This content is provided for informational purposes only and is not meant to substitute for medical advice, diagnosis, or treatment purposes. ACCC does not endorse or recommend any specific prescription drug or any other information in this publication. The programs represented herein have been set up primarily by drug companies that offer free or low-cost drugs to insured, uninsured, or underinsured individuals who cannot afford their medication. Companies offer these programs voluntarily, and the government does not require the provision of free medicine. All content and links reflect accuracy on this date.

The ACCC Patient Assistance & Reimbursement Guide was updated starting March 1, 2020 and published online in April 2020. This publication is updated four times a year.

Visit accc-cancer.org/PatientAssistanceGuide to download and print the most up-to-date information on cancer drug assistance and reimbursement programs.
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

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The ACCC Patient Assistance & Reimbursement Guide was printed in January 2020. This publication is updated four times a year. Visit 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

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6 ASSOCIATION OF COMMUNITY CANCER CENTERS
More than 100 financial navigators, cancer program leaders, and other members of the multi-disciplinary cancer care team attended this Pre-Conference on Wednesday, October 30, held during the ACCC 36th National Oncology Conference in Orlando, Fla.

Through live polling, attendees were able to submit questions and comments in sessions throughout the day. Members of the ACCC Financial Advocacy Network Advisory Committee then answered these questions in a robust Town Hall session where attendees also brought their own concerns and ideas to the table. Below Advisory Committee Chair Clara Lambert, BBA, OPN-CG, an oncology financial navigator at Advocate Good Samaritan Bhorade Cancer Center, and Committee Member Lori Schneider, business office manager at Green Bay Oncology, share their top five takeaways from the Pre-Conference.

**Clara Lambert’s Top Five Takeaways**

ACCC Financial Advocacy Network Advisory Committee Chair 2018 - 2019

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:

- **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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**Flowchart**

**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.

| No Insurance | Verify benefits. | Identify if patient qualifies for any programs (SSDI, Medicaid, etc.). Identify if replacement drugs are available. | Fill out forms for all programs. Complete forms for companies that have a replacement program if patient qualifies. | Identify if foundation funding is available for any drugs not replaced. | Fill out forms for foundation funding that is available. |
| 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 and authorize secondary insurance if necessary. | 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 and authorize secondary insurance if necessary. | 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 and authorize secondary insurance if necessary. | Identify if replacement drugs are available if necessary; will need to appeal to receive drugs. | Identify patient’s responsibility. |
| Managed Care | Verify benefits. | Verify drugs are indicated for diagnosis and authorize secondary insurance if necessary. | Identify if replacement drugs are available if necessary; will need to appeal to receive drugs. | Identify patient’s responsibility. |
| Commercial & Insurance Exchanges | Verify benefits. | Verify drugs are indicated for diagnosis and authorize secondary insurance if necessary. | Identify if replacement drugs are available if necessary; will need to appeal to receive drugs. | Identify patient’s responsibility. |
Identify if patient qualifies for charity care within the clinic or institution and complete paperwork.

Create payment plan for any balance (if available) or collect balance.

Collect out-of-pocket costs.

Fill out forms for foundation funding that is available.

Identify if patient qualifies for charity care within the clinic or institution and complete paperwork.

If patient qualifies, send in EOB and/or anything else to help verify amount for foundation to pay.

If any balance, create payment plan for any balance (if available) or collect balance.

Identify if foundation assistance is available.

Fill out forms for foundation funding that is available.

If patient qualifies, send in EOB and/or anything else to help verify amount for foundation to pay.

If any balance, create payment plan for any balance (if available) or collect balance.

Identify if foundation assistance is available.

Fill out forms for foundation funding that is available.

If patient qualifies, send in EOB and/or anything else to help verify amount for foundation to pay.

If any balance, create payment plan for any balance (if available) or collect balance.

Identify if foundation assistance is available.

Fill out forms for foundation funding that is available.

If patient qualifies, send in EOB and/or anything else to help verify amount for foundation to pay.

If any balance, create payment plan for any balance (if available) or collect balance.

If patient has responsibility, identify if foundation assistance is available.

Fill out forms for foundation funding that is available.

If patient qualifies, send in EOB and/or anything else to help verify amount for foundation to pay.

If any balance, create payment plan for any balance (if available) or collect balance.

Identify if manufacturer assistance is available and fill out forms if applicable.

If no manufacturer assistance, then identify if foundation assistance is available.

Fill out forms for foundation funding that is available.

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.

If any balance, create payment plan (if available) or collect balance from patient.

Identify if manufacturer assistance is available and fill out forms if applicable.

If no manufacturer assistance, then identify if foundation assistance is available.

Fill out forms for foundation funding that is available.

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.

If any balance, create payment plan (if available) or collect balance from patient.
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).
PATIENT ASSISTANCE

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

If patients have insurance, the program will review their qualifying financial need based on a combination of insurance coverage, household income, and out-of-pocket medical expenses. myAbbVie Assist will evaluate patients’ insurance coverage and out-of-pocket medical expenses during the application process.

If patients apply, they 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 ASSISTANCE

Amgen Assist 360™
Amgen Assist 360 is a single place for patients, caregivers, and healthcare professionals to go to find the support, tools, and resources most important to them. When patients enroll in Amgen Assist 360, their Amgen Nurse Ambassador serves as a single point of contact to help them find resources. Nurse Ambassadors are only available to patients that are prescribed certain products. Nurse Ambassadors are there to support, not replace, patients’ treatment plan and do not provide medical advice or case management services. Nurse Ambassadors can:
• Help patients understand how their Amgen medicine may be covered, and refer them to programs that may be able to help them afford it, such as Amgen FIRST STEP.
• Refer patients to independent nonprofit organizations that may provide community resources, one-on-one counseling services, and local support groups.

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. The program helps eligible commercially insured patients pay for their out-of-pocket prescription costs, including deductible, co-insurance, and co-payment. There is no income eligibility requirement.

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

Amgen First Step coverage limits and program maximums:
• Program covers out-of-pocket 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, Veterans Affairs, the Department of Defense, 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.

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.

Patient and Reimbursement Assistance Websites
amgenassist360.com
amgenfirststep.com
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.

To confirm patient eligibility and enroll in one of these programs, visit amgenfirststep.com/register-card or call 1.888.65.STEP1 (1.888.657.8371), Monday through Friday, 9:00 am to 8:00 pm ET.

Independent Nonprofit Programs
For patients with government insurance (like Medicare), Amgen Assist 360 can refer patients to independent nonprofit patient assistance programs that may be able to help them afford the co-pay costs for their prescribed medicine. Program eligibility is based on the nonprofit’s criteria. Amgen has no control over these programs and provides referrals as a courtesy only.

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 eligibility 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 medicine 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 to 1.866.549.7239.

The patient and their physician will both be notified once a decision is made. If approved, the patient will be contacted by a Patient Assistance Counselor to obtain consent to schedule a shipment of the Amgen medicine.

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.
Astellas Pharma Support Solutions™
Astellas Pharma Support Solutions offers access and reimbursement support to help patients overcome challenges to accessing Astellas products. To enroll Padcev, Xospata, or Xtandi Support Solutions, visit astellaspharmasupportsolutions.com, select the appropriate medication, and follow the patient enrollment process.

Astellas Patient Assistance Program
The Astellas Patient Assistance Program provides Xtandi or Xospata 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 or Xospata
- Patient has a verifiable shipping address in the United States
- Patient has been prescribed Xtandi or Xospata for an FDA-approved indication
- Patient meets program financial eligibility requirements.

To enroll a patient in the Astellas Patient Assistance Program, complete the Xtandi or Xospata Support Solutions enrollment process, including the PAP application faxed through the portal or faxed 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.

Xospata Support Solutions™
Xospata Support Solutions (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 co-pay card program, or the preferred network specialty pharmacy can be contacted to determine eligibility and enroll the patient in the program. 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:

Oncology-related products: Padcev™ (enfortumab vedotin-ejiv) injection (jointly owned by Seattle Genetics), Xospata® (gilteritinib) tablets, Xtandi® (enzalutamide) capsules

Patient and Reimbursement Assistance Website
astellaspharmasupportsolutions.com
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.

**Xtandi Support Solutions℠**

Xtandi Support Solutions (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 Xtandi 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. Patient eligibility for the for the 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 benefit 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. Patients can receive their savings card by contacting their specialty pharmacy or by applying at activatethecard.com/xtandi.

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, Veterans Affairs, TriCare, Puerto Rico government insurance, or any state patient or pharmaceutical assistance program.

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.

**PADCEV Patient Assistance Program**
The PADCEV Patient Assistance Program provides Padcev at not cost to uninsured patients who meet the program eligibility requirements. Padcev Support Solutions will evaluate a patient’s eligibility for the program. Patients may be eligible if they:

- Do not have insurance or have insurance that excludes coverage for Padcev
- Have a verifiable shipping address in the United States
- Have been prescribed Padcev for an FDA-approved indication
- Meet the program financial eligibility requirements.

To enroll, complete the Patient Enrollment Form (astellaspharmasupportsolutions.com/docs/PADCEV/PADCEVSUPPORTSOLUTIONS_Patient_Enrollment_Form.pdf), including
all signatures, and either upload it through the Prescriber Portal or fax it to 1.877.747.6843. If the patient is eligible for the program, Padcev Support Solutions will notify the provider and the patient.

For more information, contact 1.888.402.0627, Monday through Friday, 8:30 am to 8:00 pm ET.

**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 for the specific 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 the patient’s insurance plan for the specific medication.

Astellas Pharma Support Solutions will initiate the benefits verification upon receipt of the specific medication’s Patient Enrollment Form. 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. After determining that a PA is required, the program will obtain the appropriate PA form and transfer basic patient and healthcare provider information to the required PA form. It will be sent to the healthcare provider to review, complete, and sign. Astellas Pharma Support Solutions will follow up with the insurer to confirm receipt, check status, and obtain the outcome.

If the patient’s insurer denies a prior authorization request, Astellas Pharma 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 where to send the appeal, and track and inform the healthcare provider of the appeal’s status.
Oncology-related products: Calquence® (acalabrutinib) capsules, Faslodex® (fulvestrant) injection, Imfinzi® (durvalumab) injection, Iressa® (gefitinib) tablets, Lumoxiti™ (moxetumomab pasudotox-tdfk) for injection, Lynparza® (olaparib) tablets, Tagrisso® (osimertinib) tablets

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. Patients may have an out-of-pocket cost for an AstraZeneca specialty product.
2. If the patient meets the eligibility requirements, providers can enroll patients 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), Monday through Friday, 8:00 am to 8:00 pm ET.

AstraZeneca Access 360™
The AstraZeneca Access 360™ program provides personal support help streamline access and reimbursement for select AstraZeneca medicines. Access 360 provides:
• Assistance with understanding patient insurance coverage and pharmacy options
• Reimbursement support

• 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 Program
The AZ&Me™ Prescriptions Savings Program is designed to help qualified patients who need help affording their medicine. There are two programs:
• AZ&Me Prescription Savings program for people without insurance
• AZ&Me Prescription Savings program for people with Medicare.
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, and the same application is used for both programs. To apply for the program patients and providers may either call 1.800.AZandMe (1.800.292.6363) or visit azandmeapp.com to download, fill out, and fax the completed application from the provider’s office to the number on the form. 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.
- Patients must be without prescription drug coverage through private insurance or government programs.
- Patient annual income must be at or below a certain level.
- Patients must not be eligible for Medicaid in their state of residence.
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.

Application Checklist
The following items must be submitted in order to complete the 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 the prescription to be processed.

For more information, please visit azandmeapp.com or call 1.800.AZandME (1.800.292.6363), Monday through Friday, 9:00 am to 6:00 pm ET.

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 medicines. 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.
Bayer HealthCare Pharmaceuticals, Inc.

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/
hcp.nexavar-us.com/Resources/REACH-Financial-Support/

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.

To enroll, 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 patient and physician signatures and date, to 1.855.963.4463. Registered providers can also submit an application for patient assistance via the secure Xofigo Access Services Provider Portal at xofigoaccessonline.com.

For more information, call 1.855.6XOFIGO (1.855.696-3446), Monday through Friday, 9:00 am to 7:00 pm ET.

$0 Commercial Copay Assistance Program
Patients may be eligible for copayment/coinsurance assistance if they have 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
• Patient resides in the United States, including the District of Columbia, Puerto Rico, Guam, or the U.S. Virgin Islands.

To apply, fax a completed Xofigo Access Services Commercial Copay Assistance Application (hcp.xofigo-us.com/downloads/pdf/PP-600-US-2629_xas-commercial-copay-assistance-application.pdf) including the signed patient authorization and an assignment of commercial copay/coinsurance assistance, to Xofigo Access Services at 1.855.963.4463. Once approved, the patient will receive an approval letter with a commercial copay/coinsurance identification (ID) card.

Independent Copay/Coinsurance Assistance Foundations
If patients have Medicare or other government insurance and need assistance with their cost-share requirements for Xofigo, they may be eligible for copay or coinsurance assistance through an independent
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 Access Counselors can verify patients’ coverage for Xofigo and provide information about any available foundation. The foundations will determine patients’ eligibility for copay or coinsurance assistance based on their own criteria and contact them directly regarding their application process.

REACH®
Patients taking Stivarga or Nexavar can enroll in REACH® (Resources for Expert Assistance and Care Helpline). This is a free support program available to eligible patients and provides information about their therapy, helps them evaluate their financial assistance options, and offers education and support to health care professionals. The REACH program offers Nurse Counselors to answer medical questions and provide educational and support materials, as well as guidance on side effects. Financial access counselors can 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.

For more information, call 1.866.639.2827 or visit hcp.nexavar-us.com/Resources/REACH-Financial-Support.

Oncology $0 Co-Pay Program
For eligible, commercially insured patients prescribed Nexavar or Stivarga, the zero dollar co-pay program allows patients to fill their prescription with no out-of-pocket costs. Patients can receive up to $25,000 in savings with no monthly maximum. To be eligible patients must:

- Be a United States resident
- Be over 18-years-old
- Have commercial health insurance for a portion of their prescription drug cost
- Not be enrolled in any federal or state subsidized healthcare program that covers a portion of their prescription drug costs, including Medicare (such as Medicare Part D prescription drug benefit), Medicaid, TriCare, or any other federal or state healthcare plan, including pharmaceutical assistance programs.

Enroll online at zerocopaysupport.com by clicking on the specific medication. For questions about the co-pay program, call 1.866.581.4992 from 9:00 am to 5:00 pm ET.

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 assistance may be available through independent charitable organizations.

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

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

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

- The Bayer U.S. Patient Assistance Program is for eligible patients who are uninsured or underinsured. Bayer U.S. Patient Assistance Foundation is a charitable organization that helps eligible patients get Bayer prescription medicine at no cost.
- The Temporary Patient Assistance Program is for patients whose coverage is delayed or who experience a temporary lapse in coverage for Aliqopa.
- The Aliqopa $0 Co-Pay Program is for eligible patients with commercial insurance. Patients must not be enrolled in a government-sponsored program and must meet certain other eligibility criteria to qualify for this program. If approved, the patient may pay as little as $0, with a maximum benefit of $25,000 per year.
- Referrals to independent assistance foundations for publicly insured patients and those requiring travel assistance.
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 eligible patients
• $0 co-pay for eligible patients
• Bayer U.S. Patient Assistance Foundation
• Reimbursement and access support.

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/kmftyc1081/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.TRAK (1.888.506.8725). For more information, please call 1.844.634.TRAK (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.TRAK (1.844.634.87250).

REIMBURSEMENT ASSISTANCE

Xofigo Access Services
Xofigo Access Services provides a variety of services to support access to Xofigo, including:
• Insurance benefit verifications
• Prior authorization support
• Claims appeal research and information
• Claims tracking
• Billing and coding information
• 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/kmfty1081/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.
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.

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).

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.

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.

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, call myBeiGene at 1.833.234.4363 and speak to an 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

YourBlueprint™

YourBlueprint case managers work with providers and patients to provide seamless support throughout treatment. Case managers can help by:

- Investigating patients’ insurance benefits
- Connecting patients with financial assistance options
- Supplying helpful resources, such as sample letters of necessity
- Communicating with the provider’s office throughout the process.

To enroll, complete the Patient Support Program Enrollment Form (yourblueprint.com/wp-content/uploads/patient-services-enrollment-form.pdf) and fax the completed form with signatures to 1.866.370.3082. A dedicated case manager will confirm the patient’s enrollment and initiate the services requested.

For assistance, call YourBlueprint at 1.888.BLUPRNT (1.888.258.7768), Monday through Friday, 8:00 am to 8:00 pm ET.

Co-Pay Assistance Program

This program helps, eligible commercially insured patients reduce their out-of-pocket costs (co-pay, co-insurance, or deductible) to as little as $0. Patient may not seek reimbursement for the value received from this program from other parties, including any health insurance program or plan, flexible spending account, or health care savings account. Offer is not valid if the patient is enrolled in a federal or state healthcare program (including Medicare, Medicaid, TriCare, or any state medical or pharmaceutical assistance program), or if the patient is uninsured or paying cash for the prescription. Blueprint Medicines reserves the right to rescind, revoke, or amend the program and discontinue support at any time without notice.

To begin the process of determining patient eligibility and enrollment in the Co-Pay Assistance Program, visit portal.trialcard.com/yourblueprint/. For any questions, contact customer support at 1.888.BLUPRNT (1.888.258.7768).

Patient Assistance Program

If a patient is uninsured or has limited coverage, they may be eligible to receive their medication at no cost through this program. Financial eligibility criteria applies. To apply for this program, complete the enrollment form (yourblueprint.com/wp-content/uploads/patient-services-enrollment-form.pdf) and fax it to 1.866.370.3082.

Uninterrupted Access

YourBlueprint offers the following no cost options to patients to need assistance accessing Ayvakit.

Coverage delays: The QuickStart program offers a 15-day supply of treatment to newly prescribed patients who have insurance coverage delay of three days or more.

 Interruption in coverage: The Coverage Interruption program provides a temporary supply of treatment to patients already on therapy who face a temporary interruption in insurance coverage.

Change in dose: The Dose Exchange program allows patients who have their dose titrated to exchange remaining medication for the new dosage.

To speak with a dedicated case manager at 1.888.BLUPRNT (1.888.258.7768), Monday through Friday, 8:00 am to 8:00 pm ET.
REIMBURSEMENT ASSISTANCE

YourBlueprint™

YourBlueprint is a patient support program designed with patients’ care in mind. YourBlueprint assists patients throughout many aspects of treatment by providing:

- Financial assistance options
- Prior authorization support
- Benefits investigation.

To enroll patients, visit your-blueprint.com/hcp or call 1.888.BLUPRNT (1.888.258.7768), Monday through Friday, 8:00 am to 8:00 pm ET.
PATIENT ASSISTANCE

BMS Access Support®
Bristol-Myers Squibb (BMS) is committed to helping patients gain access to their prescribed BMS medications. The BMS Access Support program provides resources to help patients understand their insurance coverage and find information on sources of financial support.

BMS Oncology Co-Pay Assistance Program
The program provides financial assistance with out-of-pocket deductibles, co-pay, or co-insurance costs for eligible patients who have been prescribed certain BMS oncology 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 program. To be eligible, patients must have commercial (private) insurance and 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. Bristol-Myers Squibb will cover the remaining amount up to a maximum of $25,000 per year, per patient, per product. 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. Note: Absent a change in Massachusetts law, effective January 1, 2021, Massachusetts residents will no longer be able to participate in this program.

Obtain the Enrollment Form in one of the following ways:
• Begin the enrollment process online with their 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.

The provider’s office and patient complete the Enrollment Form. The patient’s name, address, insurance carrier, and member identification number are required. Fax the completed Enrollment Form to 1.888.776.2370. 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, Monday through Friday, 8:00 am to 8:00 pm ET.

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 help, 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.

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
• Are being treated as an outpatient
• 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 BMS Access Support can make a referral to independent charitable foundations offering support for your specific patient. It is important to note that charitable foundations are independent from Bristol-Myers Squibb Company. 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 details, 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, Pomalyset® (pomalidomide) capsules, Reblozyl® (luspatercept-aamt) for injection, Revlimid® (lenalidomide) capsules, Thalomid® (thalidomide) capsules, Vidaza® (azacitidine for injection)

Patient and Reimbursement Assistance Website
celgenepatientsupport.com

PATIENT ASSISTANCE

Celgene Patient Support®
Celgene Patient Support cares about making sure patients get the answers they need. That’s why specialists are ready to help answer questions about the insurance approval process, and the financial help that may be available for a 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 celgene patientsupport.com/enrollment/. 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.

Celegene Commercial Co-Pay Program
If patients have commercial insurance, they may qualify for this program. If they qualify, patients’ out-of-pocket co-pay responsibility will be:
- $25 (subject to annual benefit limits) for Revlimid, Idhifa, Inrebic, or Pomalyset

• $0 (subject to annual benefit limits) for Reblozyl and Abraxane.

This program provides up to $10,000 per calendar year to help meet co-pay/co-insurance costs. To be eligible, patients must have commercial or private insurance that does not cover the full cost of the prescribed Celgene medicine and reside within the United States or U.S. territory. Patients with government healthcare insurance (for example, Medicare, Medicaid, Medigap, TriCare, Champva) are not eligible. Other eligibility requirements and restrictions apply.

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. It can also help find other programs for which patients may qualify to help pay for their medicine. To find out more, call a Celgene Patient Support Specialist at 1.800.931.8691, Monday through Friday, 8:00 am to 8:00 pm ET.

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 them 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.

Financial and medical eligibility requirements vary by organization.

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**
Celgene Patient Support can initiate a benefits investigation to determine co-payment and other out-of-pocket costs, assess prior authorization or precertification requirements, and educate patients about insurance coverage or other programs for which they may qualify.

**Prior Authorization/ Precertification Assistance**
A specialists can assist with the prior authorization process, providing the necessary forms for completion. They can also follow up with the insurance provider to determine the outcome.

**Appeals Assistance**
If the patient’s insurance company denies a prior authorization, precertification, or claim for the prescribed Celgene medication, Celgene Patient Support can provide:
- Information about the appeals process after a denied prior authorization, precertification, and/or claim
- A checklist of the required documentation for submission to the insurance company
- An appeal submission 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 a prior authorization or an appeal.

To enroll, download the English or Spanish enrollment form at celgenepatientsupport.com/enrollment/email-or-fax/. 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 eligible patients $0 out-of-pocket costs for each Udenyca dose. The maximum benefit per claim is up to $7,200 with a maximum annual benefit of $15,000, per 12-month enrollment period. Reimbursement is done via electronic remit; 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. For any questions, call 1.844.4.UDENYCA (1.844.483.3692).

REIMBURSEMENT ASSISTANCE

Coherus COMPLETE™
Coherus COMPLETE can provide reimbursement support by contacting Patient Access Specialists.

**Insurance Benefit Verification**
Coherus COMPLETE can:
- Provide comprehensive produce-specific coverage assessments
- Determine insurance eligibility based on a patient’s benefit plan and payer policy.

**Comprehensive Prior Authorization (PA) Services**
Coherus COMPLETE can:
- Identify payer PA requirements
- Assist in PA submissions
- Provides pre-populated payer and pharmacy PA forms when necessary
• Track PA determinations with payers.

Pre-populated forms only provide patient and provider demographic information. They do not fulfill clinical requirements that are to be provided by the physician.

Coding and Billing Support
Coherus COMPLETE can:
• Provide product-specific coding support
• Assist with claims submission questions.

Claims and PA Appeals Support
Coherus COMPLETE can:
• Provide payer guidance for PA or claims denials
• Provide guidance on the appeal submission process
• Monitor the appeal require.

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
The Eisai Patient Assistance Program

Eisai has established the Patient Assistance Program for patients who need help paying for certain Eisai medications. This program provides medications at no cost to uninsured and financially burdened patients who meet program eligibility criteria.

To enroll for Lenvima, complete and submit the Lenvima Eisai Assistance Program Enrollment Form and fax the completed form to 1.855.246.5192, or call 1.866.613.4724 for more information.

Halaven Patient Assistance Program

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 1.866.613.4724, 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.

$0 Co-Pay Program

Commercially insured patients prescribed Halaven or Lenvima may be eligible for the $0 Co-Pay Program. Under this program, eligible patients may pay as little as $0 per month. Depending on patients’ insurance plan, they could have additional financial responsibility for any amounts over Eisai’s maximum liability. Limits vary depending on the Eisai medication prescribed. Limits, include:

- For patients prescribed Halaven, Eisai Inc. provides up to $18,000 per year to assist with out-of-pocket costs. $18,000 per year.
- For patients prescribed Lenvima, Eisai Inc. provides up to $40,000 per year to assist with out-of-pocket costs.

The Program is not available to patients eligible for state or federal healthcare programs, including Medicare, Medicaid, Medigap, VA, DoD, or TriCare.

To receive Lenvima through a specialty pharmacy and automatically enroll in all patient support services, complete the Lenvima Intake Form and fax the completed form to 1.855.246.5192. You can also call, 1.866.613.4724, Monday through Friday, 8:00 am to 8:00 pm ET.

For patients prescribed Halaven, the enrollment process is outlined below:

**Step 1:** Completed enrollment form (eisaireimbursement.com/-/media/Files/XRay/Halaven/Halaven-0Co-pay-Enrollment-Form.pdf) must be submitted including both the patient’s signature and the physician’s signature.

**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 physician’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 the patient and the provider.

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**

The Eisai Assistance Program provides support for patients. By contacting the program, patients can get help understanding their coverage through a benefits investigation.

For Halaven, specialists provide insurance verifications, coverage options, and information about the prior authorization process and the claims and denials process. Call 1.866.61.EISAI (1.866.613.4724) Monday through Friday, 8:00 am to 8:00 pm ET for all questions.

Specialists will complete a benefits investigation so patients understand their coverage for Lenvima. If needed, specialists can also discuss options for financial assistance to help patients access Lenvima by contacting 1.866.61.EISAI (1.866.613.4724), Monday through Friday, 8:00 am to 8:00 pm ET.
PATIENT ASSISTANCE

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).

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.

To be eligible, patients must meet the following criteria:
- Patient must be aged 18 years or older
- Patients must be residents of the United States or Puerto Rico

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

This offer is invalid for patients without commercial insurance coverage or those whose prescription claims are paid by Medicare Part D, Medicaid, TriCare, or any other state or federal program. 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 patients based upon the full criteria listed in the application
2. Apply online at lillypatientone.com/co-pay 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. Patients’ applications 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 more information, call 1.866.4PATOne (1.866.472.8663), 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 underinsured patients get the treatment they need with less financial stress. If 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™

Verzenio Continuous Care an umbrella of support options tailored to a patient’s entire Verzenio treatment journey. Once enrolled in the program, patients will have access to the following:

- Assistance with insurance and coverage
- MyFastRx accelerated initiation program
- Dedicated support staff—patients speak to the same person every time
- MyRightDose—a dose exchange program
- Verzenio savings card
- Free loperamide for patients.

The Verzenio Continuous Care Program is not a guarantee of coverage. Terms and conditions apply for all programs. To enroll, complete and fax the Enrollment Form (verzenio.com/assets/pdf/hcp_enrollment_form.pdf) to 1.855.545.5857. In order to process the requested services, Verzenio Continuous Care will require two patient signatures and a prescriber signature. Not signing the Enrollment Form will result in an incomplete submission and a delay in requested services.

For any questions, call Lilly Oncology Support Center at 1.844.VERZENIO (1.844.837.9364), Monday through Friday, 8:00 am to 10:00 pm ET.

Verzenio Savings Card

Eligible, commercially insured patients pay as little as $0 a month. Subject to a monthly cap of wholesale acquisition cost plus usual and customary pharmacy charges and a separate $25,000 maximum annual cap. Offer is good up to 12-month until December 31, 2021. 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, including, without limitation, Medicaid, Medicare, Medicare Part D, Medigap, DOD, VA, TriCare, or any state patient or pharmaceutical assistance program. Card activation is required.

Digital cards can be downloaded online at verzenio.com/hcp/savings-support and preprinted physical cards are available from a Lilly Sales Specialist for distribution to patients.

MyFastRx Accelerated Initiation Program

With MyFastRx, patients can start their Verzenio treatment as early as 48-hours which can be shipped to the patient and is free. This program applied to the first month of treatment only and is provided by Sonexus Health Pharmacy. Additional terms and conditions apply.

If there are questions about filing an appeal, call at 1.866.4PatOne (1.866.472.8663).

MyRightDose

This dose exchange program may simplify midcycle dose reductions for patients. It ships the appropriate dose directly to patients’ home in as early as 48 hours and at no cost to them. Additional terms and conditions apply.

To apply for this program, complete the Dose Exchange Program Enrollment Form (verzenio.com/assets/pdf/MyRightDose_Enrollment_Form.pdf). Fax the completed form with prescriber signature to 1.833.557.2417, Monday through Friday, 9:00 am to 6:00 pm ET or visit verzenio.com.

Lilly PatientOne

If an insurance claim is denied, Lilly PatientOne can provide information to help providers file an appeal on their patient’s behalf. Lilly PatientOne will help providers understand what documents and information are and the deadlines that will have to be met.

Lilly PatientOne also lists resources for coding, coverage, reimbursement, and appeals online at lillypatientone.com/financial-assistance.

Verzenio Continuous Care™

Verzenio Continuous Care an umbrella of support options tailored to a patient’s entire Verzenio treatment journey. Once enrolled in the program, patients will have access to insurance and coverage assistance.
Benefits Investigation
The program helps patients understand their coverage options, located the appropriate pharmacy, and identify their lowest possible out-of-pocket cost.

Field Reimbursement Manager
The program can help patients access prescribed Lilly FDA-approved medicines.

For any questions, call Lilly Oncology Support Center at 1.844.VERZENIO (1.844.837.9364), Monday through Friday, 8:00 am to 10:00 pm ET.
PATIENT ASSISTANCE

CoverOne® Patient Assistance Program

CoverOne provides patient access and reimbursement support services to help patients gain appropriate access to Bavencio in the United States.

CoverOne recognizes that each patient’s situation is different and are dedicated to helping them one at a time. For more information, contact 844.8COVER1 (844.826.8371), Monday through Friday, 8:00 am to 8:00 pm ET.

When Bavencio is used in combination with axitinib, questions related to reimbursement and access for axitinib may be referred to Pfizer Oncology Together™. PfizerRx Pathways.com.

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, 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.

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 any claims covered, paid or 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 to pay as little as 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.
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.

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 patients and practices at each step along the access journey. EASE case managers are your single point of contact at EASE and can provide the status of patients’ access journey, offer prompt support with payer coverage, financial assistance, and treatment coordination, and provide proactive follow-up. Services include:

• 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 EASE Patient Assistance Program helps eligible patients who cannot afford their drug costs receive Cabometyx free of charge. Additional restrictions and eligibility rules apply.
• The Cabometyx Quick Start Program provides free medicine to eligible patients who experience a payer decision delay of five days or more. Limited to on-label indications. Additional restrictions may apply.

• The 15-Day Free Trial Program provides free medicine to help patients start treatment quickly. Limited to on-label indications. Additional restrictions and eligibility rules apply.
• The Dose Exchange Program provides a free 15-day supply in the lower dose to help patients who require a dose reduction. Additional restrictions and eligibility rules apply.

To apply for these services, download and complete the appropriate form depending on the needed program and EASE Patient Authorization Form (cabometyxhcp.com/exelixis-access-services#overview). Fax the completed forms to 1.884.901.EASE (3273). Patients can also enroll through CoverMyMeds®. Access and submit a prior authorization request for Cabometyx through CoverMyMeds (https://www.covermymeds.com/main/), and enroll eligible patients in EASE services at the same time. 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 is your resource for questions and needs related to financial assistance for Cometriq.

EASE financial assistance, includes:
• The EASE Co-Pay Program provides eligible commercially 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 eligible patients. Additional restrictions and eligibility rules apply.

To enroll patients in EASE services, complete the Patient Authorization Form online at https://www.cometriq.com/hcp/access/ or download, print, and fax the completed form to 1.844.901.EASE (1.844.901.3273). For questions, contact an EASE case manager at 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 a provider office’s request, EASE can provide support with:
• Benefits investigation
• Prior authorization
• 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.

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<td>Share of Costs? ____________________</td>
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<td>Spend Down Amount $ ____________________</td>
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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 qualify 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 gene.com/patients/patient-foundation/see-if-you-qualify.

If one of these situations applies fax the completed enrollment forms (gene.com/patients/patient-foundation/apply-for-help) 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 or older, or have a legal guardian 18 years of age or older to manage the program
• 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 requirements. 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 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
Genentech BioOncology Access Solutions offers referrals to independent co-pay assistance foundations for eligible patients who are commercially or publicly insured, including those covered by Medicare and Medicaid.

Genentech does not influence or control the operations or eligibility criteria of any independent co-pay assistance foundation and cannot guarantee co-pay assistance after a referral. The foundations to which it may refer patients are not exhaustive or indicative of Genentech’s endorsement or financial support. There may be other foundations to support the patient’s disease state.

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 determine if a Genentech medicine is covered, if prior authorizations (PAs) are required, 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 the 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 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 the 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 enroll patients in Genentech Access Solutions and manage service requests. Features of My Patient Solutions:
• Enroll and re-enroll patients
• Communicate with a Genentech Access Solutions Specialist
• See which service requests require action
• Co-pay assistance details
• View benefits investigation reports
• Follow up on prior authorizations (PAs) or appeals
• Request benefits reverifications.

Account registration can be completed by one person for the entire practice and for multiple practice locations. 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.
PATIENT ASSISTANCE

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 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 Jakafi 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 Part D, Medicare Advantage, 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 private or commercially insured 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. Patients enrolled in a federal or state prescription program, (including Medicare Part D, Medicare Advantage, Medicaid, TriCare, or any state medical or pharmaceutical assistance program) are not eligible. 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 on Jakafi will not exceed $11,977 per month and $25,000 per year. Limit one 30-day supply per 30 days. For 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 refer patients in need to a nonprofit foundation that provides assistance with copays, transportation expenses, and more. Patient eligibility is determined solely by the foundation. For more information, contact an IncyteCARES registered nurse at 1.855.4.JAKAFI (1.855.452.5234).

**REIMBURSEMENT ASSISTANCE**

**IncyteCARES**
The program may also provide reimbursement support to patients and a healthcare professional’s office. IncyteCARES nurses will provide information about prior authorizations and give guidance on appealing insurance denials or coverage restrictions, if needed.

**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 insurance will cover Jakafi and the amount the patient may need to pay. IncyteCARES may help patients 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 the healthcare professional before deciding how much the patient will need to pay for Jakafi. IncyteCARES will work with the healthcare professional’s office as the office responds to and provides this information to the patient’s plan.

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

To contact an IncyteCARES registered nurse, call 1.855.4.JAKAFI (1.855.452.5234), Monday through Friday, 8:00 am to 8:00 pm ET.
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. Patient Access Specialists will check each patient’s pharmacy and medical benefits to determine if the medicine 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. A summary of all the information collected will be sent back to the doctor’s office in a single document, called Benefit Verification Results. 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. Providers can also help patients enroll through the online provider portal at: ipsencaresportal.biologicsinc.com/Account/Login or download the appropriate enrollment form from ipsencares.com. 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 more information, visit ipsencares.com/somatuline-patient-support or call 1.866.435.5677.

Onivyde Copay Assistance 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. 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 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.
Janssen CarePath
Janssen CarePath is your one source for access, affordability, and treatment support for patients. Janssen CarePath helps verify insurance coverage for 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.

Eligible patients can be enrolled through the Janssen CarePath provider portal at janssencarepath-portal.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. This program is only available to individuals using commercial or private health insurance for their Janssen medication, including plans available through state and federal healthcare exchanges. Not valid for patients using Medicare, Medicaid, or other government-funded healthcare programs to pay for their medications. Terms expire at the end of 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. 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. To learn more about the Janssen CarePath Savings Program for Zytiga, including full eligibility requirements, visit JanssenCarePath.com/Zytiga.

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.

JanssenPrescriptionAssistance.com
JanssenPrescriptionAssistance.com provides information on affordability programs that may be able to help.

Call Janssen CarePath at 877.CarePath (877.227.3728) for more information on affordability programs that may be available.

Johnson & Johnson Patient Assistance Foundation
The Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) 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 JJPAF program specialist at 800.652.6227, Monday through Friday, 9:00 am to 6:00 pm ET, or visit the foundation website at www.JJPAF.org.

REIMBURSEMENT ASSISTANCE

Janssen CarePath
Janssen CarePath helps verify insurance coverage for 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.

What Janssen CarePath can do for you on behalf of your patients:
• Provide support with dedicated Care Coordinators for providers and patients
• Conduct benefits investigations and provide insurance coverage information
• Review and explain patients’ insurance coverage and out-of-pocket costs for Janssen medications
• Help identify financial assistance options for eligible patients
• Provide patient support resources.

Janssen CarePath Provider Portal
Janssen CarePath helps verify insurance coverage for patients and provides reimbursement information. The Provider Portal gives you 24-hour online access to not only enroll eligible patients in the Janssen CarePath Savings Program, but also view their Savings Program transactions, request and review benefits investigations, and request prior authorization or appeals support.

Create a Provider Portal account at JanssenCarePathPortal.com. For any questions, contact 877.CarePath (877.227.3728), Monday through Friday, 8:00 am to 8:00 pm ET.

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.
PATIENT ASSISTANCE

KaryForward™
KaryForward offers resources for eligible patients to help minimize their out-of-pocket costs on their prescriptions. If patients do not have health insurance coverage to pay for medication, KaryForward has a program that may be able to offer medicine to patients at no cost. 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
• 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 the completed form 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 month and up to an annual cap of $25,000.

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™ (selinexor) QuickStart” box. Fax the complete form to 1.833.589.1603.

For more information and questions, call 1.877.KARY4WD (1.877.527.9493).

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. Nurse Case Managers can provide...
nonclinical education on patients’ medication, review prescribed dosing schedules, and educate them on what they may expect when taking their medication based upon the full prescribing information.

Patients should work with their healthcare professional to fill out the enrollment form to learn more about these services.

REIMBURSEMENT ASSISTANCE

KaryForward™
A patient support program by Karyopharm dedicated to providing assistance and resources to patients and caregivers.

KaryForward offers insurance related services, including:
• Benefit investigation
• Prior authorization
• Appeal assistance.

To apply for any of these services, download and complete the KaryForward Enrollment Form (karyforward.com/wp-content/uploads/2019/05/karyforward-enrollment-form.pdf), check the “Insurance Related Services,” box 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).

Oncology-related product: Yescarta® (axicabtagene ciloleucel) suspension for IV infusion

Patient and Reimbursement Assistance Website
kitekonnect.com

**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 enrollment form that can be signed and submitted electronically. For hard copy 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 provides certain medicines and adult vaccines for free to people who do not have prescription drug or health insurance coverage and who, without assistance, cannot afford their Merck medicines and vaccines. Its patient assistance offerings include several programs.

Merck Patient Assistance Program
This private and confidential program 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 for up to one year of medicine free of charge to eligible individuals and an individual may reapply as many times as needed.

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

Specific income requirement amounts can be found at merckhelps.com. Select the patient assistance program and prescribed medication to see qualifications.

To apply, patients and providers must complete the Enrollment Form for the specific Merck medication. Visit merckhelps.com and search for 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

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)
are available online. For additional applications or assistance, call 800.727.5400.

The Merck Co-pay Assistance Program for Keytruda
The Merck Co-pay Assistance Program offers assistance to eligible privately insured patients who need help affording the out-of-pocket costs for their medication. 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 program, 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 enrollment form. Fax the completed form 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 that have their own eligibility criteria and application process.

Merck Vaccine Patient Assistance Program for Gardasil®
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.

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

REIMBURSEMENT ASSISTANCE
Merck Access Program Benefit Investigations
The Merck Access Program (MAP) can contact insurers to request 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 healthcare professionals understand the documents and information that may be helpful when seeking a prior authorization. As always, providers should check for payer-specific requirements.

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

For any questions, call 855.257.3932, Monday through Friday, 8:am to 8:pm ET.
PATIENT ASSISTANCE

Mylan ADVOCATE™
Mylan ADVOCATE is available to assist with questions about billing and coding and patient access to Mylan medicines. 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 their prescribe Mylan medicines at a reduced 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 program can also be used to reduce the amount of an eligible patient’s out-of-pocket expenses for Ogivri. The Mylan ADVOCATE Co-Pay Assistance Program is open to both new and existing eligible patients who are residents of the United States or Puerto Rico and who have commercial insurance. For Fulphila, the program is subject to a maximum of $10,000 per 12-month period. For Ogivri, the program is subject to a maximum aggregate amount of $25,000 per 12-month period while the program remains in effect.

This co-pay assistance program is not valid for uninsured patients or commercially insured patients without coverage for their medication; 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.

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.
• 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 prior authorization 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.

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.

## 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?
- 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:
- If yes, 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
- 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 these 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)

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.

Support for patients include:
- Information about financial assistance that may be available
- Patient support counselors who are able to provide information in more than 160 languages
- Patient navigators who provide one-on-one support specific to a patient’s Novartis medication
- Dedicated case managers with private extensions whom you can contact directly for updates on patients.

To learn more about how PANO can help, call 1.800.282.7630.

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. Please be advised that access to the medicines distributed through the Novartis Patient Assistance Foundation, Inc., is free of charge to all eligible patients. Novartis is not affiliated with any individual or organization that may charge patients a fee(s) to assist them in completing applications for our program. These individuals or organizations are acting independently of the Novartis Patient Assistance Foundation, Inc., and its affiliates and do not have the consent of Novartis. To be eligible patients must:
- Be a U.S. resident
- Proof of income that meets financial eligibility requirements
- 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/f6c0fbf-d21a94073ab78a9a94368fe62/patient-novartis-oncology-service-request-form.pdf) and
fax the completed form to 1.88.891.4924. The provider should submit their part separately. Once PANO gets both parts, a case manager will review that patient’s insurance information to determine if they are eligible.

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**
The Novartis Oncology Universal Co-pay Program is available for almost all Novartis Oncology medicines.

Eligible, privately insured patients may pay $25 per month and Novartis will pay the remaining co-pay, up to $15,000 per calendar year, per product. 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 program is not available for patients who are enrolled in Medicare, Medicaid, or any other federal or state health care 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™**
Whether patients and providers have questions about Kymriah, treatment center locations, or insurance coverage, Kymriah cares can help.

To learn more, 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. Support for patients includes:
- Insurance benefits verification
- Information on prior authorization
- Information on denial appeals.

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 Oncology Together can help patients understand their benefits and connect them with financial assistance resources, regardless of their insurance coverage:

- Eligible 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 healthcare coverage.

To enroll patients, providers can use the Provider Portal (https://www.pfizeroncologytogether-portal.com/) or 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 medications for select Pfizer medications through the co-pay savings programs. For oral products, patients may receive up to $25,000 in savings annually. For injectable products, the maximum annual patient savings range from $10,000 to $25,000.

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 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 be eligible for the Pfizer Patient Assistance Program, patients must:

- Have a valid prescription from a physician licensed in the United States or a U.S. territory for the Pfizer medication for which they are seeking assistance
- 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 income limits (income limits vary by product and household size).
- Cannot be treated in an inpatient setting of care, such as a hospital or nursing home.

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.

If a patient is accepted into the Pfizer Patient Assistance Program, Pfizer will inform the healthcare professional by fax and phone and the patient by phone and letter. Uninsured patients may receive free medication for up to one calendar year, while underinsured patients are enrolled through the end of the calendar year. 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 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 with 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 why 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.
- **Online support**: Log in to the provider portal to complete and submit an online enrollment form, track the status of patient cases, and for secure messaging with Pfizer Oncology Together.

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. To get in contact with the FRM in your area, call 1.877.744.6575.

To get started, providers can use the Provider Portal (https://www.pfizeroncologytogether-portal.com/) or visit https://www.pfizeroncologytogether.com/hcp to download the enrollment form and fax the completed form to 1.877.736.6506. For questions, 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 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.com/Coupon/YouAndI/.

For more information, call 1.877.877.3536, Monday through Friday, 8:00 am to 8:00 pm and Saturday, 8:00 am to 5:00 pm ET.

Independent Charitable Organizations
For patients with federally funded Medicare, Medicaid, or commercial insurance, financial assistance may potentially be available from independent charitable organizations. Contact information for such independent charitable organizations is available upon request. Independent charitable organizations have their own rules for eligibility. YOU&i has no control over these independent charitable organizations.

YOU&i Dose Exchange Program
This program is available to facilitate a patient’s dose reduction before they have finished their current pack of Imbruvica. The program will contact the patient within 24 hours of receiving the completed form to confirm eligibility and arrange rapid shipment of the new dose.

To enroll, download a Dose Exchange Prescription and Enrollment Form (https://imbruvicahcp.com/cll/support-and-resources/dose-exchange-program/#) and submit the completed form with prescriber’s signature to the YOU&i Support Program.

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.

To enroll, fax the complete YOU&i Patient Enrollment Form (https://imbruvicahcp.com/you-i-support-program-enrollment-form.pdf) to 800.752.5896.

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, Saturday, 8:00 am to 5:00 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 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

LIBTAYO Surround®
LIBTAYO Surround™ helps eligible patients access Libtayo and navigate the health insurance process. Visit its website (libtayohcp.com) to download additional tools and helpful resources about Libtayo Surround offerings. For more information 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 with commercial insurance may pay as little as $0 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 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.

The program is not valid for cash-paying customers. To be eligible:
- Patients must be insured by a commercial health plan that requires a copayment, coinsurance and/or deductible amount for Libtayo
- 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 for an FDA-approved indication.

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/LIB-19-09-0014%20LIBTAYO%20Surround%20Enrollment%20Form.pdf?la=en) and check the box in Section 1 marked “Copay Assistance;” Complete the enrollment form and fax it to 1.833.853.8362.
- Physician offices 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.

Patient Assistance Program
Eligible patients who meet income requirements and are uninsured, lack coverage for Libtayo, or have Medicare Part B with no supplemental insurance coverage may receive Libtayo at no cost. Patients without insurance coverage or patients with inadequate insurance coverage who need assistance with out-of-pocket medication costs may be eligible for alternate funding sources for Libtayo.

- Patients must be uninsured, lack coverage for Libtayo, or have Medicare Part B with no supplemental insurance coverage.
- Patients must be residents of the United States or its territories or possessions.
- Patients must enroll in LIBTAYO Surround by signing Section 9 of the LIBTAYO Surround Enrollment Form (libtayohcp.com/-/media/EMS/Conditions/Oncology/Brands/LibtayoHCP/...
Regeneron and Sanofi

• 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 conditions may apply.

For more information, call 1.877.LIBTAYO (1.877.542.8596), Option 1, Monday through Friday, 8:00 am to 8:00 pm ET.

Identification of Alternate Sources of Funding
Patients without insurance coverage or patients with inadequate insurance coverage who need assistance with out-of-pocket medication costs may be eligible for alternate funding sources for Libtayo.

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

For more information, call your local field Reimbursement Manager or LIBTAYO Surround at 1.877.LIBTAYO (1.877.542.8296).

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
• General patient education
• Appointment reminders

REIMBURSEMENT ASSISTANCE
LIBTAYO Surround
LIBTAYO Surround can provide assistance with access and reimbursement to help patients receive their medication as quickly as possible. Upon receipt of a LIBTAYO Surround enrollment form, a LIBTAYO Surround Reimbursement Specialist may be able to provide several types of assistance. To enroll, download the LIBTAYO Surround Enrollment Form (libtayohcp.com/-/media/EMS/Conditions/Oncology/Brands/LibtayoHCP/pdf/LIB-19-09-0014%20LIBTAYO%20Surround%20Enrollment%20Form.pdf?la=en), make sure each field is complete and accurate, sign the form, and fax the completed form to 1.833.853.8362.

Upon enrollment, a Reimbursement Specialist can provide the following assistance:
• Benefits investigation, which addresses:
  • How the medication may be covered under the patient’s health plan
  • Acquisition options
  • The patient’s eligibility for financial assistance
  • Any additional coverage information to facilitate the patient’s access to medication.

• Prior authorization support to review and explain payer requirements
• 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.
PATIENT ASSISTANCE

Sandoz One Source®
Sandoz One Source provides services designed to help simplify and support patient access. Available services include:

- Benefit investigations
- Prior authorization and appeals support
- In-home injection training
- Commercial co-pay program
- Independent foundation information
- Patient assistance program.

To enroll, patients and providers can apply for support using the savings portal. Submit online or download and complete the enrollment form (ziextenzo.com/pdf/ZIEXTENZO-Sandoz-One-Source-Enrollment-Form.pdf) by selecting the prescribed medication. Once you have completed the form, fax the completed information to 1.844.726.3695.

For more information, call 1.844.SANDOZ1 (1.844.726.3691), Monday through Friday, 8:00 am to 8:00 pm ET.

Commercial Co-Pay Program
The Sandoz One Source Commercial Co-Pay Program supports eligible, commercially insured patients with their out-of-pocket costs for Zarxio or Ziextenzo. There are no income requirements. The virtual co-pay care ensures that patients have immediate access to their benefits.

Patients may pay $0 out-of-pocket for the first dose or cycle and for subsequent doses or cycles up to a maximum benefit of $10,000 annually. Patients’ prescription must be for an approved indication. This program is for insured patients only; cash-paying or uninsured patients are not eligible.

Patients are not eligible if prescription for Ziextenzo or Zarxio is paid, in whole or in part, by any state or federally funded programs, including but not limited to Medicare (including Part D, even in the coverage gap) or Medicaid, Medigap, VA, DOD, or TriCare, or private indemnity plans that do not cover prescription drugs, or HMO insurance plans that reimburse the patient for the entire cost of their prescription drugs, or where prohibited by law.

There are three ways to enroll:
1. Instruct patients to enroll in co-pay online at prescribed medication’s website
2. Submit online at Sandoz One Source enrollment form
3. Download and fax the Sandoz One Source enrollment form to 1.844.726.3695.

Product Replacement Program
As a supplement to the Sandoz Returns Policy, Sandoz One Source offers a simple product replacement process for spoiled Zarxio or Ziextenzo products under the following circumstances:

- Product was mishandled, dropped, or broken
- There was an admixture error
- Product was inappropriately stored or refrigerated, or was frozen
- Product was reconstituted but not administered due to an unforeseen reason.

Contact Sandoz One Source at 1.844.SANDOZ1 (1.844.726.3691) to request a replacement product.

Oncology-related products: Zarxio® (filgrastim-sndz) subcutaneous or intravenous injection, Ziextenzo® (pegfilgrastim) injection

Patient and Reimbursement Assistance Websites
zarxio.com/resources/patient-support/
ziextenzo.com/hcp/patient-services.html
REIMBURSEMENT ASSISTANCE

Sandoz One Source®

Sandoz One Source provides services designed to help simplify and support patient access. Available services include:

- Benefit investigations
- Prior authorization support
- Appeals support
- Reimbursement support.

To enroll, patients and providers can apply for support using the savings portal. Submit an online Sandoz One Source enrollment form or download and complete the enrollment form (ziextenzo.com/pdf/ZIEXTENZO-Sandoz-One-Source-Enrollment-Form.pdf) by selecting the prescribed medication. Once you have completed the form, fax the completed information to 1.844.726.3695.

For reimbursement information, call 1.844.SANDOZ1 (1.844.726.3691), Monday through Friday, 8:00 am to 8:00 pm ET.
PATIENT ASSISTANCE

CareASSIST™
CareASSIST offers access support for eligible patients prescribed Sanofi Genzyme medicines, including:
• Access and reimbursement
• Financial assistance
• Resource support.

To enroll, download the Enrollment Application (sanoficareassist.com/-/media/EMS/Conditions/Oncology/Brands/sanoficareassist/DTC/pdf/SAUS_ONC_19_03_1902_3_PSP_Enroll_Form_Copay_INTERACTIVE.pdf?la=en-US) and fax the completed form to 1.855.411.9689. For any questions or assistance, call 1.833.WE.CARE (1.833.930.2273), Monday through Friday, 9:00 am to 8:00 pm ET.

CareASSIST Copay Program
Eligible patients with commercial insurance may pay as little as $0 for their Sanofi Genzyme medicines, including any product-specific copay, coinsurance, and insurance deductibles—up to $25,000 in assistance per year. To be eligible, patients must:
• Have commercial or private insurance, which includes state or federal employee plans and health insurance exchanges
• Be residents of the United States or its territories or possessions.

There is no income requirement to qualify for this program. Eligible patients will remain enrolled in the program for 12 months dating from the time of approval. Patients will be evaluated for continued eligibility on an annual basis. As appropriate, their enrollment will be renewed. Other conditions apply.

To get started, download and print a CareASSIST application (sanoficareassist.com/-/media/EMS/Conditions/Oncology/Brands/sanoficareassist/DTC/pdf/SAUS_ONC_19_03_1902_3_PSP_Enroll_Form_Copay_INTERACTIVE.pdf?la=en-US). Make sure the “CareASSIST Copay Program” box in Section 1 is checked and fax the completed application to 1.855.411.9689. The application process can also be started by calling 1.833.WE+CARE (1.833.930.2273) where a CareASSIST Patient Access Specialist will assist with the next steps.

If a patient is deemed ineligible, CareASSIST will notify the provider’s office by fax and the patient by U.S. mail.

CareASSIST Patient Assistance Program
For patients who meet program eligibility requirements for financial assistance through CareASSIST, medication can be provided at no cost through the CareASSIST Patient Assistance Program. In order to be eligible, patients must meet the following requirements:
• Patient must be a resident of the United States or its territories or possessions and be under the care of a licensed healthcare provider authorized to prescribe, dispense, and administer medication in the U.S.
• Patient must have no insurance coverage or lack coverage for the prescribed therapy
• Patients with Medicare Part B with no supplemental insurance coverage may be eligible
• Patient must have an annual household income that does not exceed the greater of $100,000 or 500% of the current Federal Poverty Level.

Patient and Reimbursement Assistance Websites
elitekpro.com/careassist
sarclisahcp.com/careassist
SanofiCareASSIST.com

Oncology-related products: Elitek® (resburicase) IV infusion, Jevtana® (cabazitaxel) injection
Sarclisa® (isatuximab-irfc) injection for IV use
Approved patients may remain enrolled for up to 12 months. If longer assistance is required, they may reapply on a yearly basis. To get started, download and print a CareASSIST application (sanoficareassist.com/-/media/EMS/Conditions/Oncology/Brands/sanoficareassist/DTC/pdf/SAUS_ONC_19_03_1902_3_PSP_Enroll_Form_Copay_INTERACTIVE.pdf?la=en-US). Make sure the “CareASSIST Patient Assistance Program” box in Section 1 is checked and fax the completed application to 1.855.411.9689. The application process can also be started by calling 1.833.WE+CARE (1.833.930.2273) where a CareASSIST Patient Access Specialist will assist with the next steps.

Shortly after an application is submitted, patients will receive a letter from CareASSIST informing them of the status of their application. A copy of that letter is also sent to the healthcare provider on the form. Complete applications are usually processed within 2 business days.

Alternate Sources of Coverage
CareASSIST may be able to identify sources of coverage for patients who are uninsured or lack coverage, or who need assistance with their out-of-pocket medication costs.

Through CareASSIST, a Patient Access Specialist may be able to:
• Identify potential alternate coverage programs and explain their benefits
• Answer questions about the application process for such programs
• Provide the contact information for such programs

Possible alternate coverage sources include Medicaid, state health exchanges, state pharmaceutical assistance programs, and independent charitable foundations.

For more information, call 1.833.WE+CARE (1.833.930.2273).

REIMBURSEMENT ASSISTANCE

CareASSIST™
CareASSIST Patient Access Specialists can help evaluate insurance coverage and identify options for your patients. Patient Access Specialists are available to assist with the following:
• Insurance verification, including benefits, deductibles, and copay or coinsurance: Full benefit verification is specific to the prescribed therapy from Sanofi Genzyme and the patient’s insurance plan
• Prior authorization assistance: Patient Access Specialists identify plan-specific requirements and can provide information about the process
• Coding and billing assistance: Information on the prescribed therapy and the respective regimen. Field Reimbursement Managers are available to assist with complex reimbursement questions
• Claims management and appeals assistance: Patient Access Specialists can provide information about the appeals process if a denial is received.

To learn more, call 1-833-WE+CARE (1-833-930-2273), Monday through Friday, 9:00 am to 8:00 pm ET.
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), Monday through Friday, 9:00 am to 8:00 pm ET.

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 Case-Manager@seagensecure.com. To reach a SeaGen case manager, call 855.4SECURE (855.473.2873).

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 Case-Manager@seagensecure.com. To reach a SeaGen case manager, call 855.4SECURE (855.473.2873).

REIMBURSEMENT ASSISTANCE

SeaGen Secure®

Before patients start treatment, SeaGen Secure Case Managers are available to answer reimbursement questions about Seattle Genetics therapies, including:
- Coverage as determined by a Benefits Investigation
- Prior authorization assistance
- Billing and coding assistance
- Claims and appeals assistance.

Benefits Investigation

Enroll patients in SeaGen Secure to start the benefits investigation process. 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 is a simple pathway to savings and support services that provides a comprehensive resource for patients taking Yonsa. Support programs are subject to terms and conditions and patients must be enrolled in Yonsa Support to qualify. These services, include:

- **Co-Pay Program**: Yonsa Support will determine a patient’s eligibility and enroll them into the program. There is a $5,000 maximum program benefit per fill and $12,000 maximum program benefit per calendar year. This program is not valid for patients without commercial insurance coverage or if prescription is paid for by any state or federally funded healthcare program, including but not limited to Medicare, Medicaid, VA, DOD, or TriCare. Available to United States, Guam, Virgin Islands, or Puerto Rico residents only.

- **Early Access Program**: Yonsa Support will enroll eligible patients facing an initial prior authorization denial or delay in coverage. The program provides free product for up to 30 days.

- **Patient Assistance Program**: Yonsa Support assists eligible patients without insurance in gaining access to Yonsa. Yonsa Support will research alternate form of funding and, if the patient is eligible, will help with enrollment. Income documentation is required.

To apply, 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.

For any questions, contact Yonsa Support at 1.855.44 YONSA (1.855.449.6672).

Co-pay Program
Eligible commercially insured patients may pay as little as $10 for 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 for patients without commercial insurance coverage or if prescription is paid for by any state or federally funded health care program, including but not limited to Medicare, Medicaid, VA, DOD, or TriCare. The program is available to United States, Guam, Virgin Islands, or Puerto Rico residents only. Yonsa Support will determine a patient’s eligibility and enroll them into the program.

Additional restrictions and eligibility requirements apply. Visit activateecard.com/7702/# to enroll patients and learn additional information.

If you have any questions regarding eligibility or benefits, call the YONSA Savings program at 1.855.44YONSA (1.855.449.6672).

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

- Verify and explain patient benefits
- 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 Sun Patient Access Program Application (odomzo.com/themes/custom/odomzo/global/
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, patients 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 by 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. A program coordinator can further assist providers and patients with this process. 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. 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. It will then coordinate payment and follow up to ensure patient receives the medication.

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. For questions, contact Yonsa Support at 1.855.44YONSA (1.855.449.6672).

Odomzo Patient Access Program
The Odomzo Patient Access Program Application is used to verify patient benefits and establish prior authorization requirements. Providing complete and accurate information will ensure a timely response to benefits investigation requests.

- Verify and explain patient benefits
- Provide information on prior authorization requirements, including the appeals or denial process
- Process the prescription with a Specialty Pharmacy.
PATIENT ASSISTANCE

Taiho Oncology Patient Support™
Accessing treatments can be challenging at times. Taiho Oncology Patient Support offers personalized services to give patients, caregivers and healthcare professionals (HCPs) the help they need in getting started with Lonsurf. This includes insurance verification, help with medication costs, and treatment plan support.

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 to eligible patients who have insufficient 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 (taihopatient-support.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), 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, it 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).
**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 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 with original signatures, 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. For more information, call 1.844.T1POINT (1.844.817.6468), option 2, Monday through Friday, 8:00 am to 8:00 pm ET or visit www.takedaoncology1point.com.

**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. Patients could pay as little as $10 per prescription with an annual maximum benefit of $25,000.

This offer cannot be used if patients are a beneficiary of, or any part of their 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 patients 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 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**

If patients are uninsured or the prescribed medication is not covered, they may be eligible to receive medication at no cost through this program. 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 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. 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.

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, Tekeda 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™
Case managers can work with patients’ insurance companies to conduct benefits verifications. A summary of coverage options for each enrolled patient will be provided to the provider’s office. The program can also provide support by explaining reasons for the denial and process for appeal.

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.

Velcade Reimbursement Assistance Program
From finding financial assistance to understanding the disease, Tekeda 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. Eligible commercially insured patients could pay as little as $0 co-pay or coinsurance with a maximum benefit of $2,000 per calendar year and a monthly maximum benefit of $200 per fill for Varubi. For Zoladex, eligible cash-paying patients will receive $300 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.

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.

To apply, complete the Patient Assistance Program enrollment form (zoladexhcp.com/pdf/patient-assist-enroll_form.pdf) and fax the form to 855.836.3066. For more information, call 1.844.ZOLADEX (1.844.965.2339).
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. Teva’s commitment to patients provides 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/doiqualify 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 prescribed medication at tevacares.org/doiqualify and fax the completed form to 877.438.4404.
Completed applications should be faxed to 1.866.676.4073.
If a 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 patients. For more information, 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/.

REIMBURSEMENT ASSISTANCE

CORE
The reimbursement and insurance process can be complicated. Comprehensive Oncology Reimbursement Expertise (CORE) is available to help eligible patients, their caregivers, and healthcare professionals navigate the reimbursement process. CORE offers a range of services:
• Benefit verification and coverage determination
• Precertifications/prior authorization support
• Coverage guidelines and claims investigation assistance
• 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 it to 1.866.676.4073. For questions, call 1.888.587.3263, Monday through Friday, 9:00 am to 6:00 pm ET or visit TevaCORE.com.
Improve Care in Older Adults with Cancer
Education for the Interdisciplinary Oncology Team

“How-to” Publication
Featuring real-world case studies from three cancer programs, you’ll find effective practices to ensure comprehensive quality care is implemented in a thoughtful, proactive, cost-effective way, along with:

- Current Recommendations for Conducting Comprehensive Geriatrics Assessments (CGAs)
- The Difference Geriatric Assessments Can Make: Patient Examples
- Sample Goals for Working with Your Older Adult Patients

Digital Resource List
Explore tools, instruments, and articles that enhance the care of older adults with cancer.

Search by Topic Area
- Comprehensive Geriatric Assessment
- Screening Tools
- Comorbidity Assessment
- Cognitive, Functional, and Psychological Status
- Polypharmacy
- Patient Tools
- Articles

Six-Part Webinar Series
Access webinar recordings that address strategies for healthcare professionals managing the complex needs of older adults with cancer.

Read, Watch, and Learn at ACCC-CANCER.ORG/Geriatric

In partnership with:

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. Financial support for this educational initiative was provided by Pfizer Oncology.
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.
PATIENT ASSISTANCE

Adaptive Assist™
Adaptive Biotechnologies understands that each patient’s situation is unique. It is committed to providing guidance and support during each step of the insurance process. That’s why it offers 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.

For 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.

Patient Support Program
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 Patient Support 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 or sum of medical expenses as a percentage of household income
- Submit a completed and signed application form (clonoseq.com/sites/default/files/PM-US-CORP-0002-3_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 Support Program constitute a contract. Adaptive Biotechnologies 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 them to find appropriate support. For more information call 1.855.236.9230 or visit clonoseq.com/adaptive-assist.
PATIENT ASSISTANCE

Patient Financial Assistance Program
Foundation Medicine’s billing and reimbursement services are designed to make comprehensive genomic profiling accessible to patients regardless of their financial situation. Depending on the specific test, patients may already have coverage through Medicare or private insurance. If patients are uninsured or concerned about the out-of-pocket cost of testing, fill out a financial assistance application or contact the Care Team at 888.988.3639, Monday through Friday, 8:00 am to 8:00 pm ET. Payment plans may also be available based on patients’ financial situation. To apply for financial assistance or download a paper application, visit foundationmedicine.com/patients#financial-support.

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, Foundation Medicine 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.

Oncology-related products: FoundationOne® CDx (companion diagnostic for patients across all solid tumors), FoundationOne® Liquid (liquid biopsy test for solid tumors), FoundationOne® Heme (genomic profiling test for hematologic malignancies and sarcomas)
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."¹

For 2019 the projected total annual cost of cancer care in the U.S. was between $173 billion to $207 billion.² 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.³

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, Bhorade 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 silos 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**
ACCC 37th
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Two sets of dynamic online courses offer the tools your staff needs to help patients pay for treatment—while maximizing reimbursement at your program.

Shape up your team’s skills with introductory courses:
- Financial Advocacy Fundamentals
- Enhancing Communication
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Then continue the learning with advanced content:
- Oncology 101 for Financial Advocates
- Proactive Assessment of Financial Distress
- Cost-Related Health Literacy
- Measuring and Reporting

Additional course to be released in 2020:
- Health Policy Landscape

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
FREE to ACCC and Oncology State Society at ACCC members, and $155 for non-members. Join ACCC as an Individual Member ($155) to access this resource—and others—for free.

ENROLL at accc-cancer.org/FANBootCamp

"The Financial Advocacy Boot Camp explains all aspects of financial advocacy and is a great tool for new advocates and experienced professionals. Our team will be more prepared and confident with this tool."

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

The ACCC Financial Advocacy Network is supported by:

Pfizer Oncology  Johnson & Johnson  Pharmacyclics

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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.
Agingcare.com®
aagingcare.com

A web-based resource that connects families with elder care, senior housing, and caregiver support, 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 programs by state, medication name, or browse a list of nationwide non-profit prescription drug assistance programs.

Aunt Bertha
AuntBertha.com

Aunt Bertha’s network connects people seeking help and verified social care providers that serve them.

Aunt Bertha has created a social care network that connects people and programs—making it easy for people to find social services in their communities, for nonprofits to coordinate their efforts, and for customers to integrate social care into the work they already do.

Its team researches, verifies, and adds qualified programs to its listings so they are easy to find on the search platform. Search for free or reduced cost services like medical care, food, job training, and more at auntbertha.com.

Once a zip code has been entered into the search, simply click the “Money” option from the category list and then “Financial Assistance.” Aunt Bertha lists several options in the community that can help patients with prescription assistance, transportation for healthcare, and other assistance options.

A program or foundation’s eligibility will be listed along with its contact information. Aunt Bertha will provide “Next Steps” to help patients with the application process.

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. It matches patients’ unique needs to benefit programs and eligibility requirements using its comprehensive tool. There are over 2,500 federal, state, and private benefits programs available to help. After reviewing initial results, patients can enter more details to personalize their report of benefits they are 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:
- Medication
- Food
- Utilities
- Education
- Healthcare
- Housing
- Income Assistance
- 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 less than $18,735 if single and $25,365 if they are married
- They have resources less than $14,610 if single and $29,160 if married.

To apply, patients must live in one of the 50 United States or the District of Columbia. 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. If applying for financial assistance, all correspondence must be done electronically through email or fax. CancerCare is unable to accept applications through mail.
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 a patient, professional oncology social workers will always work to refer patients to other financial assistance resources. Check cancercare.org periodically for funding updates.

Financial 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.

Steps for applying to this program, include:
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:
   • Email the patient an individualized barcoded application
   • Request documentation to verify the patient’s income.
3. Patients must submit a completed application to the email or fax number listed on the form.

CancerCare® Co-payment Assistance Foundation cancercarecopay.org

CancerCare Co-payment Assistance Foundation (CCAF) helps qualified patients afford the co-payments, coinsurance, and deductibles for their prescribed cancer 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 CCAF’s 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.

The quickest and most secure way to enroll a patient with the foundation is to use the online process (cancercare.org/copay-apply) or speak with a Co-Payment Specialists at 866.55.COPAY (866.552.6729). Patients will be enrolled for up to one year from the time they are approved.

Patients with private insurance must contact the drug company that manufactures your medication before applying with CCAF for assistance. For more information, call 866.55.

COPAY (866.552.6729), Monday through Thursday, 9:00 am to 7:00 pm ET, and Friday, 9:00 am to 5:00 pm ET.

Cancer Financial Assistance Coalition cancerfac.org

CFAC is a coalition of financial assistance organizations joining forces to help cancer patients experience better health and well-being by limiting financial challenges. It educates patients and providers about existing resources and links to other organizations that can disseminate information about the collective resources of member organizations.

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 by specific type of assistance or need (i.e., Co-Pays, general living expenses, transportation, genetic testing). Patients and providers 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 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 four 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 representatives can submit applications on behalf of patients through the secure provider portal (copays.org/providers) available 24 hours a day.
3. Pharmacy representatives can submit applications of behalf of patients through the secure pharmacy portal (copays.org/pharmacies) available 24 hours a day.
4. Applications can also be completed over the phone by calling 1.866.512.3861, option 1, to be connected directly to a Program 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 it will show them the pharmacy savings for that specific medication. Discounts are available only at participating pharmacies.

The prescription discount card must be presented with each prescription to a participating pharmacy to be eligible for 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. The card can-not be used with other prescription drug discount cards or for prescriptions paid through a health plan or pharmacy benefit plan. All pricing and 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 a non-profit advocacy organization that provides resources for life-saving and life-extending treatments to people in need of access to care.

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. For any questions or for assistance with filling out the enrollment forms, call 877.968.7233

HealthWell Foundation®
healthwellfoundation.org

When health insurance is not enough, HealthWell Foundation fills the gap by assisting with copays, premiums, deductibles and out-of-pocket expenses. It provides financial assistance to help with:
- Prescription copays
- Health insurance premiums, deductibles, and coinsurance
- Pediatric treatment costs
- Travel costs.

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 and listed under the disease fund associated with the patient grant
- 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)
- Patients 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://healthwell-foundation.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 must use the online provider or pharmacy portal to complete and submit an application.

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 questions, call 800.675.8416 to speak with a HealthWell representative, Monday through Friday, 9:00 am to 5:00 pm ET.

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 and deductibles
- Medicare Part B, Medicare Plan D, Medicare Supplementary 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: ll.s.org/support/financial-support/co-pay-assistance-program).

Patients, providers, pharmacies can apply online at ll.s.org/support/financial-support

Patients and providers call also apply over the phone and 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 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’s Medicine Assistance Tool (MAT) is a search engine designed to help patients, caregivers, and health care providers learn more about the resources available through the various biopharmaceutical industry programs. MAT is not its own patient assistance program, but rather a search engine for many of the patient assistance resources that the biopharmaceutical industry offers.

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:
- A list of other healthcare assistance resources at [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 patients 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 the medication name using the search function in the upper left hand corner of the screen. If using the brand or generic name medication search function:
1. Click on the first letter of the medication’s name in the alphabet bar.
2. Click on the name of the 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 requirements 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.

PAPs can also be found by searching the Program Name List OR by looking through the Company Name List, both found under the “Patient Savings” tab on the NeedyMeds website. If an application form is available through a PAP, look for it in the “Program Applications” list. Look for all of your medications, not just the most expensive ones.

**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. 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 offers of brand name medicine (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. Information 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) of diagnosis-based assistance programs that can be searched. 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 programs and helpful tools and information to navigate these programs. Users 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.

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 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 must 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 services to patients with chronic, life threatening, and debilitating diseases to help access care and treatment recommended by their doctor. 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 an 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.

RxVantage, Inc.
rxvantage.com

The volume of information in oncology is growing exponentially. From the hundreds of new oral and infusion drugs developed annually to new indications and constantly changing codes, organizations may no longer be able to afford access to this information via manual processes. RxVantage offers a fully digital solution, connecting the entire team to oncology professionals and expert resources to provide the information they need to deliver the best possible patient care.

RxVantage offers a searchable database of oncology professionals in your area and the medications, devices, and services they offer. Instant messaging within the platform provides a fast and secure method of communication.

Educational Experiences for your Entire Team

Invite the entire cancer care team to create a free account with RxVantage to access the specific information they need to keep up-to-date, including:

- Pharmacy Director: Receive information about formulary management, treatment protocols, compliance, and research
- Reimbursement Specialist: Keep the billing team updated on the latest coding information, cleaning up claims and reducing write-offs
- Clinical Research Director: Meet with MSLs to learn about the newest clinical trials, set up data collection protocols, and share patient outcomes.

RxAssist
rxassist.org

RxAssist offers a comprehensive directory of patient assistance programs, as well as practical tools, news, and articles so that health care 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, users 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 Prescription 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.

RxVantage, Inc., is an ACCC Sponsor.
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 providers and staff would like to create a free account for one healthcare provider, visit rxhope.com/Prescriber/SetupAccount.aspx. To set up a 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 the above information is 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 the patient all at the same time.

RxHope acts as a 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 the 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, RxOutreach ships enough medication for 30, 60, 90, or 180 days at a time. RxOutreach is available to qualifying individuals and families. Patients can be on Medicare, Medicaid, or other health insurance and still qualify. It serves people whose income is at or below 400% of the Federal Poverty Line. Patients can quickly check their eligibility 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 rxoutreach.org/how-to-enroll-in-rx-outreach/
3. Call 1.888.RXO1234 (1.888.796.1234).

When enrolling, patients will need to provide the following information:

- Name and contact information
- Date of birth
- Information on allergies and current medications
- Income and household size
- For faster service, patients can include credit card information for payment at this time.

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.

For any questions, call 1.888.RXO.1234 (1.888.796.1234), Monday through Friday, 7:00 am to 5:30 pm CT, or email questions@rxoutreach.org.

Other Patient Assistance Programs & Resources

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2020 PATIENT ASSISTANCE & REIMBURSEMENT GUIDE
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