paid in part or in full, including, but not limited to, Medicare Part B, Medicare Part D, Medicaid, Medigap, VA, DoD, or TRICARE (collectively, “Government Programs”), or where prohibited by law. For patients with government-provided insurance, IPSEN CARES may be able to offer the contact information for independent nonprofit foundations that may be able to offer financial assistance. The maximum copay benefit per prescription for cash-paying patients is $1,666.66, subject to the $20,000 annual maximum. For more information, visit ipsencares.com/onivyde-patient-support or call 1.866.435.5677.

Patient Assistance Program
The Patient Assistance Program (PAP) is designed to provide Ipsen medications at no cost to eligible patients. Patients may be eligible to receive free medication if they are experiencing financial hardship, have no insurance coverage, and received...
a prescription for on-label use of an Ipsen medication. Eligibility does not guarantee approval for participation in the program.

Both the patient and the healthcare provider have to complete the application. To enroll, visit ipsencares.com, select the appropriate medication, and either apply through the provider portal or complete the drug-specific form and fax it to 1.888.525.2416. For further assistance, call 1.866.435.5677, Monday through Friday, 8:00 am to 8:00 pm ET.

### REIMBURSEMENT ASSISTANCE

#### IPSEN CARES

IPSEN CARES offers the following reimbursement assistance services to patients and providers:

- **Benefits Verification:** Ipsen CARES verifies patients’ coverage, restrictions (if applicable), and copayment/coinsurance amounts.

- **Prior Authorization:** IPSEN CARES provides information on documentation required by payers on prior authorization specifics and make recommendations for next steps based on payer policy.

- **Appeals Information:** IPSEN CARES provides information on the payer-specific processes required to submit a level I or a level II appeal, as well as provides guidance as needed throughout the appeals process.

Visit ipsencares.com for more information or call 1.866.435.5677, Monday through Friday, 8:00 am to 8:00 pm ET.

### 2018-2019 Federal Poverty Guidelines*

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* Federal poverty level amounts are higher in Alaska and Hawaii.
PATIENT ASSISTANCE

Janssen CarePath
Janssen CarePath is your one source for access, affordability, and treatment support for your patients. Janssen CarePath helps verify insurance coverage for your patients, provides reimbursement information, helps find financial assistance options for eligible patients, and provides ongoing support to help patients start and stay on prescribed Janssen medications.

Access Support
Janssen CarePath helps verify insurance coverage for patients and provides reimbursement information. Offerings include:
• Benefits investigation
• Prior authorization support and status monitoring
• Information on the exceptions and appeals process
• Coding and billing information, if needed
• Triage to specialty pharmacy providers, if needed
• provider portal (janssencarepathportal.com) for online benefits investigation, prior authorization support, and other resources.

Affordability Support
Janssen CarePath can help find out what affordability assistance may be available for your patients taking Janssen medications, including:
• Support for patients using commercial or private insurance
• Support for patients using government insurance
• Support for patients without insurance coverage.

Treatment Support
Janssen CarePath provides additional support to patients, including:

Education tools
• Patient education brochures
• Web-based resources
• Assistance with identifying independent organizations which may provide assistance with costs associated with travel to and from treatment (not available for all Janssen products)
• Access to nurses who can answer patients’ questions about treatment
• AdvocacyConnector.com

Adherence tools
• Appointment reminders
• Access to the Care4Today® Connect mobile app
• Prescription refill reminders.

*The nurse program is limited to education for patients about their Janssen therapy, its administration, and/or their disease, and is not intended to provide medical advice, replace a treatment plan from the patient’s doctor or nurse, or provide case management services.

Eligible patients can be enrolled through the Janssen CarePath provider portal at janssencarepathportal.com. For questions, call 877.CarePath (877.227.3728), Monday through Friday, 8:00 am to 8:00 pm ET.

Janssen CarePath Savings Program
Janssen CarePath Savings Program can help eligible patients save on their out-of-pocket costs for their Janssen medication. Depending on their health insurance plan, savings may apply toward co-pay, co-insurance, or deductible. Patients may be eligible if they are using commercial or private health insurance to cover a portion of their medication costs for the Janssen medication. There is no income requirement. Not valid for patients using Medicare, Medicaid, or other government-funded healthcare programs to pay for their medications. Terms expire at the end of 2020.

Oncology-related products: Balversa™ (erdafitinib) tablets, Darzalex® (daratumumab) injection, Doxil® (doxorubicin hydrochloride liposome injection), Erleada® (apalutamide) tablets, Procrit® (epoetin alfa), Zytiga® (abiraterone acetate) tablets
each calendar year and may change. There is no income requirement.

**Janssen CarePath Savings Program for Erleada**
Eligible patients pay $0 per month, with a $15,000 maximum program benefit per calendar year or one-year supply, whichever comes first. Patients receive instant savings on their out-of-pocket costs for Erleada. To learn more about the Janssen CarePath Savings Program for Erleada, including full eligibility requirements, visit JanssenCarePath.com/Erleada.

**Janssen CarePath Savings Program for Zytiga**
Eligible patients pay $10 per month, with a $12,000 maximum program benefit per calendar year or one-year supply, whichever comes first. Patients receive instant savings on their out-of-pocket costs for Zytiga. To learn more about the Janssen CarePath Savings Program for Zytiga, including full eligibility requirements, visit JanssenCarePath.com/Zytiga.

**Janssen CarePath Savings Program for Darzalex**
Eligible patients will pay $5 per infusion, with a $20,000 maximum program benefit per calendar year. Patients may use their card to receive a rebate, or assign benefits directly to their treatment provider. To learn more about the Janssen CarePath Savings Program for Yondelis, including full eligibility requirements, visit JanssenCarePath.com/Yondelis.

### Other Affordability Options
For patients using government-funded healthcare programs or without health coverage, Janssen CarePath can provide information about other resources that may be able to help with out-of-pocket medication costs:

- State-Sponsored Programs
- Medicare Savings Program
- Medicare Part D Extra Help – Low-Income Subsidy
- Independent Foundations.†

Independent co-pay assistance foundations have their own rules for eligibility. Janssen has no control over these independent foundations and can only refer patients to a foundation that supports their disease state. Janssen does not endorse any particular foundation.

**Johnson & Johnson Patient Assistance Foundation**
The Johnson & Johnson Patient Assistance Foundation, Inc. (JPAF) is an independent, nonprofit organization that is committed to helping eligible patients without insurance coverage receive prescription products donated by Johnson & Johnson operating companies. To see if your patient might qualify for assistance, please contact a JPAF program specialist at 800.652.6227, Monday through Friday, 9:00 am to 6:00 pm ET, or visit the foundation website at www.JPAF.org.

### REIMBURSEMENT ASSISTANCE

**Janssen CarePath Provider Portal**
Janssen CarePath helps verify insurance coverage for patients and provides reimbursement information. Offerings include:

- Benefits investigation support
- Prior authorization support and status monitoring
- Information on the exceptions and appeals process
- Coding and billing information, if needed
- Triage to specialty pharmacy providers, if needed
- Provider portal for online benefits investigation, prior authorization support, and other resources.

Create a Provider Portal account at JanssenCarePathPortal.com.

**Janssen CarePath Account**
Patients can create a personal Janssen CarePath Account at MyJanssenCarePath.com where they can learn about support resources, get answers to questions about their insurance coverage, find affordability programs, and more.

Content paid for and written by Johnson & Johnson Health Care Systems Inc.
PATIENT ASSISTANCE

KaryForward™
A patient support and resource center for Karyopharm medications. KaryForward offers resources for eligible patients that may help with the cost of medication when it is not covered by insurance or if the patient does not have insurance. Restrictions apply and patients must meet certain eligibility criteria.

KaryForward support includes:
- Insurance related services
- Financial Assistance
- Patient assistance program
- KaryForward Support Program
- Quickstart program
- Bridge program
- Patient and caregiver educational starter kit.

All services and programs are subject to eligibility requirements. To enroll, download and complete the KaryForward Enrollment Form (karyforward.com/wp-content/uploads/2019/05/karyforward-enrollment-form.pdf), check all services the patient is applying for, and fax it to 1.833.589.1603.

For more information, call 1.877.KARY4WD (1.877.527.9493), Monday through Friday, 8:00 am to 5:00 pm ET.

Xpovio Co-Pay Card Program
The Xpovio Co-Pay Card program may help minimize the out-of-pocket cost for patients with commercial insurance. The co-pay card may allow eligible patients with commercial insurance pay as little as $5 per month, with a maximum of $8,000 per 30-day prescription and up to a maximum total of $25,000 per calendar year.

Patients must meet the following criteria to enroll:
- U.S. or U.S. territory residency. Program valid only in the United States and U.S. Territories.
- Patient has commercial (private) insurance that covers Xpovio
- Patient has a valid prescription for Xpovio that is consistent with the approved indication for multiple myeloma

Patients are not eligible if they are uninsured or if they participate in any federal or state health care program, including without limitation Medicare, Medicaid, Tricare, Veterans Health Administration. This offer is not valid for cash-paying patients, where Xpovio is not covered by the patient’s commercial insurance, or where the plan reimburses patients for the entire cost of the medication. Other restrictions may apply.

To enroll in the Xpovio Co-Pay Card Program, fill out the online form at qv.trialcard.com/xpovio#/app/layout/patient, or download and complete the KaryForward Enrollment Form (karyforward.com/wp-content/uploads/2019/05/karyforward-enrollment-form.pdf), check the “Financial Assistance” box, and fax it to 1.833.589.1603.

Xpovio QuickStart Program
Patients receiving their first Xpovio prescription who cannot ascertain coverage or verification of coverage within 5 business days may be eligible for this program. Please complete the KaryForward Enrollment Form (karyforward.com/wp-content/uploads/2019/05/karyforward-enrollment-form.pdf) prescription information and check the Xpovio QuickStart Prescription box. Fax the complete form to 1.833.589.1603.

For more information and questions, oncology nurse advocates are available Monday through Friday, 8:00 am to 8:00 pm ET at 1.833.BeiGene (1.833.234.4363).

Nurse Case Managers and Other Resources
KaryForward is pleased to offer patients and caregivers the option to receive additional support from...
a dedicated Nurse Case Manager. Your Nurse Case Manager can provide additional education regarding medication and can explain prescription instructions, what to expect when taking the medication, and the importance of talking to your healthcare professional about questions you may have. Your KaryForward Nurse Case Managers are there to support and work closely with your healthcare professional, not replace or provide medical advice.

Work with your healthcare professional to fill out the enrollment form to learn more about these services.

**REIMBURSEMENT ASSISTANCE**

**KaryForward™**
KaryForward offers resources for eligible patients that may help with the cost of medication when it is not covered by insurance or if the patient does not have insurance. Restrictions apply and patients must meet certain eligibility criteria.

KaryForward offers insurance related services including:
- Benefit investigation
- Prior authorization
- Appeal assistance

To enroll, download and complete the KaryForward Enrollment Form (karyforward.com/wp-content/uploads/2019/05/karyforward-enrollment-form.pdf), check “Insurance Related Services,” and fax it to 1.833.589.1603.

For more information, call 1.877.KARY4WD (1.877.527.9493), Monday through Friday, 8:00 am to 5:00 pm ET.
PATIENT AND REIMBURSEMENT ASSISTANCE

Kite Konnect™
Kite Konnect is committed to helping patients and healthcare teams throughout Yescarta treatment. Kite Konnect can assist with:

- **Patient enrollment**: Hospital portal access, cell order completion, and leukapheresis scheduling
- **Reimbursement support**: Benefits investigation, claims appeals, and support for eligible uninsured and underinsured patients
- **Logistics support**: Connecting patients with independent foundations to help with transportation and housing
- **Ongoing commitment**: cell order tracking and continuous communication.

Yescarta is only available at authorized treatment centers. To get your patients started with Yescarta, enroll your patient using the Kite Konnect Apheresis Collection App (Vineti Application) (kitekonnect.force.com/s/). For further information, contact 1.844.454.KITE (1.844.454.5483).

How to Check for Patient Understanding

A diagnosis of cancer is never easy. In addition to complex information about cancer treatment, patients and families must now understand and deal with the cost of treatment. It is even harder when patients have trouble paying for their medications and treatment. For some patients, the financial difficulties begin when they are first diagnosed with cancer. For others, financial pressures build up over the course of treatment. Before you can help these patients and families, you must first ensure that they understand the information you are sharing. Here are some statements or questions you can use to check how well a patient or family member understands the information you are providing.

✓ Please stop me if you do not understand something. I will be happy to go over the information again.
✓ Let me know if I am going too fast or too slow.
✓ Does this information make sense?
✓ Have I answered your question(s)?
✓ Do you have other questions at this time?
✓ Are you still with me?
✓ Am I overwhelming you with this information?
✓ Should I go into more detail?
✓ Tell me if I am unclear or if I use words that you do not understand.
✓ Please stop me if I begin to explain something that you already understand.
✓ Is the information I am providing helpful to you?

Source. ACCC Financial Advocacy Network. accc-cancer.org/FAN
PATIENT ASSISTANCE

Merck Access Program
The Merck Access Program (MAP) may be able to help answer questions about access and support, including:
• Benefit investigations, prior authorizations, and appeals
• Insurance coverage for patients
• Co-pay assistance for eligible patients
• Referral to the Merck Patient Assistance Program for eligibility determination
• Reimbursement.

To enroll, visit merckaccessprogram.com/hcp/, select the prescribed medication, and use the online portal or complete the appropriate sections of the enrollment form. For hardcopy forms, print and fax the completed form to 855.755.0518. A program representative will contact the patient and provider.

For further assistance, call 855.257.3932, Monday through Friday, 8:00 am to 8:00 pm ET.

Merck Helps™
Merck Helps is a Merck patient assistance program that provides certain medicines free of charge to eligible individuals, primarily the uninsured who, without assistance, could not afford needed Merck medicines. Individuals who don’t meet the insurance criteria may still qualify for the Merck Patient Assistance Program if they attest that they have special circumstances of financial and medical hardship, and their income meets the program criteria. A single application may provide up to 1 year of product free of charge to eligible individuals, and an individual may reapply as many times as needed.

Eligibility criteria include:
• Patient must be a Legal U.S. resident, including U.S. territories; patients do not have to be a U.S. citizen
• Patient does not have insurance or other coverage for prescription medicine
• Patient meets income requirements.
• Patient must have a prescription for a Merck product from a health care provider licensed in the United States.

If a patient does not meet the prescription drug coverage criteria, their income meets the program criteria, and there are special circumstances of financial and medical hardship that apply to the patient’s situation, a request can be made that an exception be made. Specific income requirement amounts can be found at merkhelps.com, select the patient assistance program and prescribed medication to see qualifications.

To enroll, patients and providers must complete the Enrollment Form for the specific Merck medication. Visit merckhelps.com and search for, select the specific medication, download and complete the medication’s Enrollment Form, and fax it to the number at the top of the form. Spanish enrollment forms are available online. If you have any questions about the Merck Helps including the status of an application, please call 855.257.3932, Monday through Friday, 8:00 am to 8:00 pm ET.

Oncology-related products: Emend® (aprepitant) for oral suspension, Emend® (fosaprepitant dimeglumine) for injection, Intron® A (interferon alfa-2b, recombinant) for injection, Keytruda® (pembrolizumab) injection, Sylatron™ (peginterferon alfa-2b) for injection, Zolinza® (vorinostat)

Vaccine: Gardasil®9 (Human Papillomavirus 9-valent Vaccine, Recombinant)
The Merck Co-pay Assistance Program for Keytruda
The Merck Co-pay Assistance Program offers assistance to eligible patients who need help affording Keytruda. Co-pay assistance may be available for patients who:
- Are a resident of the United States (including Puerto Rico)
- Have private health insurance that covers Keytruda under a medical benefit program
- Have been prescribed Keytruda for an FDA-approved indication
- Meet all other criteria of the program.

The Merck Co-pay Assistance Program for Keytruda is not valid for patients covered under a government programs, as that term is defined in the terms and conditions. The program is not valid for uninsured patients. Once enrolled, eligible privately insured patients pay the first $25 of their co-pay per infusion. The maximum co-pay assistance program benefit is $25,000 per patient per calendar year.

To enroll, visit merckaccessprogram-keytruda.com/hcp/the-merck-copay-assistance-program/ and use the online portal or download the appropriate enrollment forms. Complete and fax the forms to 855.755.0518. If the patient is ineligible for this program, they may be able to get help from an independent co-pay assistance foundation. A representative can provide information about independent foundations with their own eligibility criteria and application process.

Merck Vaccine Patient Assistance Program for Gardasil®9
The Merck Vaccine Patient Assistance Program provides vaccines free of charge to eligible individuals, primarily the uninsured who, without assistance, could not afford needed Merck vaccinations. Eligibility criteria include:
- Patient is legal resident of the United States, including U.S. territories, and is 19 to 45 years of age; patient does not have to be a U.S. citizen
- Patient does not have health insurance coverage
- Patient meets income requirements.

If the patient does not meet the insurance coverage criteria, their income meets the program criteria, and there are special circumstances of financial and medical hardship that apply to their situation, they can request an exception be made.

To enroll, patients and providers must complete the Vaccine Patient Assistant Program Enrollment Form (merckhelps.com/docs/VPAP_Enrollment_Form_English.pdf) and fax it from a participating licensed prescriber’s office to 1.800.528.2551. The application must be submitted and approved prior to administration of the vaccine in order to qualify.

If you have any questions about the Merck Vaccine Patient Assistance Program, please call 1.800.293.3881, Monday through Friday, 8:00 am to 8:00 pm ET.

REIMBURSEMENT ASSISTANCE

Merck Access Program Benefit Investigations
MAP can contact insurers to obtain coverage and benefits information. Visit the specific product site for additional resources.

Prior Authorizations
If a prior authorization is required, or for assistance in understanding if a prior authorization is required, MAP may be able to help. The prior authorization checklist and sample letter can help you to understand the documents and information that may be helpful when seeking a prior authorization. As always, you should check for payer-specific requirements.

Appeals
MAP may be able to help the provider understand the information needed for an appeal submission. The appeal checklist and sample appeal letter can help you to understand the documents and information that may be helpful when filing an appeal. Please check for payer-specific requirements.

If you have any questions about MAP reimbursement support services, Merck Access Program representatives are available Monday through Friday, 8:00 am to 8:00 pm ET, at 1.855.257.3932.
PATIENT ASSISTANCE

Mylan ADVOCATE™

Mylan ADVOCATE is available to assist with questions about billing and coding and patient access to Fulphila. Services include coverage and claim support, alternate coverage identification, insurance coverage verification, benefit investigation, patient enrollment, prior authorization/reauthorization assistance and tracking, and billing and coding. Mylan ADVOCATE can also identify solutions such as copay assistance, patient assistance, and field reimbursement support. Mylan ADVOCARE can help with the following:

- Commercially insured patients may be able to access Fulphila for $0 copay. There are no income restrictions. Eligibility criteria apply.
- Patients without insurance coverage for Fulphila who cannot afford their medication may be able to receive their medication free of charge. Eligibility requirements apply based on residency, income, and other factors. Contact Mylan ADVOCATE for more information.
- Mylan ADVOCATE can help identify other resources, such as state programs or third-party charitable foundations, that may be able to assist your patients.


To contact experienced and caring Mylan ADVOCATE patient access specialists, call 1.833.695.2623, Monday through Friday, 9:00 am to 8:00 pm ET. Patient support services and resources are available 24 hours a day, 7 days a week, via the Mylan ADVOCATE portal at https://www.mylanadvocateportal.com/myl/login#.

Mylan ADVOCATE Co-Pay Assistance Program

Commercially insured patients may be able to access Fulphila for as little as $0 co-pay. There are no income restrictions for this program. The Mylan ADVOCATE Co-Pay Assistance Program is open to both new and existing eligible patients who are residents of the U.S. or Puerto Rico and who have commercial insurance. This co-pay assistance program can be used to reduce the amount of an eligible patient’s out-of-pocket expense for Fulphila up to the full amount of the patient’s out-of-pocket expense per prescription up to $10,000 per 12-month period.

This co-pay assistance program is not valid for uninsured patients or patients whose commercial insurance coverage does not include Fulphila; patients who are covered in whole or in part by any state or federally funded healthcare program, including, but not limited to, any state pharmaceutical assistance program, Medicare (Part D or otherwise), Medicaid, Medigap, VA or DOD, or TriCare (regardless of whether a specific prescription is covered by such government program); if the patient is Medicare eligible and enrolled in an employer-sponsored health plan or prescription benefit program for retirees; or if the patient’s insurance plan is paying the entire cost of this prescription. This program is valid in Massachusetts through June 30, 2019, unless applicable law is amended or extended by Massachusetts.

REIMBURSEMENT ASSISTANCE

Mylan ADVOCATE™

A team of dedicated patient access specialists is available to answer calls and address concerns or questions regarding:

- Billing and coding. Mylan can
provide information about applicable coding for Fulphila and its administration. (Note: Coding information is provided for informational purposes only; the physician must determine the appropriate code for each patient and payer.)

**Insurance coverage verification.** Mylan can help check patient insurance plan enrollment status.

**Benefit investigation.** Mylan can assist in researching patient-specific insurance coverage, coding, and billing requirements for Fulphila and its administration; verify patient cost-sharing requirements including deductible, copay, coinsurance, out-of-pocket maximum, and amounts met to date; determine payer access requirements (e.g. specialty pharmacy, in-office dispensing, etc.); and prepare a Summary of Benefits that documents all findings.

**Prior authorization/reauthorization assistance and tracking.** Mylan can assist in checking PA requirements, submission details, and track status, as well as provide offices with payer-specific forms.

**Coverage and claim.** Mylan can verify appeal requirements and track the status and resolution of appeals.

**Field reimbursement support.** A reimbursement expert from your area can visit your cancer program for live educational programs on coverage and reimbursement information or to assist with questions related to Fulphila access.

For more information call Mylan ADVOCATE at 1.833.695.2623, Monday through Friday, 9:00 am to 8:00 pm ET, or go to mylan advocate.com.

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### Patient Assistance Checklist for Uninsured Patients

- I have received the chemotherapy order written by the physician?  
  - YES  
  - NO

- I have met with the patient to assess his or her ability to pay for treatment?  
  - YES  
  - NO

- Based on this meeting, is the patient able to pay out-of-pocket for drug(s)?  
  - YES  
  - NO

  If no, list drug(s) below and continue on with checklist.

- Is a replacement drug program available?  
  - YES  
  - NO

  If yes, identify drug and program:

- Does the patient qualify for this program?  
  - YES  
  - NO

  If no, state reason(s) why:

- Does the patient need drug(s) that are not available through a drug replacement program?  
  - YES  
  - NO

  If yes, identify which drugs:

- Is Foundation funding assistance available for any of these drug(s)?  
  - YES  
  - NO

  If yes, identify Foundation(s) and drug(s):

- I have completed all the necessary forms and paperwork for the drug replacement program.  
  - YES  
  - NO

- Does the patient need drug(s) that are not available through a drug replacement program?  
  - YES  
  - NO

- Is Foundation funding assistance available for any of these drug(s)?  
  - YES  
  - NO

  If yes, identify Foundation(s) and drug(s):

- I have completed all the necessary forms and paperwork for the Foundation funding program(s).  
  - YES  
  - NO

- Does the patient qualify for charity care within from my clinic, cancer center, hospital, or healthcare system?  
  - YES  
  - NO

  If yes, identify program:

- I have completed all the forms and paperwork necessary to apply for this charity care.  
  - YES  
  - NO

- Is there a balance or money owed related to treatment?  
  - YES  
  - NO

  If yes, identify balance:

- If yes, I have worked with the patient and family to create a payment plan for the balance of his or her treatment costs.  
  - YES  
  - NO

Source: ACCC Financial Advocacy Network. accc-cancer.org/FAN
PATIENT ASSISTANCE

Patient Assistance Now Oncology (PANO)
The Novartis PANO program was created to assist patients and providers with accessing Novartis medicines-from insurance verification to financial assistance-all through a knowledgeable and supportive call center.

The Novartis Patient Assistance Foundation
This foundation may help provide access to Novartis medicines to patients experiencing financial hardship and/or have no third-party insurance coverage for their medicines. The Novartis Patient Assistance Foundation, Inc. (NPAF), is independent of Novartis Oncology Patient Support. However, NEW patients seeking NPAF assistance are required to submit a PANO service request form. To be eligible for the Novartis Patient Assistance Fund, patients must:
• Be a U.S. resident
• Meet income criteria, which vary by medication, and provide proof of income
• Have limited or no prescription coverage. (NOTE: Exceptions exist for individuals with limited prescription coverage.)

There are two ways to enroll in the program:
• Fill out the PANO Service Request Form online by visiting patient.novartisoncology.com/financial-assistance/PANO/
• Download and complete the PANO Service Request Form (https://www.patient.novartisoncology.com/contentassets/347dea5f-eadb4bf094775d6d9091c625/patient-novartis-oncology-service-request-form.pdf) and fax the completed form to 1.888.891.4924; patient and provider should submit an SRF that will later be matched and processed.

For more information, please call 1.800.282.7630, Monday through Friday, 9:00 am to 8:00 pm ET.

Novartis Oncology Universal Co-Pay Card
Novartis Oncology created its Universal Co-Pay Program (copay.novartisoncology.com) to help with prescription costs for all the medications listed below:
• Exjade
• Gleevec
• Jadenu
• Kisqali
• Mekinist
• Piqray
• Promacta
• Rydapt
• Sandostatin LAR Depot
• Tafinlar
• Tasigna

Oncology-related products: Adakveo® (crizanlizumab-tmca) for IV infusion, Afinitor® (everolimus) tablets, Arzerra® (ofatumumab) injection, Exjade® (deferisirox) tablets for oral suspension, Farydak® (panobinostat) capsules, Femara® (letrozole) tablets, Gleevec® (imatinib mesylate) tablets, Jadenu® (deferisirox), Kisqali® (ribociclib) tablets, Kymriah® (tisagenlecleucel) suspension for IV infusion, Mekinist® (trametinib) tablets, Piqray® (alpelisib) tablets, Promacta® (eltrombopag) tablets, Rydapt® (midostaurin) capsules, Sandostatin® (octreotide acetate) for injection, Sandostatin® LAR Depot (octreotide acetate) for injectable suspension, Tafinlar® (dabrafenib) capsules, Tasigna® (nilotinib) capsules, Tykerb® (lapatinib) tablets, Votrient® (pazopanib) tablets, Zometa® (zoledronic acid) for injection, Zykadia® (ceritinib) tablets

Patient and Reimbursement Assistance Websites
hcp.novartis.com/access
patient.novartisoncology.com
Tykerb
Votrient
Zykadia.

Eligible, privately insured patients are responsible for up to the first $25 (specific offer varies by brand. The Novartis Oncology Universal Co-pay Program includes the co-pay card, payment card, or rebate with a combined annual limit of $15,000. Patient is responsible for any costs once the limit is reached in a calendar year. This offer is not valid under Medicare, Medicaid, or any other federal or state program. Novartis reserves the right to rescind, revoke, or amend this program and discontinue support at any time without notice. Find out if a patient is eligible to enroll in the program by visiting Copay.NovartisOncology.com or calling 1-877-577-7756. Read program terms and conditions at: copay.novartisoncology.com.

Independent Charitable Foundations
There are a variety of independent charitable foundations that may be able to provide additional financial assistance. See a full list of organizations at Patient.NovartisOncology.com.

All organizations are independent of Novartis Pharmaceuticals Corporation. Novartis has no financial interest in any organization listed, but may provide occasional funding to these organizations. All descriptions are copyright of the respective organizations. Novartis is not responsible for the actions of any of these organizations.

Kymriah Cares™
From information on financial assistance to patient support programs, Kymriah Cares has resources to help eligible patients throughout their treatment journey. Whether they have questions about Kymriah or treatment center locations, Kymriah Cares is here to help.

To learn more, please call 1.844.4KYMRIAH (1-844.459.6742), 8:00 am to 8:00 pm ET.

REIMBURSEMENT ASSISTANCE

Patient Assistance Now Oncology (PANO)
PANO is the preferred first stop for access to Novartis Oncology Patient Support programs. Through 1-on-1 guidance with a dedicated case manager, patients will discover which Novartis Oncology Patient Support programs they are eligible to receive and may also be referred to other services. PANO offers resources and support designed specifically to help make that process easier, including:

• Insurance benefits verification, including information on prior authorizations and denial appeals
• Patient Support Counselors who are able to provide information in over 160 languages
• Patient Navigators who provide 1-on-1 support specific to a patient’s medication (varies by medication)
• Information about financial assistance that may be available
• Dedicated case managers with private extensions whom you can contact directly for updates on your patient
• A combination of PANO case managers and/or field reimbursement managers are available to help depending on the complexity of a patient’s case.

Get started today by submitting the PANO Service Request Form online (https://www.hcp.novartis.com/access/). To learn more call 1.800.282.7630, Monday through Friday, 9:00 am to 8:00 pm ET.
PATIENT ASSISTANCE

Pfizer Oncology Together™

At Pfizer Oncology Together, patient support is at the core of everything we do. From helping to identify financial assistance options to connecting patients to resources for emotional support, a patients’ needs are our priority.

When patients need support for their day-to-day challenges, we want to be a place they can turn to for help. That’s why Pfizer Oncology Together provides patients prescribed our medications with a dedicated care champion. Our care champions, who have social work experience, are ready to listen to patients and then connect them to resources that may help with some of their daily needs.

Pfizer offers access and reimbursement support to help your patients get Pfizer Oncology medications, including benefits verification, prior authorization assistance, appeals assistance, and online support. Pfizer will help patients understand their benefits and connect them with financial assistance resources, regardless of their insurance coverage. There’s assistance for:

- Commercially insured patients with commercial, private, employer, and state health insurance marketplace coverage
- Medicare/government insured patients with Medicare/Medicare Part D, Medicaid, and other government insurance plans
- Uninsured patients without any form of healthcare coverage.

To enroll, download the Patient Support Program & Patient Assistance Enrollment Form (pfizeroncologytogether.com/enroll) and fax the completed form to 1.877.736.6506. For questions, please call 1.877.744.5675, Monday through Friday, 8:00 am to 8:00 pm ET. Visit pfizeroncologytogether.com for more information.

Pfizer Oncology Together Co-Pay Savings Program

Eligible, commercially insured patients may pay as little as $0 per month for the oral medications or per treatment for the injectable medication for select Pfizer medications through the co-pay savings programs. The maximum annual benefit for oral medications is $25,000 per calendar year and injectable products are subject to a maximum annual patient savings of $10,000.

Patients are not eligible for these programs if they are enrolled in a state or federally funded insurance program, including but not limited to Medicare, Medicaid, TRICARE, Veterans Affairs health care, a state prescription drug assistance program, or have any other form of health insurance.
program, or the Government Health Insurance Plan available in Puerto Rico. For oral products, the offer will be accepted only at participating pharmacies. This offer is not health insurance. Pfizer reserves the right to rescind, revoke, or amend this offer without notice. For more information, call 1.877.744.5675 or visit pfizeroncologytogether.com and select the medication.

Pfizer Patient Assistance Program

Eligible patients may receive up to a 90-day supply of Pfizer medication for free, while applying for Medicaid. If patients do not qualify for Medicaid, they may be able to get a 1-year supply of medication for free through the Pfizer Patient Assistance Program, or at a savings through the Pfizer savings Program. Patients must meet eligibility requirements and reapply as needed.

To qualify for free medicine through the Pfizer Patient Assistance Program, patients must:
- Have a valid prescription for the Pfizer medicine for which they are seeking assistance
- Be treated by a healthcare provider licensed in the U.S. or a U.S. territory.
- Reside in the U.S. or a U.S. territory.
- Have no prescription coverage or not enough coverage to pay for their Pfizer medicine
- Meet certain financial requirements (income limits vary by product and household size).

The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation. The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

The Pfizer Savings Program is not health insurance. Estimated savings are 50 percent and depend on such factors as the particular drug purchased, amount purchased, and the pharmacy where purchased. There are no membership fees to participate in this program. For more information, call 1.877.744.5675 or visit pfizeroncologytogether.com and select the medication.

Support from Independent Charitable Organizations

Pfizer will assist patients with searching for financial support that may be available from independent charitable foundations. These foundations exist independently of Pfizer and have their own eligibility criteria and application processes. Availability of support from the foundations is determined solely by the foundations.

Pfizer RxPathways®

Pfizer RxPathways® may be able to help. Pfizer RxPathways connects eligible patients to a range of assistance programs to help them access their Pfizer prescriptions. Visit PfizerRxPathways.com.

REIMBURSEMENT ASSISTANCE

Pfizer Oncology Together

If patients need access or reimbursement support for their prescribed Pfizer oncology medications, the following support is here to help:
- **Benefits verification:** Pfizer can conduct a benefits verification to determine the patient’s health insurance coverage and out-of-pocket costs.
- **Prior authorization:** Pfizer will coordinate a patient’s insurer to determine the prior authorization requirements, where and how to submit requests, and typical turnaround times. Pfizer will also follow up with the insurer on behalf of the patient and track the progress until a final outcome is determined.
- **Appeals assistance:** If the patient’s claim is denied, Pfizer can review the reason for the denial and provide information on payer requirements. Once the appeal is submitted, Pfizer can follow up with the payer to track the progress of the request until a final outcome is determined.
- **Pharmacy coordination:** To help your patients access the medication prescribed, Pfizer can identify specialty pharmacy options. If the provider prefers, they can also continue to work directly with specialty pharmacies.

Pfizer Oncology Field Reimbursement Managers (FRMs) are trained to help address specific access issues in person or over the phone. They can help educate provider’s staff on Pfizer’s access and reimbursement resources and help address challenging or urgent Pfizer oncology patient cases that have been sent to Pfizer Oncology Together. You can get in touch with an FRM by calling 1.877.744.5675.

To get started, visit https://www.pfizeroncologytogether.com/hcp to download the enrollment form and fax the completed form to 1.877.736.6506. For questions, please call 877.744.5675. Monday through Friday, 8:00 am to 8:00 pm ET.
PATIENT ASSISTANCE

YOU&i™ Instant Savings Program
Eligible patients with commercial insurance and who meet eligibility requirements will pay no more than $10 per prescription for Imbruvica with a maximum limit of $24,600 per calendar year. This program applies to commercial insurance co-pay, deductible, and coinsurance medication costs. The program cannot be used with any other federally-funded prescription insurance plan which includes Medicare Part D, Medicare Advantage Plan, Medicaid, TRICARE, or any other federal or state health care plan, including pharmaceutical assistance programs. To enroll in the program, visit https://services.trialcard.comCoupon/YouAndI/. For more information, call 1.877.877.3536, Monday through Friday, 8:00 am to 8:00 pm ET.

For patients with federally funded Medicare, Medicaid, or commercial insurance, YOU&i can also provide information on independent foundations that may be able to provide patients with additional financial support upon request. Independent charitable organizations have their own rules for eligibility. YOU&i has no control over these independent charitable organizations.

The Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) is an independent, non-profit organization that is committed to helping eligible patients without insurance coverage receive prescription products donated by Johnson & Johnson operating companies. It may be able to provide Imbruvica to eligible patients who lack the financial resources to pay for them. Contact a JJPAF program specialist at 1.800.652.6227, Monday through Friday, 9:00 am to 6:00 pm ET, or visit the foundation website at jjpaf.org to see if they might qualify for assistance.

YOU&i™ Support Program
The YOU&i Support Program can provide access to Imbruvica for new patients who are experiencing insurance coverage decision delays. Eligible patients who have been prescribed Imbruvica for an FDA-approved indication and who are experiencing an insurance coverage decision delay greater than 5 business days can receive a free 30-day supply of Imbruvica. The free product is offered to eligible patients without any purchase contingency or other obligation.

For more information, call 1.877.877.3536, Monday through Friday, 8:00 am to 8:00 pm ET or visit its website at imbruvicahcp.com/you-i-support/access-support.

Nurse Call Support & Other Clinical Resources
The You&i Support Program has nurses who are available to support patients with:

- A resource-filled Starter Kit designed for new patients containing disease information, tips on building a medication routine, adherence tools, and more
- Nurse call support personalized to

REIMBURSEMENT ASSISTANCE

YOU&i™ Support Program
The YOU&i Support Program is a personalized program that helps patients learn about access to Imbruvica, find affordability support options, and sign up for information and resources to support them along their treatment journey. Patients will learn about access through:

- Rapid benefits investigation
- Information on the prior authorization process
- Navigating the exception and appeals process

To learn more about the YOU&i Support Program, call 1.877.877.3536, Monday through Friday, 8:00 am to 8:00 pm ET or visit its website at imbruvicahcp.com/you-i-support/access-support.
patients’ preferences for frequency and method of contact
• Referrals of patients seeking medical advice back to their healthcare providers.

Call 1.877.877.3536 for more information about the You&i Support Program.
PATIENT ASSISTANCE

Puma Patient Lynx™
Puma is committed to ensuring that financial barriers do not prevent anyone from getting Nerlynx. For patients prescribed with Nerlynx tablets, Puma Patient Lynx provides the following support services:

Patient Assistance Program: For patients who are uninsured and meet certain financial qualifications, Nerlynx can be provided for free through the Patient Assistance Program. For more information on the Puma Patient Lynx Support Program call 1.855.816.5421, Monday through Friday, 9:00 am to 8:00 pm ET. Referrals can also be made to nonprofit foundations for patients who are not commercially insured and are in need of financial support.

Co-Pay Savings Program: Commercially insured, eligible patients treated with Nerlynx may pay as little as $10 per prescription. Patients will be enrolled through their specialty pharmacy or can enroll at https://sservices.trialcard.com/Coupon/nerlynx. Limitations apply. Patient must have commercial insurance. Offer is not valid under Medicare, Medicaid, or any other federal or state program. Puma Biotechnology reserves the right to rescind, revoke, or amend this program without notice. Visit nerlynx.com for full terms and conditions or call Puma Patient Lynx at 1.855.816.5421.

Nerlynx Quick Start: The Nerlynx Quick Start program provides a 3-week supply of Nerlynx to eligible patients experiencing delays in gaining access to therapy.

To enroll, download and complete the Puma Patient Lynx Enrollment Form (nerlynx.com/pdf/enrollment-form.pdf) and fax it to 844.276.5153. For more information on the Puma Patient Lynx Support Program, call 1.855.816.5421, Monday through Friday, 9:00 am to 8:00 pm ET.

Supportive Care Voucher: Puma Biotechnology offers vouchers to cover the cost of anti-diarrheal treatments. Eligible patients can receive up to a 3-month supply of products used for anti-diarrheal treatment for free. Patients can access the voucher from their healthcare team or their specialty pharmacy that delivers your Nerlynx.

Nurse Call Center: Nurses are available to speak with patients and healthcare providers to answer questions about NERLYNX. The call center is open 24 hours a day, 7 days a week for your convenience. Please call our nurses at 1.855.816.5421 and press option 2 when prompted for more information.

Text Message Support Program: Patients can sign up to receive medication reminders and motivational messages to support treatment adherence. Message and data rates may apply. Message frequency determined by user. Text HELP to 82866 for help and STOP to 82866 to cancel. To see full terms and conditions and to sign up, visit nerlynx.com/access-and-support/ongoing-support or text LYNX to 82866 to enroll.

Mentor Program: The Nerlynx Mentor Program connects women who have questions with women who know what it’s like to experience Nerlynx. This free program is available to all women with early-stage HER2+ breast cancer who are considering Nerlynx or who are currently taking Nerlynx. Call 1.855.816.5421 for more information or visit https://nerlynx.com/access-and-support/stay-connected.
REIMBURSEMENT ASSISTANCE

Puma Patient Lynx™
For patients prescribed with Nerlynx, Puma Patient Lynx reimbursement counselors can conduct a benefits investigation, verify insurance approval or coverage, and obtain and submit necessary documentation for patients requiring prior authorization.

To enroll, download and complete the Puma Patient Lynx Enrollment Form (nerlynx.com/pdf/enrollment-form.pdf) and fax it to 844.276.5153. For more information on the Puma Patient Lynx Support Program, call 1.855.816.5421, Monday through Friday, 9:00 am to 8:00 pm ET.
PATIENT ASSISTANCE

LIBTAYO Surround®
LIBTAYO Surround™ helps eligible patients access Libtayo and navigate the health insurance process. Visit libtayohcp.com for more information about this program, or call 1.877.LIBTAYO (1.877.542.8296), Option 1, Monday through Friday, 8:00 am to 8:00 pm ET.

LIBTAYO Surround Copay Program
Eligible patients pay $0 out of pocket for Libtayo, which includes any product-specific copay, coinsurance, and insurance deductibles—up to $25,000 in assistance per year. There is no income requirement to qualify for this program.

This program is not valid for prescriptions covered by or submitted for reimbursement under Medicare, Medicaid, Veterans Affairs/Department of Defense, TRICARE, or similar federal or state programs. This program is not a debit card program and does not cover or provide support for supplies, procedures, or any physician-related service associated with Libtayo. General non–product-specific copays, coinsurance, or insurance deductibles are not covered. Additional program conditions apply. See libtayohcp.com for more information.

Patients are responsible for any out-of-pocket cost for Libtayo that exceeds the program assistance limit of $25,000 per year, in addition to non–product-specific expenses related to supplies, procedures, or physician-related services. To be eligible:
- Patients must have commercial or private insurance, which includes state or federal employee plans and health insurance exchanges. (Note: patients who do not have commercial or private insurance are not eligible.)
- Patients must be residents of the United States or its territories or possessions.
- Patients must be at least 18 years of age.
- Patients must be prescribed Libtayo or an FDA-approved indication
- Other restrictions apply.

There are two ways to enroll patients in the LIBTAYO Surround Copay Program:
- Download the LIBTAYO Surround Enrollment Form (libtayohcp.com/-/media/EMS/Conditions/Oncology/Brands/LibtayoHCP/pdf/LIBTAYO%20Surround%20Enrollment%20Form_US-LIB -1001.pdf) and check the box in Section 1 marked “Copay Assistance;” Complete the enrollment form and fax it to 1.833.853.8362.
- Providers or patients can call LIBTAYO Surround at 1.877.LIBTAYO (1.877.542.8296), option 1, Monday through Friday, 8:00 am to 8:00 pm ET. A LIBTAYO Surround Reimbursement Specialist will guide the caller through eligibility requirements and the enrollment process. Be sure to have patient contact information and commercial insurance information, including payer and plan names, policy and group numbers, and phone numbers.

Patient Assistance Program
The LIBTAYO Surround Patient Assistance Program helps eligible patients who are uninsured or who lack coverage for Libtayo receive Libtayo at no cost. Patient eligibility:
- Patients must be uninsured, lack coverage for Libtayo, or have Medicare Part B with no supplemental insurance coverage.

Oncology-related products: Elitek® (rasburicase) IV infusion, Libtayo® (cemiplimab-rwlc) injection
Regeneron and Sanofi

Patients must be residents of the United States or its territories or possessions.


Patients must have an annual gross household income that does not exceed the greater of $100,000 or 500% of the federal poverty level.

Other restrictions apply.

LIBTAYO Surround facilitates patient assistance enrollment process. To assist patients who wish to enroll in this program, LIBTAYO Surround will:

- Identify alternate coverage programs for which patients may be eligible and explain the benefits they provide
- Answer questions about the application process for each program
- Provide patients with the appropriate program’s contact information
- Supply patients with a copy of the program’s enrollment form (if available).

Potential alternate sources available for patients may include Medicaid, state health insurance exchanges, Medigap, state pharmaceutical assistance programs, and independent charitable foundations.

With the exception of independent charitable foundations, once an alternate source is identified and the patient applies for assistance, LIBTAYO Surround may be able to follow up with the patient and/or healthcare provider’s office staff about the status of the application and communicate the result.

Nurse Advocates

Patients can contact a LIBTAYO Surround Nurse Advocate 24/7 to receive the following additional support throughout their treatment journey:

- Information on patient advocacy groups and local support organizations, transportation services, and travel and lodging
- Answers to patient questions
- Appointment reminders

To contact a LIBTAYO Surround Nurse Navigator call, 1.877. LIBTAYO (1.877.542.8296).

Identification of Alternate Sources of Funding

LIBTAYO Surround may be able to help find alternate funding sources for patients without insurance coverage or patients with inadequate insurance coverage for Libtayo who need assistance with out-of-pocket medication costs.

To assist patients, a LIBTAYO Surround will:

- Identify alternate coverage programs for which patients may be eligible and explain the benefits they provide
- Answer questions about the application process for each program
- Provide patients with the appropriate program’s contact information
- Supply patients with a copy of the program’s enrollment form (if available).

Potential alternate sources available for patients may include Medicaid, state health insurance exchanges, Medigap, state pharmaceutical assistance programs, and independent charitable foundations.

With the exception of independent charitable foundations, once an alternate source is identified and the patient applies for assistance, LIBTAYO Surround may be able to follow up with the patient and/or healthcare provider’s office staff about the status of the application and communicate the result.

Nurse Advocates

Patients can contact a LIBTAYO Surround Nurse Advocate 24/7 to receive the following additional support throughout their treatment journey:

- Information on patient advocacy groups and local support organizations, transportation services, and travel and lodging
- Answers to patient questions
- Appointment reminders

To contact a LIBTAYO Surround Nurse Navigator call, 1.877. LIBTAYO (1.877.542.8296).
- Appeal assistance when prior authorizations are denied
- Claims assistance to address questions as healthcare providers prepare claims and to review the status of claims with the patient’s health insurer.

<table>
<thead>
<tr>
<th>Patient Assistance Checklist for Medicaid Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ I have received the chemotherapy order written by the physician?</td>
</tr>
<tr>
<td>✓ I have verified the patient's insurance coverage?</td>
</tr>
<tr>
<td>✓ I have verified that the drug(s) are indicated for the patient’s diagnosis?</td>
</tr>
<tr>
<td>✓ I have obtained prior authorization, if needed?</td>
</tr>
<tr>
<td>✓ I have identified the patient's responsibility (an estimate in dollars) for treatment costs?</td>
</tr>
<tr>
<td>✓ I have met with the patient to assess his or her ability to pay for treatment?</td>
</tr>
<tr>
<td>✓ Based on this meeting, does patient need drug replacement?</td>
</tr>
<tr>
<td>![ ] YES  ![ ] NO</td>
</tr>
<tr>
<td>If yes, is a replacement drug program available? (Note: an appeal must to be made to receive drugs.)</td>
</tr>
<tr>
<td>![ ] YES  ![ ] NO</td>
</tr>
<tr>
<td>If yes, identify drug and program:</td>
</tr>
<tr>
<td>![ ] YES  ![ ] NO</td>
</tr>
<tr>
<td>Does the patient qualify for this program?</td>
</tr>
<tr>
<td>![ ] YES  ![ ] NO</td>
</tr>
<tr>
<td>If no, state reason(s) why:</td>
</tr>
<tr>
<td>![ ] YES  ![ ] NO</td>
</tr>
<tr>
<td>If yes, I have completed all the necessary forms and paperwork for the drug replacement.</td>
</tr>
<tr>
<td>![ ] YES  ![ ] NO</td>
</tr>
<tr>
<td>If no, state reasons why:</td>
</tr>
<tr>
<td>![ ] YES  ![ ] NO</td>
</tr>
<tr>
<td>Is there a balance or money owed related to treatment?</td>
</tr>
<tr>
<td>![ ] YES  ![ ] NO</td>
</tr>
<tr>
<td>If yes, identify balance:</td>
</tr>
<tr>
<td>![ ] YES  ![ ] NO</td>
</tr>
<tr>
<td>If yes, I have worked with the patient and family to create a payment plan for the balance of his or her treatment costs.</td>
</tr>
</tbody>
</table>

Source: ACCC Financial Advocacy Network. accc-cancer.org/FAN
PATIENT ASSISTANCE

SeaGen Secure®

SeaGen Secure is a comprehensive assistance program for patients who have been prescribed Adcetris and for the health care providers caring for them. For more information about SeaGen Secure, call 855.4SECURE (855.473.2873).

Patient Assistance Program

For patients with no insurance, the Patient Assistance Program provides Adcetris at no cost. Assistance begins on a temporary 3-month period and an alternative coverage search is facilitated through SeaGen Secure. The drug must be ordered for each cycle. To be eligible, patients must meet income requirements, be a permanent U.S. resident, and provide income and residency documentation.

To enroll, complete the Patient Assistance/Benefits Investigation Request Form (seagensecure.com/assets/docs/USP-BVP-2015-0124(3)_SeaGen_Secure_PAP_Form_v03_interactive.pdf) and fax the completed form to 855.557.2480 or e-mail it to CaseManager@seagensecure.com, or you can call 855.4SECURE (855.473.2873) to reach a SeaGen case manager.

For more information, call 855.4SECURE (855.473.2873), Monday through Friday, 9:00 am to 8:00 pm ET, and select option 1.

Coinsurance and Deductible Assistance

For insured patients who cannot afford their coinsurance or copay, coinsurance and deductible assistance is available. To be eligible, patients must have commercial health insurance with coverage for Adcetris, be receiving Adcetris for an on-label indication, be a permanent U.S. resident, and meet income requirements. If eligible, SeaGen Secure will send assistance to the provider on behalf of the patient. The patient may receive assistance for the duration of their therapy if they remain eligible. There are some program limits/caps.

To enroll, complete the Patient Assistance/Benefits Investigation Request Form (seagensecure.com/assets/docs/USP-BVP-2015-0124(3)_SeaGen_Secure_PAP_Form_v03_interactive.pdf) and fax the completed form to 855.557.2480 or e-mail it to CaseManager@seagensecure.com, or you can call 855.4SECURE (855.473.2873) to reach a SeaGen case manager.

REIMBURSEMENT ASSISTANCE

SeaGen Secure®

SeaGen Secure reimbursement services include:
- Benefits investigation
- Prior authorization assistance
- Billing and coding assistance
- Claims and appeals assistance.

Benefits Investigation

Once the enrollment form is received, a benefits investigation is conducted to determine an individual patient’s coverage for Adcetris. SeaGen Secure will fax providers a summary of benefits within two business days of receiving the completed request, and the provider will receive a call to discuss the results and next steps.

Claims and Appeals Assistance

SeaGen Secure Case Managers can help providers track claims to ensure they are being processed and paid on time. Case managers can also assist with denied or underpaid claims.

To speak to a Case Manager, call 855.4SECURE (855.473.2873), option 1 for HCPs, Monday through Friday, 9:00 am to 8:00 pm ET.
PATIENT ASSISTANCE

Yonsa Support™
Yonsa Support may help eligible patients find the right financial option that fits their needs. It is a comprehensive resource for patients taking Yonsa. Support programs include:

- Benefits investigations and prior authorization assistance: Yonsa Support will initiate a benefits investigation of the patients’ insurance coverage for Yonsa, obtain information on any associated prior authorization (PA) requests and appeals, and route patient information to a specialty pharmacy.
- Co-Pay Program: Yonsa Support will determine a patient’s eligibility and enroll them into the program.
- Early Access Program: Yonsa Support will enroll patients who experience an excessive delay in coverage or delay to an initial prior authorization. If eligible, the program will provide free product for up to 30 days.
- Patient Assistance Program: Yonsa Support assists eligible patients without commercial insurance in gaining access to Yonsa through the Patient Assistance Program. Yonsa Support will research alternate form of funding and, if the patient is eligible, will help with enrollment. Income documentation is required.

To apply for these services, complete a patient enrollment form (yonsarx.com/wp-content/uploads/2019/02/YONSA-Support-Enrollment-Form.pdf) and fax it to 1.877.872.6575.

If you have questions, please contact Yonsa Support at 1.855.44 YONSA (1.855.563.6639), Monday through Friday, 8:00 am to 8:00 pm ET.

Co-pay Program
Eligible commercially insured patients may pay as little as $10 a fill for each fill of Yonsa with the co-pay card. Subject to a maximum benefit of $5,000 per fill, up to $12,000 per calendar year. This offer is not valid under Medicare, Medicaid, or any other federal or state program, for cash-paying patients, or where a plan reimburses you for the entire cost of your prescription drug. Yonsa Support will determine a patient’s eligibility and enroll them into the program. Additional restrictions and eligibility requirements apply. Visit activatethecard.com/7702/# to enroll patients and learn additional information.

If you have any questions regarding eligibility or benefits, call the YONSA Savings program at 1.855.984.6307, Monday through Friday, 8:00 am to 8:00 pm ET.

Odomzo Patient Access Program
The Odomzo Patient Access Program streamlines access to Odomzo for patients and providers. Odomzo Support will review applications and conduct benefits investigations to help better understand a patient’s coverage and the costs associated with Odomzo treatment. Once a benefit investigation is complete, Odomzo Support can:

- Verify and explain patient benefits
- Provide information on prior authorization requirements
- Process the prescription with a Specialty Pharmacy
- Inform patients of their co-pay support options and other financial support services
- Coordinate payment and delivery of Odomzo.

To enroll, fill out and fax the Odomzo Patient Access Program Application ( odomzo.com/themes/custom/odomzo/global/pdfs/Sun-Pharma-Patient-Assistance-Program-Application.pdf) to 1.877.872.6576 to start the
process. Note that patients must meet certain medical and financial criteria to qualify for any assistance in obtaining ODOMZO. For more information or any questions, call the program at 1.844.5.ODOMZO (1.844.563.6696), Monday through Friday, 8:00 am to 8:00 pm ET.

Co-pay Program
Eligible, commercially insured patients 18 years or older may pay as little as $10 a month for an Odomzo prescription, subject to a $15,000 maximum annual program benefit. After the program maximum, patient will be responsible for the difference. This offer is valid only for patients with commercial insurance and who have a valid prescription. This offer is not valid under Medicare, Medicaid, or any other federal or state program, for cash-paying patients, where the product is not covered by patient’s commercial insurance, or where a plan reimburses patient for the entire cost of prescription drug. One card per patient, not transferable, and cannot be combined with any other offer. Additional terms and conditions may apply.

Patients can activate this card by calling 1.877.ODOMZO.1 (1.877.636.6961) or visiting www.activatethecard.com/7436.

Other Financial Support Services
People who are publicly insured or uninsured and need help paying for Odomzo can be referred to a patient assistance foundation. To apply, patients must provide insurance information, recent income documentation, and the name of the referring physician. Visit www.PanFoundation.org for more information.

Independent co-pay assistance foundations have their own rules for eligibility. Sun Pharmaceutical Industries, Inc. cannot guarantee a foundation will help you. Sun Pharma does not endorse or show financial preference for any particular foundation.

Specialty Pharmacies
Specialty pharmacies manage the handling and service requirements of Odomzo and offer a range of services to patients including product distribution, benefits investigations, reimbursement, and case management. When a physician sends a prescription for Odomzo to a specialty pharmacy, the pharmacy will verify benefits and submit a prior authorization request if necessary. It will then coordinate payment and follow up to ensure patient receives the medication.

To enroll, fill out and fax the Odomzo Patient Access Program Application (odomzo.com/themes/custom/odomzo/global/pdfs/Sun-Pharma-Patient-Assistance-Program-Application.pdf) to 1.877.872.6576 to start the process. For more information or any questions, call the program at 1.844.5.ODOMZO (1.844.563.6696), Monday through Friday, 8:00 am to 8:00 pm ET.

REIMBURSEMENT ASSISTANCE

Yonsa Support
Yonsa Support is a comprehensive resource for patients taking Yonsa. It can investigate a patient’s insurance coverage benefits, obtain information on prior authorization, and investigate claim denials.

To enroll, complete a patient enrollment form (yonsarx.com/wp-content/uploads/2019/02/YONSA-Support-Enrollment-Form.pdf) and fax it to 1.877.872.6575. If you have questions, please contact Yonsa Support at at 1.855.44 YONSA (1.855.563.6639), Monday through Friday, 8:00 am to 8:00 pm ET.

Odomzo Patient Access Program
Odomzo Support will review applications and conduct benefits investigations to help better under-
PATIENT ASSISTANCE

Taiho Oncology Patient Support™
The Taiho Oncology Patient Support Program simplifies access for those who have been prescribed Lonsurf as part of their treatment. Just a phone call away, we can help determine insurance coverage, coordinate prescriptions, and more. The Taiho Oncology Patient Support Program can help identify options for financial assistance.

Co-pay Assistance Program
Eligible patients may pay $0 per treatment cycle for Lonsurf. Patients may be eligible if they:
• Have commercial prescription insurance coverage for Lonsurf
• Reside within the United States, Puerto Rico, or U.S. territories
• Use a specialty pharmacy or hospital outpatient pharmacy
• Receive medication from a doctor’s office.

Patients are not eligible for the co-pay program if they are reimbursed under Medicaid, Medicare, drug benefit program, Tricare, or other state or federal programs.*

Patient Assistance Program
Taiho Patient Program can provide financial assistance for eligible patients who have insufficient insurance coverage, insufficient financial resources, or no prescription insurance. Eligible patients may receive Lonsurf at no cost based on assistance, financial, and medical criteria.

Alternate Funding Support
Taiho Patient Support can also refer eligible, public- or government-insured patients to nonprofit foundations for co-pay or other assistance. Taiho Oncology does not influence or control the decisions of these co-pay assistance foundations. Each foundation has its own criteria for patient eligibility. Taiho Oncology cannot guarantee financial assistance once a patient has been referred.

There are three ways to enroll in Taiho Patient Support:
• Complete the Patient Enrollment Form in English (taihopatient-support.com/Content/downloads/enrollment-form-english-March2019.pdf) or Spanish (taihopatientsupport.com/Content/downloads/enrollment-form-spanish-March2019.pdf) and fax it to 1.844.287.2559.
• The patient completes the Patient Enrollment Form online and brings it to the provider’s office, or the provider completes it electronically.
• Call 1.844.TAIHO.4U (1.844.824.4648), Monday through Friday, 8:00 am to 8:00 pm ET for help with enrollment.

Once enrolled, healthcare providers can expect a Taiho Oncology Patient Support Reimbursement Specialist to confirm the patient’s enrollment and share next steps. Patients can expect a welcome to the program and explanation of their insurance benefits for Lonsurf.

REIMBURSEMENT ASSISTANCE

Taiho Oncology Patient Support
The Taiho Oncology Patient Support Program simplifies access for those who have been prescribed LONSURF as part of their treatment. Just a phone call away, we can help determine insurance coverage, coordinate prescriptions, and more.

Access and Reimbursement Support
The program can help patients understand their insurance coverage and/or out-of-pocket responsibility through benefit verifications,
determine prior authorization requirements of the insurance company, and assist with appeals if coverage is denied.

**Pharmacy Coordination**
The Taiho Oncology Patient Support Program can also triage patients’ prescriptions, coordinate prescriptions with the specialty pharmacy, self-dispensing practice, or hospital outpatient pharmacy, and communicate regularly with patients about prescription status.

To enroll, complete the Patient Enrollment Form in English (taihopatientsupport.com/Content/downloads/enrollment-form-english-March2019.pdf) or in Spanish (taihopatientsupport.com/Content/downloads/enrollment-form-spanish-March2019.pdf) and fax it to 1.844.287.2559, or the patient can complete the enrollment form online and bring it to the provider’s office to complete manually or electronically. For help, call 1.844.TAIHO.4U (1.844.824.4648), Monday through Friday, 8:00 am to 8:00 pm ET.
PATIENT ASSISTANCE

Takeda Oncology 1Point™
Takeda Oncology 1Point is a comprehensive support program committed to helping patients navigate coverage requirements, identify available financial assistance, and connect with helpful resources throughout their therapy.

To enroll, download the Takeda Oncology 1Point Enrollment Form (takedaoncology1point.com/pdf/Takeda_Oncology_1Point_Enrollment_Form.pdf) and fax the completed and signed form with original signatures along with a copy of the patient’s insurance card and prescription to 1.844.269.3038. Prescription is only valid if received by fax.

After the patient’s enrollment form is received and processed, a Takeda Oncology 1Point case manager will conduct a benefits verification to determine the patient’s prescription coverage and potential out-of-pocket costs. A summary of coverage will be provided to the provider’s office within 2 business days. Call 1.844.T1POINT (1.844.817.6468), option 2, Monday through Friday, 8:00 am to 8:00 pm ET, for more information.

Takeda Oncology Co-Pay Assistance Program
For patients with commercial insurance concerned about their out-of-pocket costs for Alunbrig, Iclusig, and Ninlaro, the Takeda Oncology Co-Pay Assistance Program may be able to help reduce the out-of-pocket costs associated with their medication. Patients could pay as little as $10 per prescription with an annual maximum benefit of $25,000.

This offer cannot be used if you are a beneficiary of, or any part of your prescription is covered or reimbursed by: (1) any federal or state healthcare program (Medicare, Medicaid, TRICARE, Veterans Administration, Department of Defense, etc.), including a state or territory pharmaceutical assistance program, (2) the Medicare Prescription Drug Program (Part D), or if you are currently in the coverage gap, Medicare Advantage Plans, Medicaid Managed Care or Alternative Benefit Plans under the Affordable Care Act, or Medigap, or (3) insurance that is paying the entire cost of the prescription. Patients must be at least 18 years old. Additional terms and conditions apply.

To enroll, visit takedaoncologycopay.com or call to speak with your Takeda Oncology 1Point case manager at 1.844.T1POINT (1.844.817.6468), option 2, Monday through Friday, 8:00 am to 8:00 pm ET.

Takeda Oncology Patient Assistance Program
For patients who do not have insurance or whose prescribed medication is not covered by insurance they may be eligible to receive their medication through the Patient Assistance Program at no cost. To be eligible for the Patient Assistance Program, patients must meet certain financial and insurance coverage criteria.

A Patient Assistance Program Application (https://www.takedaoncology1point.com/pdf/Takeda_Oncology_Patient_Assistance_Program_Enrollment_Form.pdf) must be submitted in order to confirm patient eligibility. Patient and provider must complete the form and fax it along with a valid prescription for medication to 1.844.269.3038. Prescription is only valid if received by fax.

If the patient qualifies, they may be enrolled for up to 1 year. Upon enrollment, a Takeda Oncology 1Point case manager will notify the patient and their healthcare provider.

Takeda Oncology-related products: Alunbrig® (brigatinib), Iclusig® (ponatinib) tablets, Ninlaro® (ixazomib) capsules, Velcade® (bortezomib) for injection

Patient and Reimbursement Assistance Websites

takedaoncology1point.com
velcade.com/paying-for-treatment
provider. A 1-month supply of their medication will be delivered to the patient at no cost. Each month a Takeda Oncology 1Point case manager will confirm with patient and provider that they are still being treated and are eligible to receive another month’s supply of medication.

**Velcade Financial Assistance**

From finding financial assistance to understanding the disease, Takeda Oncology 1Point can provide the information needed throughout a patient’s treatment. Case managers can connect patients and providers to personalized support for Velcade. Call to speak to a case manager at 1.844.T1POINT (1.844.817.6458), option 2, Monday through Friday, 8:00 am to 8:00 pm ET or visit takedaoncology1point.com.

**REIMBURSEMENT ASSISTANCE**

**Takeda Oncology 1Point™**

Once enrolled in Takeda Oncology 1Point, case managers can work with patients and their healthcare provider to determine a patient’s coverage options and provide additional support throughout their treatment.

To enroll, download the Takeda Oncology 1Point Enrollment Form (takedaoncology1point.com/pdf/Takeda_Oncology_1Point_Enrollment_Form.pdf) and fax the completed and signed form along with a copy of the patient’s insurance card and prescription to 1.844.269.3038. Prescription is only valid if received by fax. Call 1.844.T1POINT (1.844.817.6468), option 2, Monday through Friday, 8:00 am to 8:00 pm ET, for more information.

Once enrolled, Takeda Oncology 1Point works with the healthcare provider and insurance company to help determine if patient’s medication is covered, works with the patient’s pharmacy to arrange the delivery of the medication, evaluates patient eligibility for available support and financial assistance programs (terms and conditions apply), and connects patients to a range of support services and additional resources.

**RapidStart Program**

If patients experience a delay in insurance coverage determination of at least 5 days, they may be eligible to receive a one-month supply of their medication at no cost. To receive a RapidStart supply, a completed Takeda Oncology 1Point Enrollment Form must be on file, and a RapidStart Request Form must be completed and submitted (drug-specific forms are available at takedaoncology1point.com.) Additional terms and conditions apply.

**Velcade Reimbursement Assistance Program**

From finding financial assistance to understanding the disease, Takeda Oncology 1Point can provide the information needed throughout a patient’s treatment. Case managers can connect patients and providers to personalized support for Velcade. Call to speak to a case manager at 1.844.T1POINT (1.844.817.6458), option 2, Monday through Friday, 8:00 am to 8:00 pm ET or visit takedaoncology1point.com.
PATIENT ASSISTANCE

TerSera Support Source
TerSera is committed to help remove the financial and access barriers that so often get in the way of patients who are prescribed Zoladex and Varubi.

Co-Pay Assistance
The Zoladex and Varubi co-pay cards provide medical and pharmacy benefits for eligible patients. For eligible commercially insured patients, they could pay as little as $0 co-pay or coinsurance with a maximum benefit of $2,000 per calendar year. For Zoladex, eligible cash-paying patients will receive $500 off each one-month supply. Patients are not eligible if prescriptions are paid by any state or other federally funded programs, including but not limited to Medicare or Medicaid, Medigap, VA, DOD, or TRICARE, or where prohibited by law. Visit activatethecard.com/7526 to enroll for Zoladex, or visit activatethecard.com/7774 to enroll for Varubi. For questions regarding the Varubi co-pay card, call 1.844.864.3014, Monday through Friday, 8:00 am to 8:00 pm ET.

Patient Assistance Programs

Zoladex
The challenges of dealing with a treatment can be made more difficult when a person lacks any form of insurance. TerSera is committed to helping eligible patients access Zoladex through the Patient Assistance Program. If patients qualify, they may get free TerSera medicine for up to 1 year. TerSera will send an application for renewal once the patient’s enrollment ends. Medicines can be sent to the patient’s home or the doctor’s office; most medicines are sent in a 90-day supply. Patients may qualify for the program if they:
- Are a U.S. Resident, or a Green Card or Work Visa holder
- Meet certain household income limits
- Do not have prescription drug coverage that helps pay for your TerSera medicines.

Varubi
To apply to the Varubi Patient Assistance Program, download the enrollment form (documents.tersera.com/varubi/VarubiEnrollmentForm.pdf) and fax the completed form to 1.855.836.3066. For more information, call 1.855.686.8725, Monday through Friday, 8:00 am to 8:00 pm ET.

REIMBURSEMENT ASSISTANCE

TerSera Support Source
TerSera Support Source provides a comprehensive suite of services to help patients get the treatment they deserve, including:
- Reimbursement information
- Prior authorization information
- Benefits investigation
- Appeals support.

Visit terserasupportsource.com for more information. To enroll in coverage support for Varubi, download and complete the enrollment form (documents.tersera.com/varubi/VarubiEnrollmentForm.pdf) and fax the completed form to 1.855.836.3066. For more information, call 1.855.686.8725, Monday through Friday, 8:00 am to 8:00 pm ET.
PATIENT ASSISTANCE

The Teva Cares Foundation

The Teva Cares Foundation is a group of patient assistance programs created to make a positive difference in the lives of patients, families and local communities. For decades, Teva has been working through its Patient Assistance Programs to improve patient access to medication and ensure that cost is not a barrier to treatment. Through these programs, the Teva Cares Foundation is able to provide certain Teva medications at no cost to patients in the United States who meet certain insurance and income criteria. Eligibility is based on a patient’s income and prescription insurance status, and varies depending on the Teva medication that has been prescribed. To determine if your patient qualifies, review the Teva Cares Foundation Patient Assistance Programs eligibility requirements online at: tevacares.org/DolQualify.aspx or call 1.877.237.4881, Monday through Friday, 9:00 am to 8:00 pm ET. Then download the appropriate enrollment application for the Teva medication you have prescribed at: tevacares.org/DownloadApplication.aspx. Completed applications should be faxed to 1.866.676.4073.

If your patient does not meet the eligibility requirements for the Teva Cares Foundation Patient Assistance Programs, Teva may offer a reimbursement assistance program or other type of program to assist your patient. For more information, please call 888.TEVA.USA (888.838.2872). Some patients may be eligible for assistance from other programs. For a listing of these other assistance programs go to: tevacares.org/OtherResources.aspx.

REIMBURSEMENT ASSISTANCE

CORE

Teva offers Comprehensive Oncology Reimbursement Expertise (CORE) to patients, their caregivers, and healthcare professionals. CORE offers assistance and resources to help patients better understand reimbursement eligibility. CORE offers a range of services:

- Benefit verification and coverage determination
- Support for precertification and prior authorization
- Assistance with coverage guidelines and claims investigation
- Support through the claims and appeals process
- Templates for letters of medical necessity
- Teva Cares Foundation patient assistance program referrals

Download the CORE enrollment form at: tevacore.com/resources and fax the completed form to 1.866.676.4073. For more information on CORE, call 1.888.587.3263, Monday through Friday, 9:00 am to 6:00 pm ET or visit TevaCORE.com.

Oncology-related products: Bendeka® (bendamustine hydrochloride) for injection, Synribo® (omacetaxine mepesuccinate) for injection, Treanda® (bendamustine hydrochloride) for injection, Trisenox® (arsenic trioxide) injection

Patient and Reimbursement Assistance Websites

tevacares.org
tevacore.com
Verastem Oncology

Oncology-related product: Copiktra (duvelisib) capsules

PATIENT ASSISTANCE

Verastem Cares
Verastem Cares is a comprehensive, personalized program designed to provide information and assistance to patients who have been prescribed Copiktra. It is committed to getting patients the information and support they need throughout treatment. Verastem Cares is not intended to provide medical advice, replace prescribed treatment plans, or provide treatment or case management services. Verastem Cares has a range of support services, including:
- Oncology nurse advocates
- Co-pay/deductible assistance
- Bridge Rx program
- Psychosocial resources
- Patient assistance program.

To enroll in Verastem Cares, download the enrollment form (verastem.com/wp-content/uploads/2018/08/verastem-cares-form.pdf) and fax the completed form with a copy of patient’s insurance card(s) to 1.833.264.VERA (1.833.264.8372). Upon submission of the enrollment form, an oncology nurse advocate will confirm receipt with the provider’s office to initiate the services requested.

For more information about Verastem Cares, please call 1.833.570.CARE (1.833.570.2273), Monday through Friday, 8:00 am to 8:00 pm ET.

Patient Assistance Program
To be eligible, patients must be legal residents of the U.S. (including Puerto Rico and U.S. territories) and meet income requirements. All Verastem Cares programs are subject to eligibility requirements. Restrictions apply.

For more information about the program and to check eligibility, please call 1.833.570.CARE (1.833.570.2273).

Co-Pay/Deductible Assistance
Eligible commercially insured patients may pay an adjusted co-pay of as little as $5 per prescription with an annual benefit limit of $25,000. There is no income requirement and the patient must have commercial insurance. Patients with government-funded health insurance from Medicare, Medicaid, or any other government programs are ineligible. All Verastem Cares programs are subject to eligibility requirements. Restrictions apply.

Bridge Rx Program
Verastem Cares can help with coverage delays or loss of insurance lasting longer than 5 days. The program is only for on-label indications and includes a free 14-day supply of Copiktra. Eligible patients may receive this benefit until coverage is obtained or 4 shipments have been received. All Verastem Cares programs are subject to eligibility requirements. Restrictions apply.

REIMBURSEMENT ASSISTANCE

Verastem Cares
An oncology nurse advocate will be your primary point of contact at Verastem Cares to help with access issues related to COPIKTRA. It provides a range of support that can help eligible patients, including:
- Benefit investigations
- Prior authorizations
- Appeals support.

To enroll in Verastem Cares, download the enrollment form (verastem.com/wp-content/uploads/2018/08/verastem-cares-form.pdf) and fax the completed form with a copy of patient’s insurance card(s) to 1.833.264.VERA (1.833.264.8372). Upon submission of the enrollment form, an oncology nurse advocate will confirm receipt with the provider’s office to initiate the services requested.

For more information about the program and to check eligibility, please call 1.833.570.CARE (1.833.570.2273), Monday through Friday, 8:00 am to 8:00 pm ET.
Adaptive Biotechnologies

Oncology-related products: clonoSEQ® Assay (for the detection and monitoring of minimal residual disease in bone marrow samples from multiple myeloma and B-cell acute lymphoblastic leukemia patients)

PATIENT ASSISTANCE

Adaptive Assist™

Adaptive Biotechnologies understands that each patient’s situation is unique. We are committed to providing guidance and support during each step of the insurance process. That’s why we offer the Adaptive Assist program: to help facilitate access to clonoSEQ testing services for patients who could benefit from the clinical insights provided by next-generation measurable residual (MRD) testing.

Have questions? Call the Patient Support Team at 1.855.236.9230, Monday through Thursday, 9:00 am to 7:00 pm ET, and Friday, 9:00 am to 5:00 pm ET, for answers to your questions about insurance, billing, payment, or financial assistance.

Adaptive Biotechnologies is committed to providing financial assistance opportunities to qualified clonoSEQ patients with a demonstrated financial need and in accordance with the terms of the Adaptive Patient Financial Assistance Program. To be eligible for enrollment, a patient must meet all of the following criteria:

• Be a U.S. citizen or legal resident aged 18 years or older. Patients under the age of 18 are eligible, but require the application form to be signed by a parent or legal guardian.
• Be uninsured or have insurance that does not cover the full cost of clonoSEQ testing.
• Meet financial need requirements based on the patient’s income and the number of persons in their household.
• Submit a completed and signed application form (clonoseq.com/sites/default/files/PM-US-CORP-0002.2_Adaptive_PSP_ApplicationForm_WEB.pdf) including acknowledgment of the requirement to submit a tax return, W-2, pay stub, or other comparable document demonstrating financial need if and when selected for participation in the upfront enrollment audit.

Neither the application nor the Patient Financial Assistance Program constitute a contract. Adaptive retains the right to change the program in whole or part at any time in the exercise of its sole discretion.

Adaptive will notify you of your qualification status and work with you to find appropriate support. For more information call 1.855.236.9230 or visit clonoseq.com/adaptive-assist.

Patient and Reimbursement Assistance Website
clonoseq.com/adaptive-assist
PATIENT ASSISTANCE

Patient Financial Assistance Program
Our billing and reimbursement services are designed to make comprehensive genomic profiling accessible to patients regardless of their financial situation. Depending on the specific test, you may already have coverage through Medicare or private insurance. If the patient is uninsured or cannot afford the applicable out-of-pocket cost, contact the Client Services team with regard to eligibility at 888.988.3639, Monday through Friday, 8:00 am to 8:00 pm ET. To apply for financial assistance or download a paper application, visit access.foundationmedicine.com.

Patients with Medicare
For many patients with advanced solid tumor cancer, FoundationOne CDx is covered by Medicare. If the patient is on Medicare and meets the following criteria, they may not have out-of-pocket expenses for their FoundationOneCDx solid tumor testing:
• The patient has either recurrent, relapsed, refractory, metastatic, or advanced stages III or IV cancer.
• This is their first time having a FoundationOne CDx test for this cancer diagnosis or have had a FoundationOne CDx test before, but this is a different type of cancer—a “new primary” cancer diagnosis.
• They have decided to seek further cancer treatment such as therapeutic chemotherapy; and
• Their testing is ordered by a treating physician.

Note: If the patient is a Medicare/Medicare Advantage customer, they may need to sign an Advance Beneficiary Notice (ABN) prior to the test order. The physician will determine if an ABN is required.

Patients with Private Insurance
Foundation Medicine will work directly with insurance companies to try to obtain coverage. Depending on the terms of the insurance plan, the patient may have financial responsibility for co-pay, co-insurance, or deductible as directed by the plan.

If the insurance company denies coverage, with patient consent, we will work on behalf of the patient to attempt to obtain coverage and will work with the patient and doctor in pursuing appeals to minimize the financial burden. If the patient is eligible for financial assistance, this is applied to their out-of-pocket cost.

Note: If the patient has private/commercial insurance, a prior authorization form may be required in some cases.
ACCC Financial Advocacy Learning Labs
Improving Processes to Better Serve Patients

As innovative therapies continue to revolutionize cancer treatment, costs for cancer care are rising in tandem, creating a ripple effect of financial burden on patients. Cancer programs and institutions continue to seek effective strategies to assist their patients affected by cancer-related financial hardship, which can lead to devastating “financial toxicity.”

For 2019 the projected total annual cost of cancer care in the U.S. was between $173 billion to $207 billion. Over recent years, costs have increasingly shifted to patients through higher deductibles, co-insurance, co-payments, and out-of-pocket expenses—all of which, studies have shown, can negatively affect patient outcomes, quality of life, psychosocial health, and treatment adherence.

The ACCC Financial Advocacy Network
Since 2012, the Association of Community Cancer Centers (ACCC) has led national efforts to provide practical education, training, tools, and resources through its Financial Advocacy Network initiative. As the need for financial advocates is increasingly recognized, the role of these cancer care team members continues to evolve. Ongoing education is critical not only for financial advocates, but also for the cancer programs and practices in which these services are embedded. Led by an advisory committee of professionals experienced in financial advocacy for patients with cancer, ACCC’s Financial Advocacy Network continues to develop education in this critical area. Over the past three years, ACCC has launched a series of case-based regional workshops, on-site Learning Labs at member cancer programs, and online training through the Financial Advocacy Boot Camp (accc-cancer.org/boot-camp).

ACCC conducted its most recent series of Learning Labs on-site at two member programs in late 2018 and early 2019. Through an application process, the following programs were selected to participate in the Learning Labs: Nebraska Medicine, Fred and Pamela Buffett Cancer Center; Omaha, Nebraska and Vanderbilt University Medical Center, Vanderbilt-Ingram Cancer Center, Nashville, Tennessee.

How the Learning Labs Work
For the recent Learning Labs, member programs with demonstrated interest in ACCC’s Financial Advocacy Network were invited to apply to participate by completing a comprehensive application describing the current financial advocacy resources in place at their cancer programs. Based on pre-determined criteria, including utilization and experience with Financial Advocacy Network resources, two programs were selected as Learning Lab sites from the applicant pool. Before the workshop, these programs completed a questionnaire to give ACCC insights into their specific educational needs. ACCC and the Financial Advocacy Network faculty then customized the workshops based on the information provided.

Inside the Labs
The following members of the ACCC Financial Advocacy Network Advisory Committee served as faculty and facilitators, traveling to the cancer programs for the Learning Labs:
• Angie Santiago, CRCS-I, Lead Financial Counselor-Oncology, Thomas Jefferson University Health System, Sidney Kimmel Cancer Center
• Clara Lambert, BBA, OPN-CG, Oncology Financial Navigator, Advocate Good Samaritan, Bhorado Cancer Center
• Lori Schneider, Business Office Manager, Green Bay Oncology.

Each Learning Lab opened with a half-day interdisciplinary session. Faculty helped participants focus in on understanding their organization’s issues regarding financial advocacy care coordination and communications to assist the organization in devising strategies to help patients overcome financial barriers to care.

To make the most of the Learning Lab experience, ACCC required participation from each cancer program's financial advocacy team and any other staff who play a key role in the financial advocacy and navigation process. Interdepartmental communication is often siloed in organizations; the Learning Lab format is designed to engage cross-department stakeholders in discussion that centers on how the oncology team can better address patients' financial barriers to care. The Learning Lab process is a unique opportunity to align staff around a comprehensive, shared understanding of the multiple drivers of financial toxicity for patients with cancer and their caregivers, and to collaborate on strategies to mitigate these barriers.

Across both Learning Lab sites, participants included financial navigators, patient navigators (lay and clinical), social workers, as well as managers and leadership from research and clinical trials, cancer services, billing services, patient access, medical oncology, radiation oncology, infusion services, pharmacy, nursing, patient care services, finance, business, and administration. Such multidisciplinary, collaborative effort is often crucial to a financial advocacy program’s success and sustainability.

These teams worked with ACCC faculty facilitators to review the financial advocacy systems in place at their institution with a view toward the following three goals:
• Identifying institutional gaps in financial advocacy within diverse healthcare settings and patient populations
• Devising strategies for coordination and communication among members of the multidisciplinary cancer care team to optimize financial advocacy for patients
• Developing strategies to engage patients to actively participate in shared decision-making with members of their cancer care team.

Each workshop included a presentation by the ACCC facilitators, which outlined the model financial advocacy program that they helped design at their institutions. Throughout each session, participants shared ideas and recommendations for advancing their financial advocacy programs and processes, and then voted on priority action areas for the coming months. Facilitators emphasized the importance of recognizing the value of incremental improvements and that setting short- and long-term goals is integral to building out comprehensive financial advocacy services. (For example, some recommendations and/or objectives have foundational steps that will need to be completed first, such as collecting metrics to have data to support the need for additional staff.)

The Learning Labs wrapped up with a discussion of timelines and task delegation. This included finalizing the site’s customized action plan, to be completed in the Plan-Do-Study-Act (PDSA) format and implemented during the following three-month period. Facilitators then conducted an informal program evaluation and debrief to address any additional questions. Over the next six months, ACCC followed up with both Learning Lab sites through scheduled telephone check-in calls, supporting each program’s PDSA progress, connecting participants to the Learning Lab faculty, and providing resources as requested. At three months post-Learning Lab, ACCC conducted follow-up interviews with both sites to offer additional support, identify any further takeaways, track progress, and obtain feedback on the process.

A Common Thread
The primary challenges identified by the Learning Lab participants revealed some common themes:
• A lack of dedicated human resources
• Delayed or inconsistent assessment and delivery of supportive services and resources (often a result of communication gaps)
• Ineffective data tracking and metrics reporting.

The gaps each group identified often overlapped, which highlighted common challenges in providing optimal resources and supportive services for all patients. For example, participants agreed that obtaining buy-in from leadership for additional staff is difficult without quantifiable reporting measures in place to document need.

The groups also determined that the proper assessment and delivery of patient financial advocacy resources was hindered by inadequate transparency among teams, which indicated siloed work processes both among departments and within organizational electronic health records (EHRs). As an example, EHR access varies across departments. Thus, dashboards available through the EHR may differ.

After participating in the Learning Labs, the two participating cancer programs implemented the following strategies to improve coordination and delivery of financial services to their patients.
**Challenge 1: Lack (or Insufficient Number) of Dedicated Human Resources**

At the Fred and Pamela Buffett Cancer Center, the financial advocacy team knew metrics were necessary to justify hiring more financial navigators with experience and knowledge specific to the economic challenges that patients experience along the cancer care continuum. The organization’s existing model divided financial navigation services among multiple medical specialties, creating confusion and bottlenecks, with no clear or meaningful metrics.

The team at Vanderbilt-Ingram Cancer Center identified the need to gather additional data to justify the additional staff.

After the Learning Labs, it became clear to participants that the current financial navigation models they had in place were not adequate. As a result, stakeholders from both programs began working to involve key players in a redesign of their entire financial navigation program to better meet patient needs.

The leadership attendance at the on-site Learning Labs increased their exposure, knowledge, and awareness of the issues brought forward. At Vanderbilt-Ingram Cancer Center, for example, that awareness has already had an impact on reducing departmental siloes and increasing cross-departmental discussion.

At the conclusion of each Learning Lab, participants were instructed to gather and present relevant data to their leadership to document a case for more dedicated financial navigation resources and infrastructure improvements to support patients.

“We have drafted a future state model for our financial navigation program: What do we envision? How should this work?” said Cody Tyler, clinical business coordinator at Vanderbilt-Ingram Cancer Center. Leadership is looking to the care team on the front line to help determine how to design and build a program equipped to address the growing need for financial resources for their patients—and to enable the cancer care team to deliver them successfully at every stage of the care continuum.

**Challenge 2: Delayed or Inconsistent Assessment of Patient Financial Needs**

The primary goal of the team at Vanderbilt-Ingram Cancer Center is to reach patients at the beginning of their cancer journey and help them navigate the entire course of their care. Staff already provides cost-of-care estimates, but only to new patients and patients in the Oncology Care Model (OCM). The team has processes in place to provide facility charge estimates to patients with out-of-network insurance. There is also a process for patients without insurance. The team aims to take a more proactive approach reaching out to patients prior to their first treatment appointment to mitigate any financial barriers in advance for this high-cost scenario.

At the Vanderbilt-Ingram Cancer Center Learning Lab, participants assessed their roles and teams to create a roadmap that would illustrate the full range of services they provide. This roadmap would be a useful tool for educating providers and team members about the work they do. They also outlined their workflow processes and worked to improve coordination across teams. Since the Learning Lab, Vanderbilt-Ingram Cancer Center has found that sharing standardized information and documentation across teams has enabled better transparency for coordinating efforts between the billing department and financial counselors and navigators.

During the course of the workshop, the team decided that patients who do not qualify for assistance under current guidelines should nevertheless have an opportunity to speak with financial navigators, who may be able to identify needs and help direct patients to available resources if necessary. The team is also developing a plan to keep patients apprised of the status of financial assistance applications (e.g., to manufacturer patient assistance programs or for foundation assistance) and to decrease wait times for financial assistance.

The Learning Lab at the Fred & Pamela Buffett Cancer Center revealed some confusion over what staff member was responsible for which tasks, for example, who would reach out to patients if free drug was available. The team created a
“communication matrix” spreadsheet that defines key roles and responsibilities. This step has already helped to improve care by opening communication channels, which in turn has reduced delays in access to care.

**Challenge 3: Ineffective Process for Tracking Results of Financial Advocacy**

At the Fred & Pamela Buffett Cancer Center, the Access Team reviews bad debt, charity percentages, point-of-service collections, and drug assistance enrollment organization-wide. The team captures productivity and quality metrics on each financial counselor, but there are no oncology-unit-specific metrics captured.

For this team, varying levels of EHR access in Epic presented obstacles to communication and patient information, for example, users would not necessarily be able to view the same screen in the EHR. In turn, this affected initial contact and follow-up with patients regarding treatment costs.

Since the Learning Lab, the team has created an Access Services Team and an accountability spreadsheet, and it now has specific meetings to discuss process improvements and areas where the team (or process) may be falling short.

The team continues to evaluate how best to measure and report outcomes, working with their IT department to determine which metrics to track and how to gather the data in Epic. Among the metrics staff would like to collect are number of patients assisted, increased revenue/savings to the facility, and direct patient benefit.

Post-Learning Lab at the Vanderbilt- Ingram Cancer Center, the team began implementation of a tracking tool to monitor patients who sign up for co-pay assistance and cost-savings programs. Learning Lab participants are also working with the pharmacy billing team to collect these metrics, which include cost-savings for the patient. The team is also adding metrics to gauge cost-savings realized by the organization as a result of their financial advocacy efforts.

**Next Steps Post-Learning Labs**

Looking ahead, the Vanderbilt- Ingram Cancer Center team intends to provide more robust training and education on financial navigation and distress to enable all staff members to understand the implications of financial toxicity for patients and the importance of adopting a team approach to mitigating the economic impact of cancer.

At the Fred & Pamela Buffett Cancer Center, Learning Lab participants report a better understanding among staff of the complexities involved in financial advocacy. Meeting across teams to unpack and clarify financial advocacy processes has presented opportunities for growth and improvement.

Throughout this process, it has become increasingly clear to the team that achieving a robust financial advocacy program will take a multidisciplinary effort across teams. Learning Lab participants agreed that pharmacy, access, and nursing teams all need to work together to achieve the best outcomes for patients. A standing meeting to address workflow and communication is now on the team’s calendar keeping a focus on clearly defining processes and continually working to streamline them.

**Next Steps for Your Program**

Could your cancer program or practice benefit from an on-site ACCC Financial Advocacy Network Learning Lab? Apply to participate in the 2020 workshops. Details are available on the ACCC website at accc-cancer.org/FAN. 

**References**


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Funding and support provided by Lilly Oncology.
Innovations should advance the goals of improving access, quality, and value in cancer care delivery.

SUGGESTED AREAS OF FOCUS INCLUDE:

- New Models in Care Coordination
- Process and Quality Improvement Initiatives
- Community Outreach, Prevention, & Screening
- Telehealth & Virtual Care Models
- Financial Advocacy & Navigation
- Collaborative Practice Agreements & “Top-of-License” Practices
- Innovative Provision of Supportive Care Services
- Patient Engagement & Shared Decision-Making Strategies
- Technology Solutions to Improve Care & the Patient Experience
- Provider Resiliency & Well-Being
- Immuno-Oncology Implementation

Recipients will be selected through a peer review process. Applicants must be affiliated with ACCC as a Cancer Program Member. If you would like to become a member, please visit accc-cancer.org/membership.

INNOVATE. ACHIEVE. INSPIRE.

Visit accc-cancer.org/Innovator for more details and to apply online.
BUILD YOUR ONCOLOGY BUSINESS NETWORK!

ACCC 2020
ONCOLOGY REIMBURSEMENT MEETINGS

FEBRUARY 11
Jacksonville, FL

MARCH 24
San Diego, CA

MAY 5
Minneapolis, MN

REGISTER TODAY!
accc-cancer.org/ORM
Agingcare.com®
agingcare.com
A web-based resource for caregivers, including the Prescription Drug Assistance Program Locator: agingcare.com/Articles/prescription-drugassistance-program-locator-171753.htm. This tool allows older adults and their families to search for financial aid programs for prescription medications. Search for prescription drug assistance plans by state, medication name, or browse a list of nationwide non-profit prescription drug assistance programs.

BenefitsCheckUp®
benefitscheckup.org
The National Council on Aging (NCOA) is a respected national leader and trusted partner helping older adults meet the challenges of aging through services like BenefitsCheckUp. BenefitsCheckUp is a comprehensive, free online tool that connects older adults with benefits they may qualify for. The BenefitsCheckUp team monitors the benefits landscape for updates and changes to policies and programs. We match your unique needs to benefit programs and eligibility requirements using our comprehensive tool. There are over 2,500 federal, state, and private benefits programs available to help. After filling out a questionnaire, patients receive a personalized report that describes the programs they most likely to qualify for. Patients can apply for many of the programs online or print an application form. Here are the types of expenses patients may get help with:

- Medications
- Food
- Utilities
- Education
- Healthcare
- Housing
- In-home services
- Tax relief
- Transportation
- Employment.

If patients have Medicare and have limited income and resources, they may be eligible for the Medicare Rx Extra Help program. Patients may be able to get extra help paying for prescription drug costs if:

- Their income is below $18,735 if they are not currently married or not living with their spouse, or $25,365 if they are currently married and living with their spouse
- Their combined savings, investments, and real estate are not worth more than $14,390 if they are not currently married or not living with their spouse, or $28,720 if they are currently married and living with their spouse. (see online for exclusions).

To apply, patients must live in one of the 50 United States or the District of Columbia. If patients have more than these amounts, they may not qualify for the Extra Help. However, they can still enroll in an approved Medicare prescription drug plan for coverage. Apply online at: benefitscheckup.org/medicare-rx-extra-help-application-welcome.

CancerCare®
cancercare.org
CancerCare’s comprehensive services include counseling and support groups over the phone, online and in-person, educational workshops, publications, and financial and co-payment assistance. All CancerCare services are provided by oncology social workers and world-leading cancer experts. Limited assistance from CancerCare is available to eligible families for cancer-related costs, including transportation, home care, child care, pain medication and lymphedema supplies. CancerCare is not able to help with basic living expenses. As a non-profit organization, funding depends on the sources of support CancerCare receives at any given time. If CancerCare does not currently have funding to assist you, their professional oncology social workers will always work to refer you to other financial assistance resources. Check: cancercare.org periodically for funding updates.

Patient Assistance Program
In order to be eligible for its financial assistance program patients must:

- Have a diagnosis of cancer confirmed by an oncology healthcare provider
- Be in active treatment for cancer
- Live in the U.S. or Puerto Rico
- Meet CancerCare eligibility guidelines based on the Federal Poverty Limit.

Here’s how to apply:
1. Call 800.813.HOPE (4673) and speak with a CancerCare social worker to complete a brief interview, Monday through
Thursday, 10:00 am to 6:00 pm ET, and Friday, 10:00 am to 5:00 pm ET.

2. If patients are eligible to apply, CancerCare will:
   • Mail or email the patient an individualized barcoded application
   • Request documentation to verify the patient’s income.

3. Patients must submit a completed application.

CancerCare® Co-payment Assistance Foundation
cancercarecopay.org

CancerCare Co-payment Assistance Foundation (CCAF) helps people afford the cost of co-payments for their prescribed cancer treatments. This assistance is provided free of charge to ensure patient access to care and compliance with prescribed treatments. CancerCare provides a streamlined enrollment process that instantly determines eligibility. Grants can be awarded if funding is available. CCAF funds are disease specific. The patient’s diagnosis must match our fund definition. If CCAF does not have funds available for a specific disease, it will refer patients to another foundation that may be able to assist.

In order to be eligible for assistance:
• Patient’s primary cancer diagnosis must be the same as one of the funds that CCAF covers.
• Patient must have a valid Social Security number to apply for assistance and receive treatment in the United States.
• Patient must be in active treatment or have a treatment plan in place prior to applying for assistance.
• Patient is required to have valid insurance coverage. Some funds are restricted to assist only those insured through a federal health insurance program such as Medicare or TRICARE.
• Patient income level must be at or below 500% of the Federal Poverty Level.

Patients can apply online at cancercare.org/copay-apply. Downloaded forms may be returned by email (information@cancercarecopay.org) or can be faxed to 212.601.9760. Patients are enrolled up to one year from the time they are approved.

If patients have private insurance, please contact the drug company that manufactures their medication before you contact CCAF, as the company may offer a program that can help. CCAF is only able to assist insured individuals who need help paying the co-payment cost of their treatments. However, our co-payment specialists can refer patients without insurance to other resources that may be able to help, including drug company patient assistance programs and state prescription programs.

For more information, contact a co-payment specialist at 866.55. COPAY (866.552.6729), Monday through Thursday, 9:00 am to 7:00 pm ET, and Friday, 9:00am to 5:00 pm ET.

Cancer Financial Assistance Coalition
cancerfac.org

CFAC is a coalition of organizations and cannot respond to individual requests for financial assistance. To find out if financial help is available, use the CFAC database at: cancerfac.org. Search by cancer diagnosis or specific type of assistance or need (i.e., Co-Pays, general living expenses, transportation, healthcare). You may also contact each CFAC member organization individually for guidance and possible financial assistance.

Co-Pay Relief
copays.org

The Patient Advocate Foundation (PAF) Co-Pay Relief Program (CPR) provides direct financial assistance to qualified patients with co-payments, co-insurance, and cost-sharing associated with with prescription medications through funds dedicated to specific disease states. In some instances, assistance with insurance premiums and/or ancillary services associated with the disease also may be available. Program Specialists are available to personally guide you through the application and enrollment process. Patients approved for assistance are required to have their verified diagnosis and treatment plan along with supporting documentation completed and returned within 30 days of approval to ensure continuation of the award.
Eligibility requirements:
- Patients must be currently insured and have coverage for medication(s) seeking financial assistance.
- Patients must have a confirmed diagnosis and treatment plan.
- Patients must reside and receive treatment in the United States.
- The patient’s income must fall at or below 300 percent or 400 percent of the Federal Poverty Guideline (FPG) with consideration for the Cost of Living Index (COLI) and number in the household.

If the patient is eligible for assistance, the application will be instantly approved, and the patient will be enrolled into the program. The patient will have immediate access to their award and pharmacy card.

The CPR Program offers ways to apply for assistance:
1. Patients may apply via the patient online application portal (copays.org/patients) available 24 hours a day.
2. Medical providers can assist patients with completing an application for assistance via the provider portal available (copays.org/providers) available 24 hours a day.
3. Pharmacies can assist patients with creating an application for assistance via the pharmacy portal (copays.org/pharmacies) available 24 hours a day.
4. Applications can also be completed over the phone by calling 866.512.3861, option 1, to be connected directly to a CPR Approval Specialist.

**FamilyWize® familywize.org**

FamilyWize partners with nearly all pharmacies nationwide to negotiate prescription discounts, so patients receive a lower price. FamilyWize understands patients are looking to reduce the cost of prescription medications, and its goal is to help do that. The pharmacy discount card is for everyone nationwide, whether or not patients have health insurance coverage.

The free FamilyWize Prescription Discount Card (familywize.org/free-prescription-discount-card) is available online or through mobile app. There are no fees or eligibility requirements. This program can be used to obtain savings on prescription drugs that are excluded by insurance plans, not covered because patients have exceeded their plan’s maximum limits, or the free prescription discount card’s price is lower than a patient’s program’s co-payment amount.

With the Drug Price Look-up Tool (familywize.org/drug-price-look-up-tool), patients can enter the name of their medication and zip code and see the price they’ll pay using FamilyWize at local pharmacies. Discounts are available only at participating pharmacies.

The prescription drug discount card must be presented with each prescription to a participating pharmacy to obtain the discount price. Pricing is always the lesser of the discounted price or pharmacy’s retail price. If the pharmacy’s price is less, there is no discount. Cannot be used with other prescription or through a health plan or pharmacy benefit plan. All benefits are subject to change without notice. Additional restrictions may apply.

Learn more at familywize.org, or call 800.222.2818

**Good Days® mygooddays.org**

Good Days is here to help: helping overcome the burden of treatment costs, connecting patients to a community that cares. Good Days not only make life-saving and life-extending treatments affordable; they act as patient advocates, helping them navigate the system and guiding them to additional support through foundations and other organizations dedicated to those with specific, life-altering conditions.

Good Days covers what insurance won’t—the co-pays for treatments that can extend life and alleviate suffering. Good Days also has a premium assistance program for patients who need help paying their monthly medical insurance premiums. Its Travel Assistance program helps pay for travel costs to ensure patients have access to the care they need.

Good Days has streamlined the enrollment process so patients can receive immediate determination of eligibility for financial assistance. Eligibility criteria:
- Patient must be diagnosed with a covered disease and program must be accepting enrollments
- Patient must have a valid Social Security number to apply for assistance and receive treatment in the United States
- Patient must be seeking assistance for a prescribed medication that is FDA approved to treat the covered diagnosis
- Patient is required to have valid insurance coverage
- Patient income level must be at or below 500% of the Federal Poverty Level (FPL).

To enroll, go to mygooddays.org/apply and either apply online or
download the English and Spanish enrollment forms and fax completed forms to 214.570.3621.

HealthWell Foundation®
healthwellfoundation.org

When health insurance is not enough, HealthWell Foundation is here to help your patients — with copays, premiums, deductibles and out-of-pocket expenses for supplies, supplements, surgeries and more. It offers financial assistance through a number of Disease Funds, with new funds opening every year, so they can get the care they need.

To be eligible, patients must meet certain criteria:
• HealthWell must have a disease fund that covers the patient's illness, and their medication must be an eligible treatment for that illness
• Patients must have some form of health insurance such as, private insurance, Medicare, Medicaid, or TRICARE
• Patients have incomes up to 400 percent to 500 percent of the federal poverty level (HealthWell considers household income, the number in the household, and the cost of living in the patient’s city or state)
• Patient must be receiving treatment in the United States.

Anyone with the patient’s express permission may apply on behalf of a patient in two ways:
1. Apply online using the HealthWell provider portal at: https://healthwellfoundation.secure.force.com/
2. Apply by phone at 800.675.8416, Monday through Friday, 9:00 am to 5:00 pm ET.

Providers, pharmacists, and social workers are strongly encouraged to use the online provider or pharmacy portal to apply so that patients can readily access HealthWell hotline care managers.

Once patients are approved for a grant from one of the Disease Funds, they receive assistance for a rolling 12 months, after which they can reapply if needed and if funding is available. Upon approval, patients will receive both a HealthWell Pharmacy Card and a Reimbursement Request Form for times when they need it.

For more detailed information on reimbursement guidelines and practices, and to download important reimbursement and income verification forms, go to healthwellfoundation.org/how-to-get-reimbursed/.

For questions, Call 800.675.8416 to speak with a HealthWell representative, Monday through Friday, 9:00 am to 5:00 pm EST.

The Leukemia & Lymphoma Society
Co-Pay Assistance Program
lls.org

The Leukemia & Lymphoma Society (LLS) Co-Pay Assistance Program offers financial support toward the cost of insurance co-payments and/or insurance premium costs for prescription drugs. Patients must qualify both medically and financially for this program. The LLS Co-Pay Assistance Program offers financial help toward:
• Blood cancer treatment-related co-payments
• Private health insurance premiums
• Medicare Part B, Medicare Plan D, Medicare Supplemental Health Insurance, Medicare Advantage premium, Medicaid spend-down, or co-pay obligations.

To be eligible for Co-Pay Assistance, patients must:
• Have a household income at or below 500 percent of the U.S. Federal Poverty Guidelines as adjusted by the Cost of Living Index
• Be a United States citizen or permanent resident of the U.S. or U.S. territory
• Have medical and/or prescription insurance
• Have a blood cancer diagnosis confirmed by a doctor. Patient must be in active treatment, scheduled to begin treatment, or is being monitored by their doctor. (See a list of covered diagnoses here: lls.org/support/financial-support/co-pay-assistance-program).

Patients, providers, pharmacies can apply online at cprportal.lls.org/

You can also apply or get more information about the LLS Co-Pay Assistance Program by calling 877.557.2672, Monday through Friday, 8:30 am to 5:00 pm ET.

Support for this program is based on the availability of funds by disease diagnosis.

Patient Aid Program

The Patient Aid Program provides financial assistance to blood cancer patients. Eligible patients will receive a one-time $100 stipend to help offset expenses. There are no income criteria to qualify for this program. Program continuation is dependent on the availability of funds and the program could be modified or discontinued at any time if funding is not sufficient.
is limited or no longer available. To be eligible, patients must:

• Be a United States citizen or permanent resident of the U.S. or Puerto Rico
• Have a blood cancer diagnosis
• Be in active treatment, scheduled to begin treatment, or being monitored by their doctor.

Apply online at unpportal.lls.org or by phone at 877.557.2672, Monday through Friday, 8:30 am to 5:00 pm ET.

**Medicine Assistance Tool**
[medicineassistancetool.org](http://medicineassistancetool.org)

Pharmaceutical Research and Manufacturers of America (PhRMA) created the Medicine Assistance Tool (MAT) to provide a dedicated search engine that allows users to search for financial assistance resources available through the various biopharmaceutical industry programs available for patients who are eligible. Each assistance program has its own eligibility criteria.

The tool has three steps: Enter Your Medications, My Background and My Resources. In the final step, users can review resources that may be available based on the medications and background information entered. Each resource has a description and buttons for learning more from the program's website or for applying.

MAT offers other resources, including:

• List of other healthcare assistance resources [https://medicineassistancetool.org/My-Resources?sec=all-resources&cat=13](https://medicineassistancetool.org/My-Resources?sec=all-resources&cat=13)
• A list of discount drug card programs at: [https://medicineassistancetool.org/My-Resources?sec=all-resources&cat=3](https://medicineassistancetool.org/My-Resources?sec=all-resources&cat=3)


**NeedyMeds**
[needymeds.org](http://needymeds.org)

NeedyMeds is a non-profit that connects people to programs that will help them afford their medications and other healthcare costs. Each program has its own qualifying criteria. To find a PAP that you may qualify for click on the brand name or generic name medication page under the “Patient Savings” tab on the NeedyMeds website, or search for your medication name using the search feature in the upper lefthand corner of the screen. If using the brand or generic name medication search:

1. Click on the first letter of the name of your medicine in the alphabet bar.
2. Click on the name of your medicine to find out if there is a Patient Assistance Program (PAP) available. If there is an active program available, a PAP icon will appear under the drug name.
3. Click on the PAP icon to access the eligibility and contact information for the program(s). In some cases, the program application form can be printed from the NeedyMeds website. Applications should be faxed or mailed directly to the PAP, not to NeedyMeds.

Applications Assistance:

There are many local programs and individuals that help people take advantage of pharmaceutical company patient assistance programs - all for free or low cost. They help with such things as finding a program for prescription medications, completing of the application forms, and working with physicians who must sign the forms. Help can be found at [www.needymeds.org/local-programs](http://www.needymeds.org/local-programs). You can find local programs in two ways:

1. Enter the patient’s zip code to find a program in their area or
2. Search by state.

If a medicine does not appear on the brand name or generic name lists, then it is not available through a PAP. Other assistance options include:

• Coupons, Rebates & More are lists of offers for prescription medications (over-the-counter and prescription) and medical supplies. These offers may be in the form of a printable coupon, rebate, savings card, 7-30 day free trial offers, or free samples. There are a variety of ways to receive the offers: some may be printed right from their website, others require registration, filling out a questionnaire, or even obtaining a sample from the doctor’s office.

• **NeedyMeds Drug Discount Card** can help save up to 80 percent on many prescription medications. No personal information or registration is required and the drug discount card is free of charge. The card cannot be used in combination with any insurance. Download a card and learn more about its benefits at [www.needymeds.org/drug-discount-card](http://www.needymeds.org/drug-discount-card). Information

Look for all of your medications, not just the most expensive ones.
on other drug discount cards are also available on the NeedyMeds website.

- **Diagnosis-Based Assistance:**
  There are many government and privately-funded programs that help with costs associated with a specific diagnosis. Some programs are national in scope, while others are limited to people in specific states. Most have some type of eligibility requirements, usually financial ones. Some cover one specific diagnosis, while others cover whole categories (such as all types of cancers) or even all chronic medical illnesses. NeedyMeds has compiled a database ([needymeds.org/disease-resources](http://needymeds.org/disease-resources)) of diagnosis-based assistance programs that you or your patient can search. It’s best to search by the type of diagnosis. Other ways to search for assistance are by looking for programs that serve a specific geographical area. If you know the name of a specific program about which you want more information, you can also search by name of program.

**Assistance with Government Programs:**
Every state has programs to help needy families and individuals with the cost of healthcare. NeedyMeds has compiled a database of these state programs. You can search these programs by clicking on a state, the District of Columbia, or U.S. territory. Programs and their guidelines vary from state to state. NeedyMeds also has a list of Medicaid sites where you can learn more about Medicaid in your state, as well as general information on Medicaid.

For all questions, call 1.800.503.6897, or email info@needymeds.org.

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**Patient Access Network Foundation**
panfoundation.org

The Patient Access Network Foundation (PAN) is an independent, national charity organization dedicated to helping federally and commercially insured people living with life-threatening, chronic, and rare diseases with the out-of-pocket costs for their prescribed medications. Providers and their patients can apply for assistance by calling 1.866.316.7263 Monday through Friday, 9:00 am to 7:00 pm or online through the self-service portals at panfoundation.org/index.php/en/apply.

Patients must meet the following criteria to be eligible for PAN assistance:
- Patient must be getting treatment for the disease named in the assistance program to which they are applying
- Patient must have health insurance that covers their qualifying medication or product
- The medication or product must be listed on PAN’s list of covered medications
- Patient’s income fall at or below the Federal Poverty Level specified by the assistance program
- Patient must reside and receive treatment in the United States or U.S. territories. (U.S. citizenship is not a requirement.)

PAN grants cover medications for twelve months. If more help is needed, the patient may be able to apply for additional funding.

For questions about applications or income verification, call 1.866.316.7263 or email info@panfoundation.org.

**Patient Advocate Foundation**
patientadvocate.org

The Patient Advocate Foundation (PAF) is a national non-profit charity that provides direct case management services and financial assistance to patients and caregivers. It offers the following services:

- **Case management services:** Professional case managers at PAF work with the mission to identify and reduce the challenges that individuals have when seeking care for their disease. Case management services are available on behalf of patients meeting all of the following criteria:
  - Have a confirmed diagnosis of a chronic disease, a life-threatening disease, or debilitating disease, or be seeking screening services related to symptoms or suspicion of a chronic, life-threatening, or debilitating disease
  - Be in active treatment, had treatment within the past 6 months, or going into treatment in the next 60 days
  - Be a U.S. citizen or permanent resident of the U.S.
  - Be receiving treatment at a facility in the United States or one of its U.S. territories.

To connect with case management services, call 1.800.532.5274 or apply online at patientadvocate.org/connect-with-services/case-management-services-and-medcarelines/.

**MedCareLine:** A division of PAF, the MedCareLine’s team of professional case managers assist with disability, health insurance navigation including prior authorization, appeals for denied services, second opinion options, and screening for clinical trials. The case managers also assist patients
who are experiencing financial challenges that are impacting their ability to pay for care and basic cost of living expenses like housing, utilities, food, and transportation, researching and linking them to available financial support programs that may meet some of these needs. Uninsured patients are also supported by the program with direct support in accessing public programs, health insurance enrollment, and charity care that will allow access to necessary care. For more information, visit patientadvocate.org/connect-with-services/case-management-services-and-medcarelines.

**Co-Pay Relief Program:** The PAF Co-Pay Relief Program, one of the self-contained divisions of PAF, provides direct financial assistance to insured patients who meet certain qualifications to help them pay for the prescriptions and/or treatments they need. This assistance helps patients afford the out-of-pocket costs for these items that their insurance companies require. For more information, visit copays.org.

**Financial Aid Funds:** This independent division of Patient Advocate Foundation provides small grants to patients who meet financial and medical criteria. Grants are provided on first-come first-served basis and are distributed until funds are depleted. Qualifications and processes for each fund may differ based on fund requirements. Patients who are interested in applying for financial assistance should start by calling the division at 855.824.7941 or by registering your account and submitting an application online at financialaid.patientadvocate.org.

For questions, call 1.800.532.5274, Monday through Thursday, 8:30 am to 5:00 pm ET, and Friday, 8:30 am to 4:00 pm ET.

**RxAssist**
rxassist.org

RxAssist offers a comprehensive directory of patient assistance programs, as well as practical tools, news, and articles so that healthcare professionals and patients can find the information they need. Go to rxassist.org/search and search by either medication name or company name.

If an application is available online, you can either open (download) the application, type information directly onto the application on the screen and print it out, or print out the application and fill it out by hand. If there is no application online, use the phone number provided at the top of the Program Details page to call the company for information on how to get an application.

**RxAssist Discount Card**

With the RxAssist Discount Card, patients can save up to 80 percent on their medications. Savings are possible with or without insurance, and there is no additional cost to use the card. RxAssist guarantees the lowest price between its discounted price, patients’ insurance copay, or the pharmacy cash price. Visit rxassist.org/coupon/generic?type=patients, or email info@rxassist.org for more information.

**RxHope™**
rxhope.com

Healthcare providers and their staff can set up accounts online to order free medications for their patients through the RxHope automated patient assistance online system.

If you would like to create a free account for one healthcare provider, visit: rxhope.com/Prescriber/Set upAccount.aspx. To set up your free account and place orders online the following criteria are required:

- You must be a healthcare provider or their staff
- A valid state license number for the healthcare provider
- An email address (this will become your login)
- The medication for which the patient is applying
- The patient’s first and last name.

Once you have the above information available, go to: rxhope.com/Prescriber/Register.aspx and follow the instructions. You will be setting up your free account and creating an order for your patient all at the same time.

RxHope acts as your guide through the patient assistance maze and provides the critical link between patients and healthcare providers and ultimately with the pharmaceutical companies. It can determine if patients are eligible for patient assistance and then help them start the application process. Patients can initiate the patient assistance process by:

1. Enter their contact information and select the medication for which they are applying
2. Review the program guidelines and requirements that will be listed on the screen
3. Follow the instructions and print out your request for the healthcare provider to complete.

To complete the request, make sure to click on the blue link that says “Apply online Now.”
Rx Outreach®
rxoutreach.org

Rx Outreach is a fully-licensed non-profit mail order pharmacy that ships medication directly to patients’ homes or the provider’s office. To make this process simple and cost-effective, Rx Outreach typically ships medication for 30, 60, 90, or 180 days at a time. Patients who meet eligibility requirements can use Rx Outreach regardless of whether they use Medicare, Medicaid, or other health insurance. To be eligible to use Rx Outreach, patients must meet income requirements, which can be found online at https://rxoutreach.org/find-out-if-youre-eligible/.

Patients and providers can enroll in Rx Outreach in three ways:
1. Download and print the paper application (rxoutreach.org/wp-content/uploads/2019/09/Rx-Outreach_Application-9.19-fillable.pdf), and fax the completed form to 1.800.875.6591.
2. Create an account online at remote.rxoutreach.org/login/auth
3. Call 1.888.RXO1234 (1.888.769.1234).

When enrolling, patients will need to provide the following information:
• Name and contact information
• Date of birth

Once patients are enrolled, their provider should e-Prescribe or fax their prescription to Rx Outreach, or the provider can mail a hard copy prescription, as well.

If you have any questions, call 1.888.RXO1234 (1.888.796.1234), Monday through Friday, 7:00 am to 5:30 pm CST, or email questions@rxoutreach.org.

Tips for Assisting Patients in Applying to Patient Assistance Programs

✓ If you have any questions, call the program directly. Eligibility requirements, drugs, dosages, even programs, change regularly so it’s best to go directly to the program for information. If you do not qualify for the PAP but cannot afford your medicine, tell the representative. Some companies may make hardship exceptions and are willing to review situations on a case-by-case basis. Sometimes you can write an appeal letter to the program explaining your financial hardship.

✓ Review the Federal Poverty Guidelines and Percentages over the Poverty Guidelines when looking at the eligibility guidelines of a program.

✓ Fill out as much information on the application as possible, including the doctor’s address and phone number. Highlight the directions for the doctor and where he or she needs to sign. Give the doctor’s office an addressed-and-stamped-envelope to send in the application or highlight the fax number so it is easy to find.

✓ Plan ahead so your medicine supply doesn’t run out. When sending in an application, pay attention to the refill process and the amount of allowable refills. Each program is different; some require a call from the doctor’s office while another may allow the patient to call directly for a refill; others may require a new application, which takes time.

✓ Be neat and complete. The directions on the application should be completed exactly as directed. Print neatly. If something is unreadable or there is a blank, then the application may be denied, which can delay the process of receiving the medicine. Put “N/A” or “not applicable” in blanks that are not filled out to indicate the material was read through and not skipped over. Include supplementary forms if requested. Make sure all accompanying photocopies are clean and readable.

Source. ACCC Financial Advocacy Network. accc-cancer.org/FAN
Association of Community Cancer Centers

Oncology Drug Database

Find comprehensive coding, billing, and reimbursement information for every approved oncology drug in a single, easy-to-use location, including information on both provider-administered (Part B) and provider-prescribed (Part D) drugs.

Search for a generic or brand name drug to find information on:

- Billing (HCPCS, NDC) and diagnosis (ICD-9 and ICD-10) codes
- Medicare payment limits (does not include the reduction due to sequestration)
- Reimbursement amounts
- FDA-approved indications
- Drug manufacturer information, including contact information for the medical affairs department and reimbursement specialists

For more information, visit accc-cancer.org/drugdatabase

Questions on how to use the ACCC Oncology Drug Database?
Email drugdatabase@accc-cancer.org.

Reimbursement Made Easy

Brought to you by

ACCC
Association of Community Cancer Centers
## Quick Reference Guide

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Brand Name</th>
<th>Drug Company</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abemaciclib</td>
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## Quick Reference Guide

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<td>Tarceva®</td>
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<td>Pfizer</td>
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<td>Daurismo®</td>
<td>Pfizer</td>
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<td>Gleevec®</td>
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<td>Merck</td>
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This table provides a quick reference guide to the drug names, brand names, and the corresponding drug companies associated with them. It is designed to assist patients and healthcare providers in identifying the correct assistance programs for various medications. The information is extracted from the 2020 PATIENT ASSISTANCE & REIMBURSEMENT GUIDE of the ASSOCIATION OF COMMUNITY CANCER CENTERS.
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Powerful Training to Boost Your Financial Navigation Services!

Two sets of dynamic online courses offer the tools your staff needs to help patients pay for treatment—while maximizing reimbursement at your program.

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Angie Santiago, CRCS-I, Lead Financial Counselor-Oncology, Thomas Jefferson University Health System, Sidney Kimmel Cancer Center

Who Should Enroll?
Financial advocates, nurses, patient navigators, social workers, pharmacists and techs, medical coders, administrative staff, cancer program administrators, and other healthcare professionals.

Cost
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The Association of Community Cancer Centers (ACCC) is the leading education and advocacy organization for the cancer care community. Founded in 1974, ACCC is a powerful network of 25,000 multidisciplinary practitioners from 2,100 hospitals and practices nationwide. As advances in cancer screening and diagnosis, treatment options, and care delivery models continue to evolve—so has ACCC—adapting its resources to meet the changing needs of the entire oncology care team. For more information, visit accc-cancer.org or call 301.984.9496. Follow us on Facebook, Twitter, and LinkedIn; read our blog, ACCCBuzz; and tune in to our podcast, CANCER BUZZ.