ASSOCIATION OF COMMUNITY CANCER CENTERS (ACCC)

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ABOUT THE ASSOCIATION OF COMMUNITY CANCER CENTERS

The Association of Community Cancer Centers (ACCC) is the leading advocacy and education organization for the multidisciplinary cancer care team. Approximately 23,000 cancer care professionals from 2,000 hospitals and practices nationwide are affiliated with ACCC. Providing a national forum for addressing issues that affect community cancer programs, ACCC is recognized as the premier provider of resources for the entire oncology care team. Our members include medical and radiation oncologists, surgeons, cancer program administrators and medical directors, senior hospital executives, practice managers, pharmacists, oncology nurses, radiation therapists, social workers, and cancer program data managers. Not a member? Join today at accc-cancer.org/membership or email: membership@accc-cancer.org. For more information, visit the ACCC website at accc-cancer.org. Follow us on Facebook, Twitter, LinkedIn, and read our blog, ACCCBuzz.
Financial Counselors: A Must-Have in Oncology
By Gretchen Van Dyck

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As an innovator in the oncology field, Green Bay Oncology has created a solid financial counseling program to ensure that no patients have to carry the financial burden that may accompany a cancer diagnosis by themselves. By sharing our story, the financial counseling team hopes other cancer programs can benefit from our experiences to either develop their own financial counseling services or to enhance existing services.

Our Story
The financial counseling position at Green Bay Oncology began as a 1 person team 10 years ago when our group consisted of 7 physicians and 6 clinic locations. At a time when prior authorizations for IV chemotherapy were still unheard of, the financial counselor’s basic responsibilities consisted of meeting with uninsured patients who needed to start treatment and working with the pharmaceutical companies to get free drug, if available. Over the next few years, however, the financial counselor position continued to grow along with patient demand and began to include assistance for oral anti-cancer agents as well.

Given the growing complexity of cancer care, along with the increase in the number and cost of oral anticancer therapies, it is no surprise that the financial counselor program quickly became an important part of Green Bay Oncology. In 2015, Green Bay Oncology aligned with Hospital Sisters Health System St. Vincent Hospital, becoming part of the regional cancer center and making us the largest oncology group in northeast Wisconsin.

Today, we have a team of 6 counselors assisting 9 medical oncologists, 3 pediatric oncologists, 3 radiation oncologists, 1 gynecology oncologist, 8 nurse practitioners, and 3 physician assistants across 6 cancer center locations in northeast Wisconsin and the Upper Peninsula of Michigan.

In our comprehensive cancer program, financial counselors follow patients from the start to the completion of their treatment journey and are an integral part of the patient’s experience. We act as a liaison between the patient, the provider, and other clinic departments, as well as the patient’s insurance carrier. Efficient communication between all of these individuals and departments is the core of our program’s success. We are also fortunate to have providers who understand the key message concerning financial toxicity and its potential to impact patient outcomes. “Medicine in general, and oncology in particular, used to believe that money shouldn’t be a consideration in treatment,” said Green Bay Oncology provider Mitch Winkler, MD. “This led us to act as if ‘money was no object’ where cancer treatment was concerned. We feared that considering financial
factors would harm our patients or impede their care. But by neglecting financial factors in cancer treatment, we’ve exposed our patients to terrible harm.”

**Our Process**
The financial counselor’s job begins before the patient steps foot in our clinic. Acting as an advocate for patients, our benefits specialist will first verify their insurance benefits to ensure patients are in-network with our physicians.

Once treatment is prescribed, whether IV, oral, or radiation therapy, the financial counselor will immediately verify that the treatment is indicated for the patient’s diagnosis, checking the National Comprehensive Cancer Network (NCCN) Compendium and/or the Medicare Compendium.

Next, we verify whether the patient’s insurance requires prior authorization. If so, we initiate the authorization process immediately to ensure that treatment can start within three to five days. Once we’ve obtained the authorization approval, we continue to follow the patient to ensure that if treatment continues longer than anticipated, the approval does not lapse. We are able to generate a notification in our electronic health record (EHR) that will alert us of an expiring authorization two weeks before the expiration date. We can then go into the patient’s chart and determine if reauthorization is needed.

For patients treated with oral therapies, our financial counselors initiate the first prescription fill with specialty pharmacy to verify insurance approval and make sure the medication is affordable for the patient. The financial counselors first meet with patients while they are in the clinic, explain how specialty/mail-order pharmacies operate and—depending on their insurance—discuss co-pay assistance.

After meeting with the patient, we fax the prescription along with the patient’s demographics, current medication list, and copies of insurance cards to our single point of contact at the specialty pharmacy. Because we have a pre-existing relationship with this point of contact, communication is often quick and easy, helping to ensure that the medication gets to the patient in a timely manner.

Our pharmacy contact will notify us if an authorization is required. Once we receive that notification we then submit to the insurance company for the approval. When approval has been obtained, we notify the pharmacy and the financial counselor is then given a date when the patient is scheduled to receive his or her medication. We then verify that the patient has an appointment scheduled for a toxicity evaluation within 10 days from the date the medication is received.

**Financial Assistance for IV & Oral Therapy**
If the physician is ordering a treatment that is not yet FDA approved for the patient’s diagnosis, or not indicated (i.e., off-label), we will always try to get approval through the insurance company first. If we receive a denial from the insurance company, we then go straight to the pharmaceutical company and apply to the patient assistance program in hopes to receive free drug assistance for our patients. We do not ask patients to fill out any patient assistance forms; all forms are completed and sent in by the financial counselor. All that is needed from patients is their signature and, if required, income documentation to ensure eligibility.

When patients are first diagnosed and prescribed treatment, one of their first concerns is usually “How am I going to afford this?” Most will have insurance to assist

continued on page 6
Understanding Your Health Insurance Benefits

Date Prepared:_____________________
Patient Name:_______________________________________ Date of Birth:________________________
Insurance Carrier: __________________________________ Policy Number:________________________
In Network? Yes □ No □ Primary Policy? Yes □ No □

Health care expenses can vary from patient to patient. The following is prepared to assist you in understanding your health care terms and benefits.

$_______________ Co-Pay: A fixed amount you pay for a healthcare service, paid when you receive the service, i.e. office visits. As this is a specialist office, this amount may be higher than what you normally pay for your primary care physician visits. Co-pays are due at the time of service.

$_______________ Annual Deductible: A specified amount of money that the insured (you) must pay before an insurance company will pay a claim.

Deductible met: $_______________
Deductible remaining: $_______________

% Co-Insurance: Your share of the costs of a healthcare service. This is usually figured as a percentage of the amount your insurance carrier allows to be charged for services. You start paying coinsurance after you’ve paid your plan’s deductible.

$______________ Out-of-Pocket Maximum: The most you will have to pay for covered healthcare services in a plan year through deductible and coinsurance before your insurance plan begins to pay 100% of covered healthcare services. Co-Pays and deductibles may or may not apply to this amount, this varies by insurance plan.

Out-of-Pocket Maximum met: $______________
Out-of-Pocket Maximum remaining: $______________

Do co-pays apply to my out-of-pocket maximum? YES □ NO □

Notes:____________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Financial Counselors are available to assist you with any insurance or financial related questions during the course of your treatment. Please feel free to stop in or call 920-884-3135 (toll free 866-884-3135) to speak with a Financial Counselor.

This is not a guarantee of benefits; we have made every effort to obtain correct benefit information from your insurance carrier. Final determination of your benefits will be dictated by your insurance company at the time claims are processed. Therefore, your patient responsibility may be different.
them with their treatments and appointments but, as we all know, the out-of-pocket maximums on insurance plans just keep getting larger. It is important to meet with patients before they start treatment and discuss cost and options to help alleviate any financial burdens of cancer treatment.

Depending on the type of treatment, we will go over options, such as foundation assistance on the national level (Patient Advocate Foundation, Patient Access Network Foundation, CancerCare, etc.) or on the local level. For example, in northeast Wisconsin we have some great local foundations, such as Ribbon of Hope and the Ovarian Cancer Community Outreach (OCCO), to help reduce not only treatment costs, but everyday living costs as well.

Once approved, we will add these foundations to the patient’s EHR and take care of all submissions for payment. Claims are sent to the foundation before patients receive a bill. This process is in place to alleviate as much of the financial burden as we can from patients in hopes of reducing any anxiety caused by additional bills and/or collection phone calls.

For commercially-insured patients who do not qualify for foundation assistance and/or for whom there are no funds available for their diagnosis, we will turn to pharmaceutical company co-pay cards. These drug-specific cards can be a great option for reducing out-of-pocket costs. There is no income limitation for these cards so long as patients give us their consent to enroll them; financial counselors can take care of everything, including submitting charges on their behalf.

In 2015 alone, we saved our patients $573,328.50 on their oral chemotherapy co-pays. This amount is only from three of the main specialty pharmacies we use: Accredo, Diplomat, and Community Pharmacies. Recently, in 2016, the financial counseling team worked closely with the hospital’s charity foundation and reached out to donors to create a specific fund for our patients on oral therapy that could be used when all other foundation funds were exhausted.

With the constant increase of insurance plans’ yearly out-of-pocket maximums, the amount of money our program saves our patients each year continues to grow. Figure 1, page 7, illustrates exactly what was paid to our clinic from foundations and pharmaceutical co-pay cards. This does not reflect the full grant amount that was issued to patients. In 2015, between IV and oral chemotherapy assistance, the financial counselors at Green Bay Oncology saved patients more than 1 million dollars!

Financial Assistance for Radiation Oncology

Unfortunately the radiation oncology world is a little bit different in terms of financial assistance. There is very limited access to patient assistance for radiation oncology patients when it comes to treatment; for that reason we like to meet with these patients before they start radiation therapy.

Our financial counselors provide patients with an overview of their insurance coverage, including their out-of-pocket responsibility, what they’ve met, and how much they have remaining. Also, specific forms (see page 5) are given to each patient, depending on their type of coverage, i.e., commercial, Medicare Advantage, or Medicare and a supplement. This information helps give patients an idea of how much they may be responsible for.

We also talk to these patients upfront regarding payment plans, as well as Community Care/Charity Care if they feel this is something they would be eligible for. Patients are also made aware that a financial counselor will be given their treatment plan in order to verify that everything is indicated and authorized prior to their beginning therapy.

Due to the success of these forms in our radiation oncology department, our goal is to meet with and provide these same benefits to all patients in the medical oncology clinic by 2017.

At Green Bay Oncology, our financial counselors do not just handle the above-mentioned duties. Financial coun-
selors are constantly involved in projects, creating new processes and building teams within other departments to continue driving our cancer program forward.

Financial counselors work closely with social workers and nurse navigators to make sure patients are taken care of both inside and outside of the clinic, including ensuring patients have all the necessary appointments scheduled, transportation to and from the clinic, or assistance to help with everyday bills that seem to take a backseat when medical bills start accumulating.

Our team also works with outside resources to enroll eligible patients in Medicaid. Financial counselors can also refer underinsured patients to the proper resources to gain the additional coverage they need going forward, such as Medicare supplemental plans and/or prescription coverage (Medicare Part D). The open communication between departments is a prime example of how our cancer program strives to always put patients first.

Financial counselors work closely with physicians to develop and continually update clinical pathways. These disease-specific pathways help standardize our approach to how we treat our patients while showing payers that we are consistent in our treatment plans. Counselors verify that all treatments are listed in the NCCN Compendium while taking into consideration the cost of the therapy—not only for the patient, but also for the clinic.

The financial counselors are the patient’s direct point of contact for any and all billing concerns. Patients are instructed to call their financial counselor with any questions or concerns they may have once they start receiving bills. We work with patients to set up payment plans tailored to their comfort level.

Community Care applications are also given to patients once all other assistance options have been exhausted. Some factors taken into consideration while processing Community Care applications include annual household
income, household size, assets and debt information, and the past three months of bank statements. Once the signed application and all required financial documentation are returned, financial counselors process these and inform patients of the amount of assistance for which they have been approved.

On top of all medication authorizations, including chemotherapy and retail prescriptions, our team also authorizes any radiology imaging that is ordered by providers, as well as molecular lab testing such as chromosome analysis, BCR/ABL, and JAK2 orders. It’s very important to verify coverage for any testing ordered by physicians to prevent that financial burden from falling into our patients’ laps.

When our clinic does receive a denial from a payer on any physician-ordered treatment, it is our financial counseling team’s responsibility to appeal. We will draft a letter to send to the payer along with all supporting documentation, such as compendium listings, FDA indications, insurance policies, etc. Our team is proud to say it’s not very often that the denials are upheld once our appeals are submitted.

Working for a hospital system that understands the need for financial counselors is imperative. We hear far too often while attending conferences around the region that cancer programs are trying to “prove” to their leadership that a financial counselor position is feasible. We think to ourselves, “What? You have to prove it?” Don’t the numbers speak for themselves?

Institutions that do not think they need financial counselors should answer these questions:

- What does your Patient A/R (Accounts Receivable) stand at?
- How are your patients affording their treatments?
- How much are you writing off as charity?
- How many patients are you sending to collections?

Financial counseling is not only a service to assist the patients; it also guarantees the clinic is going to get paid. It’s 2017 and the cost of care is going to continue to climb. Committing as a practice or program to be financially responsible to patients has to be at the forefront.

By attending multiple ACCC meetings (the Financial Advocacy Network [FAN] Meetings, Oncology Reimbursement Meetings [ORMs], and the National Oncology Conference) our financial counselors have experienced ample opportunity for networking with other clinics across the country who have continually expressed their desire to learn more about our comprehensive financial counseling program. We have provided consulting services to several other cancer programs in Wisconsin and Michigan, helping them replicate our financial counselor position within their own program. ACCC meetings have opened our eyes to the fact that there are far too many cancer programs that are unaware of how they can help mitigate financial toxicity for their patients. It is vital for us to educate the cancer community on the importance of financial toxicity prevention. Won’t you join us?

Gretchen Van Dyck is a financial counselor, St. Vincent Regional Cancer Center, Green Bay, Wisc.
The Eisai $0 Co-Pay Programs

Expanding patient access to HALAVEN® and LENVIMA®

Eisai Inc., the maker of HALAVEN and LENVIMA, offers $0 Co-Pay Programs to assist eligible, commercially insured patients with the out-of-pocket costs for their prescriptions.*

The $0 Co-pay Programs are offered through the Eisai Assistance Program, which is designed to help facilitate access and reimbursement support for health care providers and patients. Additional benefits include reimbursement information, insurance verification, alternate coverage advising, and financial assistance programs. Eisai cannot guarantee coverage or eligibility for any benefits or programs.

To learn more about the $0 Co-Pay Programs and the Eisai Assistance Program

• Call 1-866-61-EISAI (1-866-613-4724), 8 AM to 8 PM ET, Monday through Friday
• Visit www.EisaiReimbursement.com

*Maximum benefit: The HALAVEN and LENVIMA $0 Co-Pay Programs each provide eligible patients up to $18,000 and $40,000 per year, respectively, to assist with the out-of-pocket costs for prescriptions. Depending on the insurance plan, your patient could have additional financial responsibility for any amounts over Eisai’s maximum liability. Other terms and conditions apply.
THE MERCK ACCESS PROGRAM

May Help Answer Questions About

- Benefit investigations for your patients
- Billing and coding
- Product distribution
- Information about prior authorizations and appeals
- Referrals to the Merck Patient Assistance Program
- Co-pay assistance for eligible patients

Contact The Merck Access Program (MAP)
Call 855-257-3932 Monday through Friday, 8 AM to 8 PM ET.

Register for the secure Merck Access Portal to

Complete the MAP enrollment form online and submit it electronically. The Portal provides for the use of electronic signatures
Track benefit investigation and enrollment requests to help you monitor where your patients are in the enrollment or benefit investigation process
Receive notifications and update practice information from a central dashboard

To register your practice for the Merck Access Portal, visit merckaccessprogram-keytruda.com.
As an oncology service line within a healthcare system, St. Luke’s Mountain States Tumor Institute (MSTI), Boise, Idaho, is the only service line that has a dedicated financial advocacy program staffed with 19 FTES. The Advocates are budgeted under the Administrative Support of each of the five MSTI clinics. Key to the success of our financial advocacy program is our ability to leverage co-pay, foundation, and patient assistance programs for our patients through our consistent authorization process, successful management of our self-pay population, and documented data on all levels of assistance provided to our patients.
Step 1. Engage Key Stakeholders

When setting up a process for accessing co-pay, foundation, and patient assistance funds, transparency and good communication are essential. The first step in setting up the billing process for these financial advocacy services is to engage key stakeholders, including:

- Payments and Cash Posting Management
- Billing
- Customer Service
- Financial Advocacy team members.

These stakeholders have a vital role in ensuring the long-term viability of the billing process. For example, Payments and Cash Posting Management must establish a process for identifying and tracking payments from co-pay, foundation and patient assistance programs, which can come in a variety of forms, including credit card authorization numbers and checks from third-party payers that look like they are coming from an insurance company.

Billing needs to submit patient claims in a timely fashion to avoid bottlenecks and so co-pay, foundation, and patient assistance programs can be billed in a timely manner.

Customer Service may receive calls from patients trying to pay with their Co-Pay Card or from patients who are upset at being balanced-billed when they have a Co-Pay Card or Foundation Assistance, and must be prepared to respond or refer these patients to the appropriate staff member. A designated billing coordinator assigned to track patients and their co-pay, foundation, and patient assistance funds can help to alleviate confusion.

Financial Advocacy needs to screen all patients to not only ensure claims are getting paid but to help limit and/or decrease patient financial liability. Financial advocates must be aware of patients’ prescribed treatments, and then apply for available assistance based on disease and treatment type. If your financial advocates do not handle authorizations, the authorizations team can set up a process to notify Financial Advocacy to apply for patient assistance when needs are identified.

Step 2. Develop a Process for Insurance Billing & Follow-Up

When we first designed our financial advocacy program, the billing coordinator role was initially envisioned as a clerical one, but it quickly became clear that we needed more from this position. We hired someone from our Insurance Follow Up Team within our healthcare system’s billing department who already knew how to access the correct forms needed to bill the programs and how to identify when claims needed to be billed, rebilled, or corrected. This individual also had working relationships established in all areas of the billing department, making her job easier. In addition to billing co-pay cards, foundations, and patient assistance programs, the coordinator also bills patients’ cancer policies and provides billing support to our Financial Advocacy team. The savings realized from our billing process continues to exceed the cost of hiring this vital staff person.

To bill a co-pay, foundation, and/or patient assistance program, the billing coordinator faxes the Explanation of Benefits (EOB), showing the program-designated charge (for example, the supported drug) that was charged by the provider and then processed by the payer and the subsequent patient responsibility resulting from that charge after claim processing. This process is more efficient than waiting for patients to bring in their EOBs. In some situations, the billing coordinator is able to upload these documents if the program portal has that capability.

The response time for payment by the co-pay, foundation, and/or patient assistance program
Step 3. Identify Future Needs & Process Improvements

MSTI started its financial advocacy program three years ago in January 2014, and we are still working to simplify our billing and payment recovery processes. Our health system uses EPIC as its electronic health record (EHR), and we have not yet found a way to bill co-pay, foundation, and/or patient assistance programs electronically or to set up a secondary payer plan to print out paper claims. This limitation creates work queues with patient responsibility claims that are waiting for programs to pay, which can drive up our Accounts Receivable days.

Payment identification is another area that needs improvement. Any payments other than insurance payments are listed as “patient payments,” even though these payments may be co-pay, foundation, and/or patient assistance payments. This lack of clarity causes additional work for the billing coordinator to determine if payments have been received. Communication is critical between the billing coordinator and Payment and Cash Posting Management. Currently, when Cash Management does not recognize a payment or identifies that payment as one of the programs that our billing coordinator follows up on, a notification is sent out to the billing coordinator to follow up on these payments.

We continue to talk with pharmaceutical representatives and foundation groups about how we can remove these barriers. One avenue that I have yet to explore is talking with various EHR vendors since they create the billing modules that we all work with.

Our healthcare system has not yet instituted automated billing; however, automated reports would be a huge win for the Financial Advocacy program. Currently we manually track data in Excel spreadsheets to show administration the dollar amount brought in as a service line to help drive down patient collections, charity write-offs, and bad debt. Those Excel reports are good, but automated reports would certainly contain less human error and could be generated faster.

Neglecting to implement a streamlined process to bill these co-pay, foundation, and/or patient assistance programs is like saying you don’t want to get paid. Assistance funds are available and—with a bit of work—can be relatively easy to access for your patients. Our innovative financial advocacy process has increased patient satisfaction, freed up financial advocate staff to perform other duties, helped patients pay down out-of-pocket costs, and reduced our charity and bad debt write-offs.

Ann Kline is the former manager of Revenue & Reimbursement at St. Luke’s Mountain States Tumor Institute, Boise, Idaho. Ann has returned to being a Patient Advocate and continues to help other facilities learn how to have a successful Advocacy program through ACCC and Genentech Speaker Bureau.

Powerful Training to Take Your Financial Advocacy Skills to the Next Level

Whether you’re an experienced financial advocate or new to the field, there’s no better time to shape up your skills.

FINANCIAL ADVOCACY BOOT CAMP offers a dynamic online curriculum for you to help cancer patients navigate the complex and fragmented healthcare system.

Brought to you by the Association of Community Cancer Centers (ACCC) and its Financial Advocacy Network (FAN), this FREE online program provides the key knowledge and skills to excel in the increasingly essential arena of financial advocacy:

- Financial Advocacy Fundamentals
- Enhancing Communication
- Improving Insurance Coverage
- Maximizing External Assistance
- Developing & Improving Financial Advocacy Programs & Services

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

Enroll today: accc-cancer.org/FANBootCamp

The Financial Advocacy Network (FAN) provides needed resources and expands the skills and knowledge base of providers who deal directly with patients on complex financial issues surrounding their cancer diagnosis and treatment.
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ACCC INTRODUCES

FINANCIAL ADVOCACY

BOOT CAMP

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### STEP 1.
Provider writes chemotherapy order for patient.

### STEP 3.
Staff identifies the patient’s financial status and follows the appropriate flow chart below.

<table>
<thead>
<tr>
<th>Category</th>
<th>Action 1</th>
<th>Action 2</th>
<th>Action 3</th>
<th>Action 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NO INSURANCE</strong></td>
<td>Identify if patient qualifies for any programs (SSDI, Medicaid, etc.).</td>
<td>Fill out forms for all programs. Complete forms for companies that have a replacement program if patient qualifies.</td>
<td>Identify if foundation funding is available for any drugs not replaced.</td>
<td>Fill out forms for foundation funding that is available.</td>
</tr>
<tr>
<td><strong>MEDICAID PROGRAM</strong></td>
<td>Verify benefits.</td>
<td>Verify drugs are indicated for diagnosis and authorize if necessary.</td>
<td>Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.</td>
<td>Identify patient’s responsibility.</td>
</tr>
<tr>
<td><strong>MEDICARE ONLY</strong></td>
<td>Verify benefits.</td>
<td>Verify drugs are indicated for diagnosis.</td>
<td>Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.</td>
<td>Identify patient’s responsibility.</td>
</tr>
<tr>
<td><strong>MEDICARE &amp; SUPPLEMENTAL</strong></td>
<td>Verify benefits.</td>
<td>Verify drugs are indicated for diagnosis.</td>
<td>Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.</td>
<td>Identify patient’s responsibility; if none, start treatment.</td>
</tr>
<tr>
<td><strong>MEDICARE &amp; SECONDARY</strong></td>
<td>Verify benefits.</td>
<td>Verify drugs are indicated for diagnosis and authorize secondary insurance if necessary.</td>
<td>Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.</td>
<td>Identify patient’s responsibility.</td>
</tr>
<tr>
<td><strong>MEDICARE ADVANTAGE</strong></td>
<td>Verify benefits.</td>
<td>Verify drugs are indicated for diagnosis and authorize secondary insurance if necessary.</td>
<td>Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.</td>
<td>Identify patient’s responsibility.</td>
</tr>
<tr>
<td><strong>OTHER GOVERNMENT PROGRAMS</strong></td>
<td>Verify benefits.</td>
<td>Verify drugs are indicated for diagnosis and authorize secondary insurance if necessary.</td>
<td>Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.</td>
<td>Identify patient’s responsibility.</td>
</tr>
<tr>
<td><strong>MANAGED CARE</strong></td>
<td>Verify benefits.</td>
<td>Verify drugs are indicated for diagnosis and authorize secondary insurance if necessary.</td>
<td>Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.</td>
<td>Identify patient’s responsibility.</td>
</tr>
<tr>
<td><strong>COMMERCIAL &amp; INSURANCE EXCHANGES</strong></td>
<td>Verify benefits.</td>
<td>Verify drugs are indicated for diagnosis and authorize secondary insurance if necessary.</td>
<td>Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.</td>
<td>Identify patient’s responsibility.</td>
</tr>
</tbody>
</table>
STEP 2. Chemotherapy order is sent to finance staff.

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.

Identify if foundation assistance is available. Fill out forms for foundation funding that is available.

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.

Identify if patient has responsibility. If foundation assistance is available.

Fill out forms for foundation funding that is available. Identify 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.

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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 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.
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- accc-cancer.org
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Oncology-related products: Lupron Depot® (leuprolide acetate for depot suspension)

Patient and Reimbursement Assistance Website

abbviepaf.org

PATIENT ASSISTANCE

AbbVie Patient Assistance Foundation

The foundation offers a variety of assistance programs to meet the needs of the specific people who are prescribed AbbVie medications. Income eligibility criteria varies by medication and is based on the federal poverty guidelines, which are adjusted each year. To apply:

- Click on the medication (abbviepaf.org/apply.cfm).
- Complete the application. Fill out the sections completely (please refer to the checklist on the application).
- Attach proof of income if required.
- Be sure the patient and provider sign and date the application.
- If patient has Medicare Part D and is applying for assistance, download and complete the appropriate attestation form.

Submit the completed application by fax: 866.483.1305 or mail: AbbVie Patient Assistance Foundation, PO Box 270, Somerville, NJ 08876. Questions? Call 1.800.222.6885, Monday through Friday, 8:00 am to 5:00 pm CST.

The foundation will contact patients and providers about the application within a week to let patients know if they are approved for assistance. If the application was missing information the patient and/or provider will be asked to provide missing information. Once received, the foundation will evaluate the application. The foundation will contact patients and providers about the application to let them know if the patient is now approved for assistance.

If the patient is eligible for assistance, a supply of the medication will be shipped to the prescriber’s office. It is the responsibility of the prescriber or office staff to reorder at least 7 business days prior to the patient requiring further medication.

REIMBURSEMENT ASSISTANCE

Reimbursement Resources

Providers with reimbursement questions can call the toll-free reimbursement hotline at: 1.800.453.8438. If you are experiencing reimbursement issues, customer service representatives are available to assist.
Oncology-related products: Aranesp® (darbepoetin alfa), Blincyto® (blinatumomab), Epogen® (epoetin alfa), Imlygic™ (talimogene laherparepvec) suspension for intrallesional injection, Kyprolis® (carfilzomib), Neulasta® (pegfilgrastim), Neupogen® (filgrastim), Nplate® (romiplostim), Prolia® (denosumab), Sensipar® (cinacalcet), Vectibix® (panitumumab), Xgeva™ (denosumab)

Patient and Reimbursement Assistance Website
amgenassist360.com

PATIENT ASSISTANCE

Co-pay Assistance Support
Amgen offers co-pay coupon programs for Imlygic, Kyprolis, Neulasta, Neupogen, Nplate, Prolia, Vectibix, and Xgeva to help eligible patients who are commercially insured with their deductible, co-insurance, and/or co-payment requirements. To confirm patient eligibility and enroll in one of these programs, call 1.888.65.STEP1 (888.657.8371) or visit amgenfirststep.com.

Amgen FIRST STEP™ Program
This financial support program helps commercially-insured eligible patients with their co-pay and other treatment costs. Patient eligibility requirements:

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

Coverage Limits

- Program covers out-of-pocket medication costs for the Amgen product only. Program does not cover any other costs related to office visit or administration of the Amgen product. Other restrictions may apply.
- No out-of-pocket cost for first dose or cycle; $25 out-of-pocket cost for subsequent dose or cycle. Maximum benefit of $10,000 per patient per calendar year. (For Prolia: maximum benefit of $3,000 per patient per calendar year. For Kyprolis: maximum benefit of $20,000 per patient per calendar year.) Patient is responsible for costs above these amounts.

Restrictions may apply. Amgen reserves the right to revise or terminate this program, in whole or in part, without notice at any time. This is not health insurance. Program invalid where otherwise prohibited by law. Register before any Amgen treatment.

Learn more at the Amgen FIRST STEP Co-pay Card Program Health Care Provider Portal: https://amgenfirststep.com/hcp. From the portal, healthcare providers can enroll patients, review records, download forms, and upload documents. Questions? Call 1.888.65.STEP1 (1.888.657.8371) Monday through Friday, 9:00 am to 8:00 pm EST.
Uninsured Patients

Patients may be able to receive Amgen medications at no cost from The Safety Net Foundation (safetynetfoundation.com/index.html) if they meet the following eligibility requirements:

- Are a resident of the U.S. or its territories
- Satisfy income eligibility requirements
- Have no or limited drug coverage
- Do not have any other insurance or financial support options

NOTE: Qualifying Medicare Part D patients may also be eligible if they meet additional criteria demonstrating inability to afford medications based on income.

To enroll in The Safety Net Foundation, patients must meet program eligibility requirements and complete the Patient Application Form:


The facility can then submit requests for replacement product using the Product Replacement Request Form (http://www.safetynetfoundation.com/pdf/Product_Replacement_Form_3_28_16.pdf). Institutions that have enrolled as Individual Patient Assistance Program (IPAP) facilities may use the IPAP Patient Application (safetynetfoundation.com/pdf/RE-SNF-011-C_IPAP_Patient_Application_UpdatedV3.pdf) to enroll their patients.

Questions? Call 1.888.762.6436.

Amgen Assist 360™

This comprehensive, personalized program provides information and patient assistance for patients on Blincyto and Kyprolis, including:

- Insurance Verification
  Verifying patient’s insurance information and determining patient coverage responsibility for services to be provided
- Free product assistance for uninsured patients or those rendered uninsured through payer denial who meet certain income, medical, and eligibility criteria
- Independent foundation assistance. Co-pay and/or co-insurance assistance through third-party foundations
- Appeals Support
  Appeals process information
- Transportation and lodging cost assistance. Referral to third-party organizations for those patients who qualify and need assistance with or help paying for gas, lodging, tolls, and parking in connection with receiving therapy.
- Patient and caregiver support services. Referral to support services for patients, families, and caregivers that provide product information, support group information, nutritional information, side effect management, along with practical matters related to the patient’s condition.

Providers can enroll their patients online at: http://www.amgenassist360.com/hcp/. All services are subject to eligibility requirements. The online form includes three sections, and you should have the following information available:

Section 1. Patient Information
1. Your patient’s contact information, including address and phone number
2. Your professional contact information.

Section 2. Physician Information
1. Your professional contact information
2. The referring physician’s contact information
3. Your state license, DEA number, tax ID number, NPI/PTAN number, patient diagnosis ICD-9 code, patient dose, treatment start
date, and previous patient therapy information.

Section 3. Insurance Information
1. Your patient’s insurance information, including carrier, phone number, policy ID, group number, and subscriber’s date of birth.

Section 4. Free Product Assistance
1. Your patient’s current annual household adjusted gross income
2. Your patient’s federal tax return, W2 form, or Social Security benefit statement.

You can also enroll patients by phone by calling 1.888.4ASSIST (1.888.427.7478) Monday through Friday, 9:00 am to 8:00 pm EST.

REIMBURSEMENT ASSISTANCE

Amgen Assist 360™
This comprehensive, personalized program provides information and reimbursement assistance for patients on Blincyto and Kyprolis, including:
• Insurance verification. Verifying patient’s insurance information and determining patient coverage responsibility for services to be provided.
• Appeals support.

Providers can enroll their patients online at: http://www.amgenassist360.com/hcp/ (see the instructions above) or by calling: 1.888.4ASSIST (1.888.427.7478) Monday through Friday, 9:00 am to 8:00 pm EST.

Communication Skills 101

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

Tips for Effective Speaking

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

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

ARIAD PASS™
To support your patients, ARIAD has partnered with Biologics, an oncology pharmacy that provides a comprehensive and personalized approach to supporting patients throughout their prescribed therapy. Each of your ARIAD patients will be assigned a Biologics Oncology Pharmacist and Nurse Specialist to provide clinical support from receipt of prescription throughout treatment.

Enrolling your patients in ARIAD PASS is easy with the ARIAD PASS Prescription Form found online at: ariadpass.com/hcp.html, which can be faxed to ARIAD PASS at 1.855.557.PASS (1.855.557.7277).

A Patient Access Specialist will conduct a benefits investigation and provide the results. The Patient Access Specialist will also work with patients who are unable to identify programs or services for which they may be eligible. Once a benefits investigation is complete, a Biologics Oncology Pharmacist will contact your patient to schedule delivery and perform an initial baseline assessment. The Biologics multidisciplinary pharmacy care team will:

• Counsel your patient, including a review of drug and food interactions, dosage, and possible side effects
• Provide information on adherence and side effect management support throughout therapy
• Coordinate with your patient to set up free delivery and free refill delivery based on your patient’s therapy schedule
• Contact your office if a new prescription is needed
• Advise your patients on how to take, store, and properly dispose of medication.

The Patient Access Specialist provides eligible patients with an array of financial assistance options, including co-pay or co-insurance support, based on their insurance coverage and financial needs. If your patient requires medication during a coverage delay, the benefits coordinator can provide your patient with a one-time, 30-day supply to ensure that they can start medication free of cost. If your patient has a qualifying disruption in insurance coverage ARIAD has created ARIAD Assurance PASS. The plan is designed to ensure that patients who start on treatment are able to stay on treatment even if there’s a change in their insurance status. For ARIAD Assurance PASS, medication can be provided at no cost for up to 90 days. There are three ways you can get your patients access to ARIAD PASS:

1. Call toll-free 1.855.447.PASS (1.855.447.7277) Monday through Friday, 9:00 am to 6:00 pm EST
2. Visit ariadpass.com to download the Prescription Form, then fax the completed ARIAD PASS Prescription Form to 1.855.557.PASS (1.855.557.7277).

REIMBURSEMENT ASSISTANCE

ARIAD PASS
A Patient Access Specialist quickly determines your patient’s level of insurance coverage and any additional requirements, such as prior authorizations, so your patient can promptly begin therapy.
**PATIENT ASSISTANCE**

**Xtandi Support Solutions℠**

Xtandi Support Solutions (astellaspharmasupportsolutions.com/products/xtandi) provides services to help patients and healthcare providers with access and reimbursement, and information regarding coverage options and financial assistance programs. Xtandi Support Solutions offers:

- Instructions for filling out the Xtandi Solutions patient enrollment form
- Benefits verification
- Prior authorization requests
- Assistance with appeals when prior authorization requests are denied
- Xtandi Quick Start+ Program
- Patient assistance
- Specialty pharmacy coordination.

To enroll your patient in Xtandi Support Solutions, complete the Patient Enrollment Form (astellaspharmasupportsolutions.com/docs/xtandi/XSS_Patient_Enrollment_Form.pdf) in its entirety (required fields marked with an asterisk), including the signatures section. (NOTE: It is critical that the enrollment form is signed by both the prescribing doctor and the patient or the patient’s authorized representative.) Return by fax to 1.855.982.6341.

**Xtandi Quick Start+™ Program**

The Xtandi Quick Start+ Program provides a free, one-time 14-day supply of Xtandi to new patients who experience a delay in insurance coverage. Providers should complete the Quick Start+ Program portion of the Patient Enrollment Form so their patients will be eligible for the program if needed. If prescriptions are not filled within 7 business days due to insurance coverage delays, Xtandi Support Solutions assesses the case for eligibility. A 14-day supply of Xtandi is shipped overnight directly to the patient.

In order to be eligible for the Quick Start+ program, patients need to:
- Be new to Xtandi therapy
- Have experienced an insurance-related access delay
- Have been prescribed Xtandi for an FDA-approved indication.

Xtandi Quick Start+ Program allows your patient to start their Xtandi treatment while Xtandi Support Solutions or a network specialty pharmacy works with the patient’s insurer to resolve coverage issues.

**Commercially Insured Patients**

The Xtandi Patient Savings Program is for patients who have commercial and/or private health insurance but who may have trouble paying their out-of-pocket costs. Under this program:
- Patients should expect to pay no more than $20 per prescription
- Co-pay assistance is available for up to 12 refills
- Your patient is covered for savings up to $5,000 for each prescription and a maximum savings up to $25,000 per year
- There are no income requirements.
The program is not available to patients who have prescription drug coverage paid in part or in full under any state or federally funded programs, including but not limited to Medicaid, Medicare, Medicare Part D, Medigap, DoD, VA, TRICARE, or any state patient or pharmaceutical assistance program.

To enroll your patient in Xtandi Patient Savings Program, complete the Xtandi Support Solutions Patient Enrollment Form (astellaspharmasupportsolutions.com/docs/xtandi/XSS_Patient_Enrollment_Form.pdf), including all patient and healthcare provider signatures, and fax the completed form to 1.855.982.6341 or contact your preferred network specialty pharmacy to determine eligibility and enroll in the program.

**Uninsured Patients**
The Astellas Access Program is for patients without prescription coverage for Xtandi. The program provides free Xtandi to patients who qualify. Eligibility is determined on a patient-specific basis. To be eligible for the Astellas Access Program patients must meet the following criteria:

- Patient is uninsured or has insurance that has denied coverage for Xtandi
- Patient has a verifiable shipping address in the United States
- Patient has been prescribed Xtandi for an FDA-approved indication
- Patient has an annual adjusted gross household income of less than $100,000 per year.

Xtandi Support Solutions can determine whether a patient meets these criteria. To enroll a patient with the Astellas Access Program, complete the Xtandi Support Solutions Patient Enrollment Form (including the signatures section of this form) (astellaspharmasupportsolutions.com/docs/xtandi/XSS_Patient_Enrollment_Form.pdf) and fax it to 1.855.982.6341. Retain a copy of your patient’s proof of income, which may include one of the following:

- Copy of the patient’s most recent tax return
- Copy of the patient’s most recent W-2 form
- Copy of the patient’s 1099 Social Security form
- Copy of the patient’s most recent Social Security benefits letter
- Copy of the patient’s latest pay stubs for 4 consecutive pay periods.

Once your patient is approved for assistance under the Astellas Access Program, Xtandi Support Solutions will notify both the prescriber and patient. A 30-day supply of Xtandi is then shipped directly to the patient’s home each month they are enrolled in the program.

**Medicare Patients**
Medicare typically covers Xtandi under the Medicare Part D prescription drug benefit. However, a patient’s cost share may vary, depending on their Medicare plan. Xtandi Support Solutions can help evaluate a Medicare patient’s financial need and assistance options. Xtandi Support Solutions can:

- Help determine what type of cost-sharing the patient has, such as a flat co-payment or a percentage-based co-insurance
- Evaluate eligibility for Medicare Part D patients who may qualify for the Low-Income Subsidy (LIS)
- Help determine whether a patient is eligible for assistance from an independent co-pay foundation.

**REIMBURSEMENT ASSISTANCE**
**Xtandi Support Solutions**
Specialists are available to help patients find the best option to gain rapid access to Xtandi. Xtandi Support Solutions can help with:

- Reimbursement support (benefit verification, prior authorization tracking, appeal assistance)
- Prescription triage to a specialty pharmacy in the Xtandi Support Solutions network
- Questions on using specialty pharmacies
- Support for in-office dispensers
- Referrals to programs to help with out-of-pocket expenses
- Facilitating immediate access to Xtandi via the Quick Start+ program
- Determining patient eligibility for the Astellas Access Program.
## Benefits Verification

Xtandi Support Solutions performs the benefits verification upon receipt of the Patient Enrollment Form. After performing a comprehensive assessment of patient coverage for Xtandi, Xtandi Support Solutions provides patients with a summary of benefits that includes:

- The patient’s insurance coverage requirements for Xtandi
- Requirements for prior authorization, step edit, or other coverage restrictions
- Cost-sharing responsibility, including deductibles, co-insurance or co-payment, and out-of-pocket maximums
- A list of specialty pharmacies that participate in your patient’s insurance coverage.

Xtandi Support Solutions will send your office a summary of benefits typically within 2 hours of receipt of the Patient Enrollment Form.

## Prior Authorization

Xtandi Support Solutions will determine whether a patient’s plan requires prior authorization for Xtandi, and if it does, how to obtain the prior authorization. Xtandi Support Solutions will also:

- Provide a summary of prior authorization requirements and obtain the appropriate prior authorization form
- Pre-populate the prior authorization form using the information provided on the patient enrollment form
- Send the form to the healthcare provider to complete and sign
- If the healthcare provider returns the completed form to Xtandi Support Solutions, Xtandi Support Solutions will submit the completed form to the patient’s insurer.

At the request of the healthcare provider, Xtandi Support Solutions will follow up with the patient’s insurer to confirm receipt of the prior authorization form, check on the status of the form, and determine the outcome. Xtandi Support Solutions will follow up with the healthcare provider regarding the prior authorization results, inform them if any additional information is required, and assist with denial appeals as necessary.

## Prior Authorization Denial Appeals

If a patient’s insurer denies a claim or prior authorization request, Xtandi Support Solutions can assist with the appeals process by:

- Identifying the reason for the denied claim or prior authorization request
- Determining the additional required documentation
- Informing the healthcare provider what information is needed and where to send the appeal
- Tracking and relaying the status of the appeal.

## Astellas Access eService Portal

The Astellas Access eService tool is an interactive website for healthcare providers to securely and efficiently submit, track, and manage requests online. Available 24 hours a day, eService allows providers to:

- Submit, track, and view the results of benefit verifications
- Submit, track, and view the results of Astellas Access Program℠ applications.

Go to [https://eservice.astellasaccess.com/](https://eservice.astellasaccess.com/) to get started with Astellas Access eService.
Products: Faslodex® (fulvestrant) Injection, Imfinzi™ (durvalumab) Injection, Iressa® (gefitinib) Tablets, Lynparza™ (olaparib) Capsules, Tagrisso® (osimertinib) Tablets

**AstraZeneca**

Patient Savings Programs for FASLODEX, IRESSA, LYNPARZA, and TAGRISSO help eligible, commercially insured patients with the out-of-pocket costs of their prescriptions. Patients enrolled in government-funded healthcare programs such as Medicare, Medicaid, Medigap, Veterans Affairs (VA), or TRICARE are not eligible for AstraZeneca’s patient savings programs.

**How the Programs Work:**

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

For more information about eligibility and details on these programs, please visit astrazenecaspecialtysavings.com or call AstraZeneca Access 360 at 844.ASK.A360 (844.275.2360).

**AstraZeneca Access 360™ Program**

AstraZeneca Access 360™ provides patient access, reimbursement support, and information about affordability programs for AstraZeneca’s medicines.

This program helps patients and providers with:

- Identifying and understanding prescription coverage, out-of-pocket costs, and pharmacy options
- Prior authorization support
- Pharmacy coordination
- Reimbursement process
- Denial and appeal support
- Connecting to patient savings programs
- Referring patients to patient assistance programs
- Connecting to nurse assistance or educational support programs, if applicable (not for all medicines)

The program is staffed with knowledgeable AstraZeneca Reimbursement Counselors who are available at 844.ASK.A360 (844.275.2360) Monday-Friday, 8:00 am-8:00 pm EST. For additional information, visit MyAccess360.com.
The AZ&Me™ Prescriptions Savings Programs
The AZ&Me™ Prescriptions Savings Programs are designed to help qualifying people without insurance and those in Medicare Part D who are still having trouble affording their AstraZeneca medications. There are two programs:
• AZ&Me Prescription Savings program for people without insurance
• AZ&Me Prescription Savings program for people with Medicare Part D

There is a shared application process for the AZ&Me Prescription Savings program for people without insurance and the AZ&Me Prescription Savings program for people with Medicare Part D, and the same application is used for both programs. To apply for the program you may either call 1.800.AZandMe (1.800.292.6363) or visit azandmeapp.com to download an application. For an updated list of the medications available through the AZ&Me Prescription Savings Program, please visit azandmeapp.com.

Patients without Insurance
Program Highlights
• AstraZeneca medicines provided at no cost
• Medicines mailed to patient’s home or physician’s office
• Up to 30 days of product provided for each fill
• Qualified patients provided with a temporary enrollment and up to 30 days’ supply of medication while application is being processed
• Applications accepted via phone, fax, or mail
• Annual enrollment; patients may re-enroll after 12 months if eligible

Eligibility Requirements
• Patient must be without prescription drug coverage through private insurance or government programs
• Patient must have annual gross household income at or below $100,000*
• Patient must be a legal US resident
• Patient must not be eligible for Medicaid in their state of residence

Application Checklist
The following items must be submitted in order to complete enrollment in the program:
• A completed application signed and dated by the patient and prescriber
• A completed prescription (included on page 3 of the application)
• Proof of household income

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

* Income eligibility criteria for some products may be different from the income level listed above. For more information, please visit azandmeapp.com or call 1.800.AZandMe.

Patients with Medicare Part D
Program Highlights
• AstraZeneca medicines provided at no cost
• Medicines mailed to patient’s home or physician’s office
• Up to 30 days of product provided for each fill
• Qualified patients provided with a temporary enrollment and up to 30 days’ supply of medication while application is being processed
• Applications accepted via phone, fax, or mail
• Enrollment is by calendar year; patients are enrolled until 12/31 of the current year and may re-enroll if eligible

Eligibility Requirements
• Patient must be enrolled in a Medicare Part D Plan
• Patient must have annual gross household income at or below $100,000*
• Patient must have spent 3% or more of total household income on prescription medicines through a Medicare Part D Prescription Drug Plan during the current year
• Patient must not be eligible for LIS (“extra help”)
• Patient must be a legal US resident
• Patient must not be eligible for Medicaid in their state of residence

* Income eligibility criteria for some products may be different from the income level listed above. For more information, please visit azandmeapp.com or call 1.800.AZandMe.
Application Checklist

The following items must be submitted in order to complete enrollment in the program:

• A completed application signed and dated by the patient and prescriber
• A completed prescription (included on page 3 of the application)
• Proof of household income
• A copy of the front and back of the patient’s Medicare Part D Plan Card
• A copy of the patient’s Medicare Part D Prescription Drug Plan statement (Explanation of Benefits [EOB]), a pharmacy printout, or a summary document from a pharmacy indicating the amount spent on prescriptions in the current calendar year; this total should be at least 3% of the patient’s income

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

*Income eligibility criteria for some products may be different from the income level listed above. For more information, please visit azandmeapp.com or call 1.800.AZandMe.
Bayer HealthCare Pharmaceuticals, Inc.

Oncology-related product: Nexavar® (sorafenib) tablets, Stivarga® (regorafenib) tablets, Xofigo® (radium Ra 223 dichloride injection)

Patient and Reimbursement Assistance Websites
hcp.xofigo-us.com/patient-financial-assistance
reachpatientsupport.com

PATIENT ASSISTANCE

Xofigo Access Services
Uninsured Patients
You must apply for assistance on your patient’s behalf by submitting a completed application (hcp.xofigo-us.com/downloads/PP-600-US-1278_Xofigo_Access%20Services%20PAP_Copay%20App_Digital.pdf), including a signed patient authorization. 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
- Treatment provided in an outpatient setting.

Call an Access Counselor at 855.6XOFIGO (1.855.696.3446), 9:00 am to 8:00 pm EST, Monday through Friday, if you have any questions or to obtain more information. Fax a completed application, including the signed patient authorization to 1.855.963.4463. Registered users can also submit an application for patient assistance via the secure Xofigo Access Services Provider Portal: xofigoaccessonline.com.

Co-Pay Assistance for Patients with Private Commercial Insurance
You must apply for assistance on your patient’s behalf by submitting a completed application, including a signed patient authorization. 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
- Treatment provided in an outpatient setting.

You and your patient must sign and submit the Application for Patient Assistance/Commercial Co-pay Assistance that includes a signed patient authorization. By signing this form, the patient gives permission for the program to pay co-pay/co-insurance assistance funds directly to the provider. Once approved, your patient receives an approval letter with a Commercial Co-pay/Co-insurance Assistance identification (ID) card. Patients approved for assistance will not have to pay anything to access Xofigo. Call an Access Counselor at 1.855.6XOFIGO (1.855.696.3446), 9:00 am to 8:00 pm EST, Monday through Friday, if you have any questions or to obtain more information. Registered users can also submit an application for patient assistance via the secure Xofigo Access Services Provider Portal: xofigoaccessonline.com.

Co-Pay Assistance for Patients Insured by Public Payers
Medicare beneficiaries and patients with other government insurance who need help paying for treatment with Xofigo are not eligible for co-pay assistance through Xofigo Access Services. These patients may be eligible for co-pay or co-insurance assistance through an indepen-
dent co-pay assistance foundation. If co-pay assistance needs are identified, a Xofigo Access Services Access Counselor can provide information about other foundations that will determine a patient’s eligibility for co-pay or co-insurance assistance based on their own criteria.

**REACH®**

Patients taking Stivarga or Nexavar can enroll in REACH® (Resources for Expert Assistance and Care Helpline). This free program is here to support patients and caregivers with information about therapy and financial assistance options.

The REACH program offers: Nurse Counselors to answer medical questions and provide educational and support materials, as well as guidance on side effects, and Financial Access Counselors to provide help with:

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

**Uninsured/Underinsured**

- Patient Assistance Program (PAP)
- Eligibility requirements apply
- Up to 12 months of free drug for qualified patients
- Alternate funding options. Call 1.866.639.2827 to speak with a reimbursement counselor (9:00 am-5:00 pm EST).

**Privately Insured Patients**

- No monthly cap
- Up to $25,000 per year

**Government Insured**

- Information on Part D prescription drug plans
- Financial assistance may be available through independent charitable organizations
- Alternate funding options. Call 1.866.639.2827 to speak with a reimbursement counselor (9:00 am-5:00 pm EST).

**REIMBURSEMENT ASSISTANCE**

**XOFIGO ACCESS SERVICES**

Comprehensive reimbursement assistance, 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 8:00 pm EST, Monday through Friday. You can also access these services online 24/7 through the Xofigo Access Services Portal: xofigoaccessonline.com. Or download the Quick Reference Reimbursement Guide Hospital Outpatient and Quick Reference Reimbursement Guide Freestanding Center forms at: https://xofigoaccessonline.com/StaticPageContent.aspx?Category=StaticReimbursementForms.

**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 has Nurse Counselors to answer medical questions and provide educational and support materials, as well as guidance on side effects, and Financial Access Counselors to provide help with:

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

Patient and Reimbursement Assistance Website

gilotrifhcp.com/solutions-plus/access-reimbursement

PATIENT ASSISTANCE

Solutions Plus™

This program offers a range of services to help alleviate financial concerns around access. Insurance coverage should not be a barrier to cancer treatment—we will explore multiple options to help a variety of patients afford their treatment, including:

• **Commercially insured patients** who are eligible pay no more than a $25 co-pay per month through the Co-pay Assistance Program. (NOTE: patients must be U.S. residents.)

• **Publicly insured patients** are connected to alternative funding support, which may help offset co-pays, deductibles, or other treatment-related expenses. If denied alternative funding, publicly insured patients may be eligible for BI Cares Foundation support. (NOTE: patients must be U.S. residents.)

• **Uninsured and underinsured patients** who have been denied financial assistance from other foundations may be eligible for free medication through the

To determine if a patient is eligible for programs offered by or through Solutions Plus, BI Cares Foundation, or other support programs, please reference Gilotrif access and reimbursement tools at: https://gilotrifhcp.com/solutions-plus/access-reimbursement#coverage-and-reimbursement. Or enroll your patient by calling 1.877.814.3915, 8:00 am to 8:00 pm EST or by downloading the application at: https://www.gilotrifhcp.com/sites/default/files/pdfs/PC-GF-0328-PROF_Solutions_Plus_Enrollment_Form_Squamous.pdf.

Complete the entire enrollment form with a signed patient authorization form and Gilotrif prescription and fax it to: 1.866.240.4556. Fax confirmation will be provided within 2 hours of enrollment form submission.

To help with Gilotrif treatment initiation and continued adherence, all patients taking Gilotrif will receive a Patient Support Kit (https://www.gilotrifhcp.com/solutions-plus/clinical-support#patient-support-kit).

This helpful kit includes the following patient resources:

• My Guide patient brochure
• My Diary treatment journal
• Topical lotion and loperamide (OTC) samples.

Gilotrif Dose Exchange™


Gilotrif Dose Exchange is designed to help facilitate dose adjustments. It is offered to patients who meet the following eligibility requirements:

• Serviced through our dedicated specialty pharmacy partner, Accredo, or the Gilotrif Dispense Network
• For patients exchanging ≥ 9 tablets.

Here’s how the Gilotrif Dose Exchange facilitates transition to new dose:

• Eligible patients sent new dose promptly once their oncologist submits new prescription
• Covers up to 2 dose modifications
• Patients can easily return unused drug using the prepaid envelope that is sent with the replacement dose.

The Exchange also eliminates additional co-pays in a given month:
• Insurers will not be billed, and patients will not be charged a co-pay for replacement drug.

How Gilotrif Dose Exchange™ works:
• Patient serviced through Accredo or the Gilotrif Dispense Network is prescribed a new dosing strength of Gilotrif (afatinib) tablets and ≥9 pills remain in old dose.
• Oncologist provides new prescription to Solutions Plus on the designated enrollment form.
• Solutions Plus confirms Gilotrif Dose Exchange eligibility.
• Accredo or a central pharmacy at Solutions Plus sends new dose and prepaid return envelope to patient; health plan is not billed and patient is not charged a second co-pay for the new prescription.
• Patient returns pills remaining from old dose using prepaid envelope provided by Solutions Plus.

**Nurse and Pharmacy Support**

Nurse support: Real-time patient education and assistance to complement care. Oncology-trained nurses will call participating Gilotrif patients during critical time points of NSCLC treatment to assist with adherence.

• Five outbound calls will be made to patients
• Treatment-related adverse events education and tips for adherence are addressed
• Language interpreter service available in 170 languages.

Oncology-trained nurses are also available to answer questions as needed. Contact Solutions Plus at 1.877.814.3915, 8:00 am-8:00 pm ET. Solutions Plus® keeps your practice informed throughout each patient’s participation in the program. When a nurse speaks to a patient about treatment with Gilotrif, your office receives a fax update.

Pharmacy support: Dedicated Gilotrif professionals are available for patients and physicians who have questions related to Gilotrif. Physicians and healthcare practice professionals may connect directly with Gilotrif-trained pharmacists with Accredo. Call 1.844.569.2837 from 8:30 am-7:00 pm ET or fax 1.888.454.8488. Patients can reach Patient Care Advocates and Gilotrif-trained nurses with Accredo by calling 1.844.569.2836 from 8:00 am-8:00 pm ET.

**REIMBURSEMENT ASSISTANCE**

**Solutions Plus**

This program helps providers and patients navigate coverage and reimbursement challenges. Knowledgeable reimbursement specialists assist with the coverage and reimbursement process throughout the patient’s Gilotrif treatment journey.

To get patients started on therapy as easily and quickly as possible and minimize reimbursement challenges, Solutions Plus provides assistance with:

• **Benefit verification.** Upon enrollment, reimbursement specialists investigate and verify coverage for patients within 2 business days from initiation.
• **Prior authorization.** Reimbursement specialists anticipate and communicate prior authorization requirements for payers. If prior authorization is needed and the patient receives Gilotrif tablets from our dedicated specialty pharmacy partner, Accredo, then Solutions Plus may assist with submission and tracking of prior authorization consistent with health plan requirements.
• **Gilotrif Bridge.** If a patient experiences a payer delay of more than 7 days for the FDA-approved indication, they may receive a 15-day supply of Gilotrif tablets. This program allows patients to start therapy and avoid a prolonged delay. **NOTE:** This program is for commercially and publicly insured patients treated with Gilotrif for the FDA-approved indication.
• **Denials & appeals.** Reimbursement specialists follow up with programs when patient claims are denied, and Boehringer Ingelheim Access Reimbursement and Distribution Managers provide additional support with the appeals process.
Providers can obtain a Solutions Plus enrollment form by calling 1.877.814.3915, 8:00 am to 8:00 pm EST or download the application at: https://www.gilotrifhcp.com/sites/default/files/pdfs/PC-GF-0328-PROF_Solutions_Plus_Enrollment_Form_Squamous.pdf.

Complete the entire enrollment form with a signed patient authorization form and Gilotrif prescription and fax it to: 1.866.240.4556. Fax confirmation will be provided within 2 hours of enrollment form submission.

**Distribution**
Solutions Plus<sup>®</sup> works closely with Accredo, our single, dedicated, specialty pharmacy partner, to ensure:
- Timely distribution
- Seamless transition from enrollment to prescription fulfillment
- Consistent support experience for patients.

Gilotrif is also available at select on-site pharmacies:
- Select, large group practices
- Kaiser Permanente<sup>®</sup>
- NCI-designated Cancer Centers
- Select hospitals with outpatient clinics
- Integrated delivery networks
- Veterans Administration/Department of Defense.
Bristol-Myers Squibb

Oncology-related products: Empliciti™ (celotuzumab), Ixempra® (ixabepilone), Opdivo® (nivolumab), Sprycel® (dasatinib), Yervoy® (ipilimumab)

Patient and Reimbursement Assistance Website
bmsaccesssupport.bmscustomerconnect.com/oncology/services/patient-financial-assistance

PATIENT ASSISTANCE

BMS Access Support™
Bristol-Myers Squibb (BMS) Access Support can help identify financial assistance programs for eligible patients who need help managing the cost of treatment. The appropriate program will depend on the patient’s coverage.

BMS Oncology Co-Pay Program
This program (bmscustomerconnect.com/bmsaccesssupport/oncology/services/patient-financial-assistance/copay) is designed to assist with out-of-pocket co-pay, deductible, or co-insurance costs for eligible, commercially insured patients who have been prescribed certain BMS products. Patients with state or federally-funded insurance plans are not eligible for this co-pay program. Enrolled patients pay the first $25 of their co-pay per infusion. If the patient receives two BMS medications covered by this Program on the same day, the combination of those two medications will be treated as one dose, requiring the patient pay only $25 of the medications’ co-pay for that day. BMS will cover the remaining amount up to $25,000 per year per product, or $50,000 per year for two BMS products administered in combination. Other restrictions may apply. Final determination of program eligibility is based upon review of completed application.

Enrollment is simple. The provider collects the patient’s name, address, insurance carrier, and member identification number. The provider then completes the application through BMS Access Support in one of the following ways:
- Use the BMS Access Support Form Wizard.
- Download the enrollment form on your computer and fax to 1.888.776.2370.
- Enroll online with our secure portal: MyBMSOncologyCases.com.

When completing the form, check the box for the BMS Oncology Co-Pay Program. BMS Access Support determines patient eligibility, including verifying commercial insurance coverage to establish the appropriate benefit amount. BMS Access Support then notifies the provider and patient of enrollment and the appropriate next steps. Finally, the provider submits the primary claim to the commercial insurance carrier. If the Explanation of Benefits form indicates that your patient has a cost-sharing expense, notify BMS Access Support and submit the required documentation to initiate appropriate next steps. For questions or to confirm receipt of the application, call the Support Center at 1.800.861.0048, 8:00 am to 8:00 pm EST, Monday through Friday.

Assistance for Uninsured Patients
For patients without prescription drug insurance, or for patients that are underinsured, BMS Access
Support can refer them to independent charitable foundations that may be able to provide financial support, including, the Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF): bmspaf.org. This charitable organization provides medicine, free of charge, to eligible, uninsured patients who have an established financial hardship. The BMSPAF accepts the BMS Access Support application. Patients may be eligible for assistance through the BMSPAF if they:

- Do not have insurance coverage, or have been denied coverage for a requested medicine
- Are enrolled in a Medicare Part D plan and have spent at least 3 percent of their yearly income on out-of-pocket costs for prescription medicines in the current year
- Are being treated on an outpatient basis
- Live in the United States, Puerto Rico, or the U.S. Virgin Islands
- Meet the income limits for the requested medicine.

These are just some of the eligibility requirements. 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 with federally-funded insurance plans are not eligible for co-pay assistance programs sponsored by Bristol-Myers Squibb. However, there are independent foundations that can help. BMS Access Support can refer providers to the foundation offering the best support for their specific patient and help them through the application process. It is important to note that these foundations are independent and not affiliated with Bristol-Myers Squibb. Each foundation has its own eligibility criteria and evaluation process. Bristol-Myers Squibb cannot guarantee that a patient will receive assistance. For details, contact BMS Access Support at 1.800.861.0048.

**REIMBURSEMENT ASSISTANCE**

**BMS Access Support: Benefits Investigation**

From the moment a treatment plan is determined, BMS Access Support is here to help you streamline your patients’ experience. BMS Access Support can review patients’ insurance coverage for Bristol-Myers Squibb products and help identify additional sources of support. To begin the benefits investigation process:

- Use the BMS Access Support Form Wizard. Or download the enrollment form at: bmsaccesssupport.bmscustomerconnect.com/oncology/services/benefits-investigation.
- For questions or to confirm receipt of the application, call the Support Center at 1.800.861.0048, 8:00 am to 8:00 pm EST, Monday through Friday.
- You can also enroll, track, and manage your cases online with the BMS Access Support secure portal: MyBMSOncologyCases.com.

If you have further questions, you can contact a BMS Access Support Care Coordinator. BMS Access Support Care Coordinators are always local. That means a familiarity with your office, knowledge of your patients’ cases, and experience with the insurers in your area. Program Care Coordinators are available to your oncology office Monday through Friday, from 8:00 am to 8:00 pm EST at 1.800.861.0048.

**BMS Access Support: Prior Authorization Assistance**

BMS Access Support can provide plan-specific prior authorization forms when one is required by the patient’s health plan. Some health insurers require that a prior authorization be issued before certain items or services are covered. This may require specific forms and supporting documents before a prior authorization may be issued (e.g., medical history, physicals, pathology reports, etc.). When necessary, make sure your patients understand coverage for the service before they have a financial obligation to their provider. Please note: If a prior authorization requirement is not met, some health insurers may deny coverage, even if the claim would have otherwise been covered. If coverage is denied, either the physician or the patient may appeal. See below for details on prior authorization appeals.

Some insurers will make a predetermination of coverage decision upon
request. This generally applies to an item or service that does not require a prior authorization. If a predetermination decision denies coverage, either the physician or patient may appeal the decision with the insurer, in the same manner an appeal can be made on a denial of prior authorization.

For prior authorization assistance from BMS Access Support, providers will need:
- Patient demographics
- Complete insurance information and copy of card
- Physician demographics and signature
- Diagnosis and drug name.

**BMS Access Support: Claims Appeal Assistance**

Almost all health insurers have a specific process to appeal an unfavorable coverage decision. BMS Access Support can assist in navigating the appeals process. However, the preparation and submission of documents to support the appeal is the responsibility of the patient and/or healthcare provider. Bristol-Myers Squibb and its agents make no guarantee regarding the outcome of appeals assistance. When you’re filing an appeal, keep in mind:

- Coverage decisions may be made by an insurer before the treatment is rendered or after a claim is filed. Coverage decisions that are made before a treatment regimen is initiated are often referred to as “prior authorization” or “coverage determinations.”
- Medicare Part B and many other health insurers will not make a coverage decision regarding individual patients before a claim is filed. Coverage is considered only at the time a claim is presented for payment.
- The billing provider can usually appeal an insurer’s decision to deny coverage for a claim. Appeals are almost always subject to timeliness requirements. The window of time allowed for a provider to appeal an unfavorable coverage decision usually begins on the date a claim was adjudicated (processed) by the insurer.
- If the health insurer approves an appeal, you will be notified and the claim will be reconsidered.
- If the health insurer denies the appeal, contact BMS Access Support for further assistance at 1.800.861.0048.
- Each plan has its own process and timeline for appeals. The appeals process for Medicare Part B contractors is determined by the Centers for Medicare and Medicaid Services (CMS).

More questions? Download the full Reimbursement Guide at: bmscustomerconnect.com/bmsaccesssupport/servlet/servlet.FileDownload?file=00Pi000000AQAiDEAX.
Celgene Oncology

Oncology-related products: Abraxane® for Injectable Suspension (paclitaxel protein-bound particles for injectable suspension) (albumin-bound), Idhifa® (enasidenib), Istodax® (romidepsin) for Injection, Pomalyx® (pomalidomide), Revlimid® (lenalidomide), Thalomid® (thalidomide), Vidaza® (azacitidine)

Patient and Reimbursement Assistance Website
celgenepatientsupport.com

PATIENT ASSISTANCE
Celgene Patient Support® provides:
• A single specialist assigned to help patients in your geographic area
• Assistance with understanding patient insurance coverage for Celgene medications
• Information about financial assistance for prescribed Celgene medications

Celgene Commercial Co-Pay Program
This program is for eligible patients with commercial or private insurance (including healthcare exchanges).
• Provides assistance to help patients meet co-pay/co-insurance costs
• Reduces co-pay responsibility to $25 or less for the prescribed Celgene medication

Eligibility criteria for patients include:
• Gross annual household income of $100,000 or less (patients may be subject to a random audit to verify income)

Celgene Commercial Co-Pay Program

Celgene Patient Assistance Program (PAP)
The Celgene Patient Assistance Program is for qualified patients who are uninsured or underinsured.
• Celgene medications may be available at no cost to patients who meet insurance and financial criteria

Celgene Patient Assistance Program (PAP)

- Your patients must meet specified financial and eligibility requirements to qualify for assistance

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

Financial and medical eligibility requirements vary by organization.
Transportation Assistance
Celgene Patient Support® can provide information about financial assistance for transportation costs to and from medical appointments.
- Independent third-party organizations may be able to help patients with transportation costs, such as gasoline, parking, tolls, and taxi, bus, or train fare, to and from medical appointments.

Financial and medical eligibility requirements vary by organization.

REIMBURSEMENT ASSISTANCE

At the request of the patient, specialists are available to assist with each of the following steps in the insurance approval process for prescribed Celgene medications. Celgene cannot provide insurance advice or make insurance decisions.

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

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

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

Enrolling in Celgene Patient Support®

We have 3 simple ways for you to enroll in Celgene Patient Support®. Choose the way that is easiest for you.
- Enroll online now: You can enroll patients in Celgene Patient Support® online at www.celgenepatientsupport.com
- Call 1-800-931-8691: Patients can be enrolled over the phone at 1-800-931-8691, Monday –Thursday, 8 AM – 7 PM ET, and Friday, 8 AM – 6 PM ET (translation services available)
- E-mail or fax the enrollment form: Download the English or Spanish enrollment form at www.celgenepatientsupport.com and return it to us by e-mail at patientsupport@celgene.com or fax it to us at 1-800-822-2496
Eisai Co., Ltd

Oncology-related products: Aloxi® (palonosetron hydrochloride), Halaven™ (eribulin mesylate), Lenvima (lenvatinib) Capsules

Patient and Reimbursement Assistance Website
eisaireimbursement.com

**PATIENT ASSISTANCE**

**The Eisai Patient Assistance Program**

Certain Eisai medications may be available at low-or-no cost to financially needy patients who satisfy eligibility criteria. To learn more call 1.866.61.EISAI (1.866.613.4724). The same program enrollment form is used for all eligible Eisai products. You can download the form here: [http://www.eisaireimbursement.com/-/media/Files/XRay/Aloxi/Patient-Assistance-Enrollment-Form.pdf](http://www.eisaireimbursement.com/-/media/Files/XRay/Aloxi/Patient-Assistance-Enrollment-Form.pdf).

The Eisai insurance verification form (also used for all Eisai medications) can be downloaded here: [http://www.eisaireimbursement.com/-/media/Files/XRay/Aloxi/Insurance-verification-form.pdf](http://www.eisaireimbursement.com/-/media/Files/XRay/Aloxi/Insurance-verification-form.pdf).

**Pay $0 Savings Program**

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

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

The enrollment process also varies depending on the Eisai medication that has been prescribed.

If you have prescribed Lenvima, no activation or enrollment is required. Call your patient’s specialty pharmacy for details.

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

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

**Step 2:** If the patient is determined to be eligible they will be sent a Welcome Letter and a card. This card should be given to your 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 responsibility: deductible; co-payment; and co-insurance.

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

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

The card is solely intended to provide savings on any purchase of the approved Eisai medication. Use of the card for any one purchase does not obligate the patient to make future purchases of the same Eisai medication or any other product. For patients prescribed Lenvima, this offer is available to MA residents through June 30, 2017, and to all other patients through March 31, 2020. For patients prescribed Halaven, this offer will expire November 20, 2019.

REIMBURSEMENT ASSISTANCE

eisaireimbursement.com
This program is your dedicated resource to help you answer your coverage questions. This website eisaireimbursement.com provides you with information about payor-specific coverage policies for the Eisai medication(s) you have prescribed, billing and coding requirements, and alternative financial assistance options for your patient. What to expect when you access eisaireimbursement.com:
• Product specific reimbursement information
• Understanding of coverage, coding and payment issues
• Payer policy information.

Eisaireimbursement.com offers providers a wide range of online tools for each of its products, including:
• Product information
• Billing forms
• ICD-10-CM diagnosis codes
• ICD-10-CM Supplementary Classification Codes
• CPT drug administration codes
• HCPCS Level II code
• National drug codes
• Revenue codes
• Medicare reimbursement rates
• A checklist for claims submission.

Questions? Contact the Eisai Assistance Program at 1.866.61. EISAI, Monday through Friday, 8:00 am to 8:00 pm EST.
EMD Serono, Inc.
Pfizer Inc.

Oncology-related product: Bavencio® (avelumab) injection

Patient and Reimbursement Assistance Website
coverone.com

PATIENT ASSISTANCE

CoverOne™ Patient Assistance Program

CoverOne includes a patient assistance program that provides Bavencio at no charge for patients who meet certain income, insurance (i.e., uninsured), and residency eligibility criteria. To determine patient eligibility, patients and providers should complete and fax a CoverOne Enrollment Form and a prescription prior to treatment 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 for Bavencio.

CoverOne Co-Pay Assistance Program

CoverOne provides co-pay assistance for privately insured Bavencio® (avelumab) injection 20 mg/mL patients with co-pay/co-insurance responsibilities who meet the program eligibility criteria.

Privately insured patients may apply for assistance through the CoverOne Co-pay Assistance Program by faxing a completed CoverOne Enrollment Form to 1.800.214.7295. Government-insured patients, including Medicare and Medicaid beneficiaries, are not eligible for the CoverOne Co-Pay Assistance Program. Limits, terms, and conditions apply. Full terms and conditions for co-pay assistance can be found at CoverOne.com.

CoverOne will notify patients and providers of the eligibility determination as soon as possible. Enrolled patients will be responsible for a $10 co-pay/co-insurance, and may be eligible for Bavencio co-pay assistance up to a maximum of $30,000 per year. For enrolled patients, disbursement of co-pay assistance funds occurs after the patient has received treatment in an outpatient setting, and an Explanation of Benefits (EOB) showing a separately payable Bavencio claim eligible for co-pay assistance is sent to CoverOne.

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 Reimbursement Support Services

CoverOne™ will help providers and patients understand the specific coverage and reimbursement guidelines for Bavencio. Reimbursement support services include:

ACCC 2017 Patient Assistance and Reimbursement Guide | accc-cancer.org / 49
• 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
• Alternate Funding Research

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.

Please fax a completed CoverOne Enrollment Form to 800-214-7295 to request services.
Oncology-related products: Alecensa™ (alectinib), Avastin® (bevacizumab), Cotellic™ (cobimetinib) tablets, Erivedge™ (vismodegib), Gazyva™ (obinutuzumab), Herceptin® (trastuzumab), Kadcyla® (ado-trastuzumab emtansine), Perjeta™ (pertuzumab), Rituxan® (rituximab), Tarceva® (erlotinib), Tecentriq (atezolizumab injection), Venclexta™ (venetoclax tablets), Xeloda® (capecitabine), Zelboraf® (vemurafenib)

Patient and Reimbursement Assistance Website

For insured patients who have coverage for their Genentech medicine:
- Patient annual household adjusted gross income (AGI) must be $150,000 or less and the out-of-pocket costs for his or her Genentech medicine accounts for at least 5 percent of his or her annual household AGI
- All patient assistance options, including Genentech brand-specific co-pay cards and support from co-pay assistance foundations, have been exhausted
- The patient meets medical criteria determined by the GATCF Clinical Advisory Board.

To apply to GATCF, the following forms must be completed and submitted:
1. The Statement of Medical Necessity (SMN) form.
2. The Patient Authorization and Notice of Release of Information (PAN) form in English or Spanish.
3. The GATCF Insurance Attestation form.
5. The confirmation of Infusion or Injection form (if applicable).

Forms can also be e-submitted online through the Genentech’s Forms and Documents page specific to your Genentech medication. Forms are drug-specific, so you must follow the prompts at: genentech-access.com to access the correct forms. Questions? Call Access Solutions at: 888.249.4918, Monday through Friday, 6:00 am to 5:00 pm PST.

NOTE: Eligible patients with a Medicare Part D plan who do not qualify for support from a co-pay assistance foundation may receive certain Genentech medicines free of charge provided they meet the eligibility criteria for insured patients outlined above.
**Genentech BioOncology™ Co-pay Card**

This Co-pay Card helps patients with the out-of-pocket costs of their prescription. Qualified patients must:

- Be covered by commercial or private insurance
- Be receiving treatment that is consistent with the FDA-approved use of the Genentech therapy
- Not participate in a government funded healthcare program, such as Medicare, Medicaid, Medigap, VA, DoD, or TRICARE
- Be 18 years of age and older
- Currently live and receive treatment in the United States or Puerto Rico
- There is no income requirement for the Genentech BioOncology Co-pay Card Program.

NOTE: Patients receiving funding from the Genentech Access to Care Foundation are not eligible for the Genentech BioOncology Co-pay Card Program. Some health plans might not accept a co-pay card. Patients should contact their insurance providers to find out if their plan allows the use of co-pay cards.

Under the Genentech BioOncology Co-pay Card Program, the patient is responsible for a $25 co-pay per prescription or infusion. The annual benefit limit of the co-pay card is $25,000. Retroactive requests for assistance from the BioOncology Co-pay Card program may be honored if the infusion or prescription fill occurred within 120 days prior to enrollment, and the patient met eligibility requirements when the Genentech product or service was received. Patients do not need the physical card to receive benefits; they just need their ID code. If a patient is taking more than one Genentech cancer medicine, these benefits apply to each medicine individually. Need help with enrollment? Call 855. MYCOPAY (855.692.6729), Monday through Friday, 9:00 am-8:00 pm EST, or visit copayassistancenow.com.

**Referrals to Co-pay Assistance Foundations**

If patients need help with their medication co-pays, Access Solutions can connect them to co-pay assistance foundations supporting their disease state. Genentech does not influence or control the operations of these co-pay assistance foundations, but Access Solutions can assist patients by making an appropriate referral to a foundation that may be able to help. Genentech cannot guarantee co-pay assistance once a patient has been referred by Access Solutions. The foundations to which patients are referred will have their own criteria for patient eligibility, including financial eligibility.

**REIMBURSEMENT ASSISTANCE**

**Genentech Access Solutions Benefits Investigation**

Access Solutions conducts a benefits investigation (BI) to help you better understand your patient’s health plan coverage for some or all of the costs associated with treatment. The BI can also determine if a prior authorization or patient assistance might be needed. To have Access Solutions conduct a BI, providers must request the assistance on the signed SMN form. There are three possible outcomes of a BI:

1. Treatment is covered
2. Prior authorization is required
3. Treatment is denied.

To begin with Access Solutions, you must complete and submit the Statement of Medical Necessity (SMN) form and have your patient complete and submit a Patient Authorization and Notice of Release of Information (PAN) form. Login or download at genentech-access.com. Forms are drug-specific, so you must follow the prompts to access the correct forms. Patients can submit the PAN online at: pan.iassist.com/forms/bioonc or download it online at: genentech-access.com.

**Prior Authorization Assistance**

Access Solutions can help providers identify whether a prior authorization (PA) is needed and help them secure it. Simply complete and sign a SMN form requesting assistance with the PA, as well as a signed and dated PAN form (see instructions above). Access Solutions can help providers submit the required PA forms and documentation. If the PA is not granted, Access Solutions can work with providers to determine next steps.

**Appeals**

If providers have prescribed a Genentech product but an insurer has denied coverage, they can appeal that decision. Access
Solutions might be able to help providers resolve the situation. Here is what you can do:

1. Understand why the request or claim has been denied. This should be in the insurer’s letter of denial or the patient’s Explanation of Benefits (EOB) letter.
2. Contact Access Solutions for guidance as you put together an appeal. Use the resources provided to help you gather the documents and information you need for a successful appeal.
3. Complete and submit the required forms and documents to the insurer before the appeal deadline. Access Solutions can provide information about this process.

Here is a checklist of the forms and documents you may need for an appeals package if an insurer denies treatment to your patient.

NOTE: Each insurer and each patient might need different information. Please review each denial and the insurer’s guidelines, as well as this website, to determine what to include in your patient’s appeals package.

✓ Statement of Medical Necessity
✓ Patient Authorization and Notice of Release of Information
✓ Copy of the patient’s health plan or prescription card (front and back)
✓ Appeal letter
✓ Denial information including the patient’s denial letter or Explanation of Benefits letter
✓ Supporting documentation:
  • Patient history and physical findings
  • Healthcare provider’s chart notes
  • List of current medications, with dose and frequency
  • List of treatments tried without success
  • Test and lab results
  • Hospital admission/emergency department notes.
✓ Other supporting documents, including journal articles, abstracts, textbook excerpts, practice guidelines, and/or compendia indications.

My Patient Solutions™
My Patient Solutions allows you the flexibility to work with Genentech Access Solutions online whenever you need. Features of My Patient Solutions:

• Paperless enrollment: Enroll your patients entirely online using electronic signatures.
• Full benefits investigation reports: Review benefits investigation reports for all your patients enrolled in Genentech Access Solutions.
• Patient case management: Search for open or closed cases initiated online or via fax for easier patient case management, re-enrollment or recertification.
• Customized alerts: Customize which email alerts you receive about a patient’s case status so you know what actions need to be taken.

To register your program or practice, you will need the following information:

• Primary Genentech products prescribed by your program or practice
• User information including email addresses (you may add additional users at a later date)
• Program or practice location information (you may add additional locations at a later date)
• Prescriber licensing information, including: a Prescriber National Provider Identifier and State license number (required).

Providers will be asked to agree to the My Patient Solutions Practice Agreement. They must agree to these terms to proceed with My Patient Solutions. For support, call 866.4ACCESS (866.422.2377), 6:00 am to 5:00 pm PST, Monday through Friday. Learn more at: https://www.genentech-access.com/hcp/learn-about-our-services.html.
PATIENT ASSISTANCE

IncyteCARES

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 to continuing support and resources. The program offers:

• Reimbursement support including insurance benefit verifications, information about prior authorizations and guidance with appealing insurance denials or coverage restrictions.

• Access assistance including copay/coinsurance, free medication program & temporary access for insurance coverage delays for those that qualify and referrals to independent nonprofit organizations and foundations.

• Education and support including access to a registered nurse, OCN®, who can provide educational information about their condition and Jakafi as well as review information that is included in the Patient Welcome Kit.

• Connection to support services including referrals for transportation assistance and access to patient advocacy organizations for counseling and emotional support resources.

To enroll your patient download the enrollment form at: incytecares.com/pdf/jakafi-enrollment-form.pdf or call IncyteCARES at 1.855.4.Jakafi (1.855.452.5234).

NOTE: Providers and patients must work together to fill out the enrollment form. Completed forms should then be faxed to: 1.855.525.7207. In most states, the enrollment form will serve as the patient’s initial prescription for Jakafi. By signing the form, the patient is automatically enrolled in the Access, Reimbursement, Education and Support services. If patients do not want these services, they may opt out. Once IncyteCARES receives the form, the program will confirm the patient’s prescription drug coverage and then coordinate with the appropriate specialty pharmacy to fill the prescription. The specialty pharmacy will then contact the patient to make delivery arrangements.

IncyteCARES will determine whether patients qualify for additional services, such as co-pay/coinsurance or free product assistance.

Uninsured Patients

Patients who do not have prescription drug coverage for Jakafi may be eligible to receive the drug free of charge through the IncyteCARES patient assistance program. This program helps people who do not have a prescription drug plan, as well as those whose plans have turned them down for Jakafi treatment. Certain conditions apply for prescription savings. 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), whichever is greater. Free product is offered to eligible patients without any purchase contingency or other obligation. In addition,
patients insured through Medicare, Medicaid, TRICARE, and health-care exchange plans are not eligible. An IncyteCARES nurse can help determine if patients qualify for patient assistance. Visit IncyteCARES.com or call 1.855.4.Jakafi (1.855.452.5234) for more information and full eligibility criteria. Terms of the program are subject to change.

Co-pay/Coinsurance Assistance
If patients are eligible, the co-pay/coinsurance assistance program for Jakafi may be able to reduce their co-payment to as little as $25 per month. Patients may be eligible for co-pay/coinsurance assistance if they have commercial or private insurance, they are a resident of the U.S. or Puerto Rico, they are 18 years of age or older, and they have a valid prescription for Jakafi for an FDA-approved treatment. Uninsured, cash-paying patients are not eligible. Not valid for patients covered under state or federally-funded health-care programs, such as Medicare, Medicaid, or TRICARE. Patients must have minimum out-of-pocket cost of $25.01 to redeem this card and must contribute $25 towards that out-of-pocket cost. Patients must disclose the use of the co-pay card to their insurers. Amount of savings of the purchase of Jakafi will not exceed $25,000 per year. Program benefits are subject to a monthly limit. Limit one 30-day supply per 30 days. Card is valid for one year after activation, after which time a card must be reactivated to continue use. Visit IncyteCARES.com or call 1.855.4.Jakafi (1.855.452.5234) for full program terms and eligibility. Terms of the program are subject to change.

Temporary Access
Eligible patients experiencing coverage delays can receive a free supply of Jakafi. Patients insured through Medicare, Medicaid, and TRICARE are not eligible. Free product is offered to eligible patients without any purchase contingency or other obligation. To qualify, patients must submit a proof of insurance claim verifying delay.

Referral to an Independent Nonprofit Organization
For patients who are not eligible for assistance through IncyteCARES or who need additional support beyond what the program can provide, IncyteCARES can identify and refer patients to other resources, such as independent nonprofit organizations (INOs) or foundations. INO’s may be able to assist patients with arranging transportation to and from medical appointments, travel cost assistance, copay/coinsurance assistance and emotional and educational support.

INOs may also be able to provide the following services to patients and caregivers:
• Supporting counseling for emotional, social, and practical concerns
• Information about support groups and referrals to local services at no cost. Each of these organizations has its own set of rules, and Incyte does not influence or control them in any way.

REIMBURSEMENT ASSISTANCE

IncyteCARES
A trained IncyteCARES nurse will work with providers and patients to provide assistance with prescription drug plan requirements that must be met before patients can get access to Jakafi. Some healthcare plans may require prior authorization, which means they will ask for more information from the provider before deciding to pay for the patient’s Jakafi.

IncyteCARES will work with physicians to provide the necessary information to their patient’s healthcare plan. In addition, if a healthcare plan will not pay for Jakafi, IncyteCARES can help providers and patients understand what needs to be provided to the healthcare plan to appeal the denial. While IncyteCARES cannot apply for the appeal, it can help providers and patients determine the steps they may need to take to overturn the denial. If patients experience insurance coverage delays, IncyteCARES may be able to provide access to Jakafi. Eligible patients who have been prescribed Jakafi for an FDA-approved indication, and who are experiencing an insurance coverage delay can receive a free supply of Jakafi after proof of claims submission is provided. The free product is offered to eligible patients without any purchase contingency or other obligation. For more information, contact IncyteCARES.
PATIENT ASSISTANCE

IPSEN CARES*
The IPSEN CARES® (Coverage, Access, Reimbursement & Education Support) program provides free medication to eligible patients through its Patient Assistance Program. IPSEN CARES will determine patient’s eligibility for free product after the enrollment process has been completed. Patients can call 866.435.5677, Monday through Friday, 8:00 am to 8:00 pm EST, to begin the enrollment process. You can also enroll patients online at: https://ipsencaresportal.biologicsinc.com/Account/Login or download the drug specific enrollment form (http://ipsencares.com/somatuline-patient-support) and fax the signed and completed form to 888.525.2416. IPSEN CARES offers the following services for patients:
• Help minimize delays or interruptions in treatment
• Provide financial assistance, including: copay assistance (referring eligible patients to Somatuline® Depot Copay Program, Onivyde® Copay Program, or an independent non-profit organization) with free product for eligible patients under the IPSEN CARES Patient Assistance Program
• Coordination of specialty pharmacy delivery
• Arrange for eligible patients to have a home health administration nurse visit their home to administer injections at no additional cost to the patient (for Somatuline® Depot)
• Benefits verification and reimbursement support.

Somatuline Depot Electronic Medical Claim Program
Patients who are enrolled in IPSEN CARES and are beginning or currently receiving treatment with Somatuline Depot for an FDA-approved indication, who have commercial insurance that covers the medication and associated costs, or are uninsured and paying their entire out-of-pocket cost, may be eligible for the Somatuline Depot Electronic Medical Claim Program. Under this program, most eligible commercially insured patients pay no more than $5 per prescription. Program exhausts after 12 months, 13 injections, or a maximum benefit of $20,000, whichever comes first. Patients must enroll annually to receive a continued benefit. Cash paying patients may receive up to $1,666.66 of support per prescription, subject to the annual maximum of $20,000. The steps for patients enrolled in IPSEN CARES to receive their Somatuline Depot savings are:
1. Electronic Medical Claims information is provided to the patient’s provider.
2. Provider inputs Electronic Medical Claim information into EMR system or onto the CMS-1500 form and submits claim to insurance company.
3. Provider receives payment directly from their EMR vendor via EFT or check, depending on how their preferences are set.
4. Patient’s account is credited directly.

Oncology-related products: Somatuline® Depot (lanreotide) Injection, Onivyde® (irinotecan liposome) Injection

Patient and Reimbursement Assistance Website
ipsencares.com
Onivyde Copay Assistance Program

Patients who are enrolled into IPSEN CARES, formerly Provyde, receiving treatment with Onivyde that have commercial insurance or are uninsured and paying cash for their treatments are eligible for the Onivyde Copay Assistance Program. The Onivyde Copay Assistance program offers patients up to $20,000 of annual support paying for their Onivyde treatment. Patients have a $0 out-of-pocket responsibility until they reach the $20,000 annual maximum.

Patients will receive their treatment at their HCP office and have their office submit the claim to the insurance. The Explanation of Benefits (EOB) should be sent to IPSEN CARES for processing. Once processed, a check will be mailed to the HCP office on the patient's behalf.

NOTE: This program is not available to individuals enrolled in federal or state subsidized healthcare programs that cover prescription drugs, including Medicare (such as Medicare Part D prescription drug benefit), Medicaid, TRICARE, or any other federal or state healthcare plan, including pharmaceutical assistance programs. This offer is only available in the U.S. and Puerto Rico, and is restricted in certain states. This offer may not be combined with any other coupon, discount, prescription savings card, free trial, or other offer.

REIMBURSEMENT ASSISTANCE

IPSEN CARES

IPSEN CARES offers the following Reimbursement Assistance services to patients and providers:

• **Benefits Verification**: IPSEN CARES will help determine patient's coverage, coverage requirements, and co-payment or co-insurance amount.

• **Prior Authorization**: IPSEN CARES will provide information on documentation required by payers, and make recommendations for next steps based on payer policy.

• **Appeals Support**: IPSEN CARES will provide information on the payer specific process required to submit a level I or a level II appeal as well as provide guidance as needed throughout the appeals process.

Visit ipsencares.com for more information. Questions? Call 866.435.5677, Monday through Friday, 8:00 am to 8:00 pm EST.

Patient Assistance Program

Ipsen is happy to provide free product to eligible uninsured patients who need Somatuline Depot or Onivyde. To qualify, patients must 1) have no insurance or be functionally uninsured, 2) be a US resident, 3) have an on-label diagnosis, and 4) meet income criteria (% of FPL).
Oncology-related products: Darzalex™ (daratumumab), Doxil® (doxorubicin HCl liposome injection), Procrit® (epoetin alfa), Sylvant® (siltuximab), Yondelis® (trabectedin), Zytiga® (abiraterone acetate)

**Patient and Reimbursement Assistance Website**

**JanssenCarePath.com**

**Janssen Biotech, Inc.**

**PATIENT ASSISTANCE**

**Janssen CarePath**

**JanssenCarePath.com**

Janssen CarePath is your one source for resources focused on access, affordability, and treatment support for your patients.

Our Care Coordinator Team supports all the Janssen medications you prescribe. We can help make it easier for you and your patients to get the resources you both may need with a single, dedicated team supporting you and your patients for all Janssen products.

Access support to help patients start on treatment prescribed by provider

Janssen CarePath helps verify insurance coverage for patients and provides reimbursement information.

Our offerings include:
- Benefits investigation support
- Prior authorization support
- Triage to specialty pharmacy providers, if needed.

Affordability support to help patients start and stay on treatment prescribed

Janssen CarePath can help find affordability assistance that may be available for patients taking Janssen medicines:
- Support for patients using commercial or private insurance
- Support for patients using government insurance
- Support for patients without insurance coverage.

Treatment support to help patients get informed and stay on prescribed treatment

Janssen CarePath helps keep patients informed about their condition and the importance of staying on treatment with:

**Education tools**
- Patient education brochures
- Web-based resources
- Education about and referral to independent organizations that provide assistance with costs associated with travel to and from treatment (not available for all Janssen products)

**Adherence tools**
- Personalized reminders (not available for all Janssen products)
- Access to the Care4Today® Connect App.

Call a dedicated Care Coordinator:
877-CarePath (877.227.3728)
Monday-Friday,
8:00 am – 8:00 pm EST
Multilingual phone support available.

Visit us online
**JanssenCarePath.com**

**Janssen CarePath Savings Program**

Janssen CarePath Savings Program for ZYTIGA®
The Janssen CarePath Savings Program may provide an instant savings on patient’s private or commercial health insurance deductible,
co-pay and coinsurance costs for ZYTIGA®. If eligible, patients will pay no more than $10 per month, up to a $12,000 maximum benefit or a one-year supply per calendar year. This program is not available to individuals who use any state of federal government subsidized healthcare program to cover a portion of medication costs, such as Medicare, Medicaid, TRICARE, Department of Defense of Veterans Administration. To learn more about the program, including eligibility and restrictions, visit JanssenCarePath.com/Zytiga.

Care Team members*, such as Providers, Pharmacists, and Caregivers, can now utilize ZytigaCareTeam.com to activate a Janssen CarePath Savings Program Card on behalf of an eligible patient receiving ZYTIGA®.

*Care Team members include the patient’s Provider, Pharmacists, Caregivers, and/or other individuals who provide care for a patient and/or have permission from the patient to assist with the activation of a Janssen CarePath Savings Program Card.

Janssen CarePath Savings Program for DARZALEX®

Eligible patients will pay no more than $10 per infusion and the program can provide a rebate to patients for medication out-of-pocket costs, including deductible, co-payment, and coinsurance. For infusions 1-8, patients pay $5 per infusion. For infusions 9+, patients pay $10 per infusion. Maximum benefit per calendar year is up to $15,000. Eligible patients must be beginning or currently receiving treatment with DARZALEX® and must have commercial insurance that covers medication costs for DARZALEX®. Eligible patients must use commercial or private health insurance that covers a portion of their medication costs for DARZALEX®. Patients using Medicare, Medicaid, or other federally funded programs to pay for DARZALEX® medication are not eligible to participate. To learn more about the Janssen CarePath Savings Program, including full eligibility requirements, visit JanssenCarePath.com/Darzalex.

Janssen CarePath Savings Program for YONDELIS®

Eligible patients pay $20 for each infusion. Subject to a $15,000 maximum annual program benefit for each calendar year. Not valid for patients enrolled in Medicare or Medicaid. Other restrictions may apply. Savings are determined by medication cost only, and not the cost associated with intravenous infusion. For additional details, including complete eligibility and restrictions, please visit JanssenCarePath.com/Yondelis.

Patients may be eligible for the Janssen CarePath Savings Program for YONDELIS® benefits if beginning or currently receiving treatment with YONDELIS® (trabectedin) and currently have commercial or private health insurance that covers a portion of medication costs for YONDELIS®. The costs of IV infusion services are not covered by this program. Other restrictions may apply.

Janssen CarePath Savings Program for SYLVANT®

The Janssen CarePath Savings Program may provide a rebate for patients' out-of-pocket SYLVANT® costs. Patients may be eligible if they have been prescribed SYLVANT® and currently have commercial insurance that covers medication costs for SYLVANT®. If eligible, patients may receive a rebate for their out-of-pocket SYLVANT® medication expenses after they pay their full co-pay amount to their healthcare provider when they receive their treatment. Patients will receive a rebate up to $1,000 per infusion for their medication costs and pay $50 per infusion. Costs of IV infusion services are not covered by this program. The program exhausts 12 months from the patient's first eligible date of service. Patients may re-enroll annually to continue receiving a benefit from the program. This program is not available to individuals who use any state of federal government subsidized healthcare program to cover a portion of medication costs, such as Medicare, Medicaid, TRICARE, Department of Defense of Veterans Administration. For additional program details, including eligibility and restrictions, or to download the enrollment form, visit JanssenCarePath.com/Sylvant.
## Insurance Verification Form

Update  □  New  □  Patient Name: ___________________________ ID/SSN #: ______________________

Patient Insurance ID __________________ Group Policy # __________________ Insurance Company: ______________________

(If different)


Name of Contact __________________________ Date/Time of Auth: __________________________

Phone/Fax/Address for Auth: __________________________

Effective Date: __________________________ PCP: __________________________ Tel #: __________________________

Specific Pharmacy Requirement: __________________________ □  Mail order: __________________________

Co-insurance/Co-pay: __________________________ Cap for drugs or diagnosis: $ __________________________

Catastrophic Coverage or Stop-loss __________________________ When? __________________________

Medicare Card Number: __________________________ Effective: __________________________


Does policy include a Deductible? □  Yes □  No  Co-insurance? □  Yes □  No  Prescription Drugs? □  Yes □  No

Medicaid? □  Yes □  No  Pending? __________________________ Spend Down? □  Yes □  No

Share of Costs? __________________________ Spend Down Amount $ __________________________

Source. ACCC Financial Advocacy Network. accc-cancer.org/FAN
Oncology-related products: Alimta® (pemetrexed for injection), Cyramza® (ramucirumab), Erbitux® (cetuximab), Lartruvo™ (olaratumab), Portrazza™ (necitumumab)

PATIENT ASSISTANCE

Lilly PatientOne
Lilly PatientOne (lillypatientone.com) provides a resource for access and reimbursement assistance. Through Lilly PatientOne, you may be able to help your qualified patients get the assistance they need, allowing them to start treatment with one less worry. Your patients may qualify for the Lilly PatientOne program if they meet eligibility requirements, including:

- Patient is age 18 years or older
- Patient must have proof of residency in the United States or Puerto Rico
- Patient must be treated with ALIMTA® (pemetrexed for injection), CYRAMZA® (ramucirumab), ERBITUX® (cetuximab), LARTRUVO™ (olaratumab), or Portrazza™ (necitumumab) for an FDA-approved indication
- Patient must be commercially insured
- Patient is ongoing therapy

The date of service is within 120 days of the date of submission

If you have questions about patient eligibility requirements, PatientOne program specialists are available Monday through Friday, 9:00 am to 7:00 pm EST. Call 1.866.4PatOne (1.866.472.8663).

Lilly Cares Foundation
The Lilly Cares Foundation, Inc., a separate nonprofit organization, provides free Lilly medications to qualifying patients. For more information about Lilly Cares, please visit LillyCares.com or call 1-800-545-6962.

Insured Patients
Even if your patient is fully insured, a claim may still be denied. Lilly PatientOne offers benefits investigation and appeals assistance to qualified, insured patients. If a patient’s claim is eligible, download and complete a Lilly PatientOne Application Form at LillyPatientOne.com or call 1.866.4PatOne (1.866.472.8663) to request a copy of the application be sent to you. Fax the completed form to 1.877.366.0585. As you fill out the form be sure to check all services that your patient might need. The treating physician will receive a response from Lilly PatientOne once the patient’s application has been reviewed. PatientOne may:

- Conduct a benefits investigation to help verify coverage.
- Provide prior authorization requirements for the patient’s insurer.
- Provide templates, forms, and checklists for filing an appeal for denied claims for eligible Lilly Oncology products. (These

Patient and Reimbursement Assistance Websites
LillyPatientOne.com
LillyCares.com

Learn more at: lillypatientone.com/financial-assistance-for-cancer-patients.html.
forms can also be found online in the “forms” section of the Lilly PatientOne website.

• Upon request provide status updates for appeals that have been filed for eligible Lilly Oncology products.

**Lilly PatientOne Co-Pay Program**

With the Lilly PatientOne Co-pay Program for Alimta, Cyramza, Erbitux, Lartruvo, or Portrazza, eligible patients can lower co-pay or coinsurance costs to pay no more than $25 per dose. Eligibility criteria:

• Patient is age 18 years or older
• Patient must have proof of residency in the United States or Puerto Rico
• Patient must be treated with ALIMTA® (pemetrexed for injection), CYRAMZA® (ramucirumab), ERBITUX® (cetuximab), LARTRUVO™ (olaratumab), or Portrazza™ (necitumumab) for an FDA-approved indication
• Patient must be commercially insured
• Patient is ongoing therapy
• The date of service is within 120 days of the date of application submission
• Maximum patient benefit $25,000 per 12-month period

Non-eligible:

• Participants in Medicaid, Medicare, Medicare Part D, Medigap, CHAMPUS, DoD, VA, TRICARE, or any state patient or pharmaceutical assistance program
• Patients currently eligible for, or enrolled in, a Lilly patient assistance program or another co-pay assistance program.
• Patients, pharmacists, and prescribers cannot seek reimbursement from health insurance or any third party for any part of the benefit received by the patient through this offer.

**Patient Enrollment Steps:**

1. Download an application form: lillypatientone.com/assets/pdf/patient_assistance_program_application.pdf or call Lilly PatientOne at 1.866.4PatOne (1.866.472.8663) for a faxed copy.
2. Review program eligibility with your patient based upon the full criteria listed in the application.
3. Fax the completed application to 1.877.366.0585.
4. Your patient’s application will be reviewed to determine eligibility pursuant to business rules.
5. Approved patients will receive an enrollment letter and their co-pay card in the mail.
6. Your office will be informed of patient’s enrollment status through a faxed letter. (NOTE: remind patients to bring their co-pay card with them to their next appointment.)

**Questions?** Call 1.866.4PatOne (1.866.472.8663).

**REIMBURSEMENT ASSISTANCE**

**Lilly PatientOne Reimbursement Services**

PatientOne offers resources that may help your qualified patients obtain financial and reimbursement assistance, including:

**Insurance Expertise**

• Coding and billing information
• Payment methodologies and allowables
• Payer policy information.

**Reimbursement Assistance**

• Eligibility determination
• Benefits investigation
• Prior authorization
• Evaluation other funding options.

**Denied Claim Appeals**

• Appeals status if requested
• Denied claims appeals templates, forms, and checklists.

Lilly PatientOne program specialists are available Monday through Friday, 9:00 am to 7:00 pm EST. Call 1.866.4PatOne (1.866.472.8663). Learn more at: lillypatientone.com.
Oncology-related products: Emend® (aprepitant), Emend® (fosaprepitant dimeglumine) for Injection, Intron® A (interferon alfa-2b, recombinant) for Injection, Keytruda® (pembrolizumab) for injection, for intravenous use, Sylatron™ (peginterferon alfa-2b) for Injection, Temodar® (temozolomide) available as capsules or for injection, Zolinza® (vorinostat)

Vaccine: Gardasil [Human Papillomavirus Quadrivalent (Types 6, 11, 16, and 18) Vaccine, Recombinant], Gardasil®9 (Human Papillomavirus 9-valent Vaccine, Recombinant)

Merck Access Program
The Merck Access Program (merckaccessprogram.com) can help answer questions about access and support, including:

• Insurance coverage for patients
• Reimbursement
• Co-pay assistance for eligible patients
• Benefit investigations, prior authorizations, and appeals
• Referrals to the Merck Patient Assistance Program.

A dedicated representative of the Merck Access Program may be able to:

• Research your patient’s insurance benefits
• Obtain information on your patient’s out-of-pocket costs
• Provide information on co-pay assistance options
• Refer patients to the Merck Patient Assistance Program

Answer questions about filling out the enrollment form.

Contact the Merck Access Program at 855.257.3932, Monday through Friday, 8:00 am to 8:00 pm EST. Or download the enrollment form at: merckaccessprogram.com/static/pdf/ONCO-1143560-0002.pdf and fax it to: 855.755.0518.

The Merck Patient Assistance Program
This program (merckhelps.com) provides certain Merck medicines and vaccines free of charge to eligible individuals, primarily the uninsured, who without assistance could not afford these needed Merck medicines. The Merck Access Program was designed to help patients who have been prescribed any of the following Merck medicines:

• Emend (aprepitant) 80 mg, 125 mg capsules
• Emend (fosaprepitant dimeglumine) for Injection 150 mg
• Intron A (interferon alfa-2b, recombinant) for Injection, 10 million IU, 18 million IU, 50 million IU
• Keytruda (pembrolizumab) Injection [liquid formulation] 100 mg
• Sylatron (peginterferon alfa-2b) for injection, for subcutaneous use, 200 mcg, 300 mcg, 600 mcg
• Temodar (temozolomide) Capsules 5 mg, 20 mg, 100 mg, 140 mg, 180 mg, 250 mg
• Zolinza (vorinostat) 100 mg Capsules.

The Merck Patient Assistance Program offers temporary assistance to patients who generally meet the following requirements:

1. They are a U.S. resident and physician/prescriber has determined that a Merck product may be appropriate for treating the patient
2. They have no pharmaceutical insurance coverage
3. They meet specified financial criteria and cannot afford to pay for their medicine.

NOTE: Individuals who do not 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.

To enroll in the Merck Patient Assistance program, visit merckhelps.com. This site will refer you to the Merck Access site for the specific medication you are prescribing, and it is where patients can begin the enrollment process, using the prescription specific enrollment form. Questions about the Merck Patient Assistance Program? Call 1.800.727.5400, Monday through Friday, 8:00 am to 8:00 pm EST.

Co-Pay Assistance for Keytruda
The Merck Co-Pay Assistance Program offers assistance to eligible patients who need help affording Keytruda. Co-pay assistance may be available for patients who:
• Are at least 18 years of age
• Are a resident of the U.S. (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 financial eligibility criteria (to view the criteria visit: merckaccessprogram-keytruda.com/hcp/the-merck-copay-assistance-program/ and select the link for “Terms and Conditions”)
• Meet all other terms and conditions as outlined on the Keytruda co-pay assistance website.

Once enrolled, eligible, privately insured patients pay the first $25 of their co-pay per infusion. The maximum benefit under this program is $25,000 per patient per calendar year (based on income).

Download the Merck enrollment form at: merckaccessprogram-keytruda.com/static/pdf/merck-access-program-keytruda-enrollment-form.pdf and fax it to: 855.755.0518 or enroll online at: merckaccessprogram-keytruda.com/hcp/merck-access-program-keytruda-enrollment-form/.

NOTE: Co-pay assistance from the Merck Co-pay Assistance Program is not insurance. Visit the Merck Co-pay Assistance Program website (link above) for restrictions, terms, and conditions. If your patient is deemed ineligible for the Merck Co-pay Assistance Program for Keytruda, a representative can provide you with information about independent foundations that may be able to provide your patient with financial support. Each independent foundation has its own eligibility criteria and application process.

Vaccine Patient Assistance Program
Patients who want to receive the Gardasil vaccine may be eligible for the program if all three of the following conditions apply:
• Patients reside in the U.S. and are 19 to 26 years of age.
  (NOTE: Patients do not have to be U.S. citizens. Legal residents of the U.S. and U.S. territories are also eligible to apply.)
• Patients have no health insurance coverage. (Some examples of health insurance coverage include private insurance, HMOs, PPOs, college health plans, Medicaid, veterans’ assistance, or any other social service agency support.)
• Patients have an annual household income less than:
  - $47,520 or less for individuals
  - $64,080 or less for couples
  - $97,200 or less for a family of 4.

For income limits in Alaska and Hawaii, please call 1.800.727.5400.

NOTE: Individuals who do not meet the insurance coverage criteria may still qualify for the vaccine program if the patient has special circumstances of financial and medical hardship, and their income meets the program criteria.
Enrollment is Easy
1. Complete and sign the application form. It is available online at: merckhelps.com/docs/VPAP_Enrollment_Form_English.pdf (English) and merckhelps.com/docs/VPAP_Enrollment_Form_Spanish.pdf (Spanish). Providers and their office personnel can also call 1.800.293.3881, Monday through Friday, 8:00 am-8:00 pm EST, to obtain enrollment applications for patients and to request additional information about the program.

2. Fax the completed form to: 1.800.528.2551 from a participating licensed provider’s office. The application must be submitted and approved prior to administration of vaccine in order to qualify. Forms will be processed quickly—with a goal of less than 10 minutes (between business hours of 8:00 am-8:00 pm, EST, Monday through Friday)—and the provider’s office will be notified by phone so that qualifying patients can receive the Merck vaccine during that visit.

3. A new application will need to be completed and submitted to the Merck Vaccine Patient Assistance Program for eligibility assessment prior to a patient receiving a subsequent dose in a multidose series or for another Merck vaccine.

**2016-2017 Federal Poverty Guidelines**

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Novartis Pharmaceuticals Corporation

Oncology-related products: Afinitor® (everolimus) tablets, Arzerra® (ofatumumab) injection, Exjade® (deferasirox) tablets for oral suspension, Farydak® (panobinostat) capsules, Femara® (letrozole) tablets, Gleevec® (imatinib mesylate) tablets, Jadenu™ (deferasirox) tablets, Mekinist® (trametinib) tablets, Odomzo® (sonidegib), Promacta® (eltrombopag) tablets, Rydapt® (midostaurin) capsules, Sandostatin® (octreotide acetate) for injection, Sandostatin LAR® Depot (octreotide acetate for injectable suspension), Tafinlar (dabrafenib) capsules, Tasigna® (nilotinib) tablets, Tykerb® (lapatinib) tablets, Votrient® (pazopanib) tablets, and Zykadia™ (ceritinib) capsules

Patient and Reimbursement Assistance Websites
hcp.novartis.com/access
patientassistancenow.com

PATIENT ASSISTANCE

The Novartis Patient Assistance Foundation
This foundation (patientassistancenow.com/info/programsto/patientassistanceinformation.jsp) provides assistance to patients experiencing financial hardship who have no third-party insurance coverage for their medicines. To be eligible for the Novartis Patient Assistance Fund, patients must:
• Be a U.S. resident.
• Meet income criteria, which vary by medication, and provide proof of income. Financial eligibility program requirements are 250% to 500% of the Federal Poverty Level, depending on the Novartis medicine.
• Not have private or public prescription coverage. (NOTE: Exception process exists.)

Patients must reapply and re-qualify every 12 months. Questions? Contact the Novartis Patient Assistance Foundation at: 1.800.277.2254, or go online to: patientassistancenow.com.

There are three ways to enroll in the program:
• Enroll online by visiting: pharma.us.novartis.com/info/patient-assistance/patient-assistance-enrollment.jsp, and selecting the appropriate Novartis medication from the drop down menu, and following the instructions
• Call 1.800.277.2254 to enroll by phone. (Note: If you have prescribed Exjade [deferasirox] tablets to your patient, call the EPASS Prescription and Reimbursement Hotline at 1.888.903.7277.)

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

It’s simple to use and easy to find out if patients are eligible for the program. Eligible patients may pay no more than $25, subject to a maximum benefit of $15,000 per calendar year. Find out if this program is right for your patient by calling 1.877.577.7756 or by going to: copay.novartisoncology.com and clicking on the name of the medication. This offer is not valid under Medicare, Medicaid, or any other federal or state program. Novartis reserves the right to rescind, revoke, or amend this program without notice. Limitations apply. Read program terms and conditions at: copay.novartisoncology.com.

**Patient Assistance NOW Oncology (PANO)**

PANO (oncologyaccessnow.com) offers quick and easy access to information about the wide range of resources available to your patients. Enroll your patients into Novartis Oncology support programs by completing this form: hcp.novartis.com/globalassets/approved_onc-1112163-novartis-universal-enrollment-form-gsk-update-digital1.pdf.

Follow the steps below to complete the Novartis Service Request Form:

1. **Patient Information (Section 1).** Complete with all relevant information. Be sure to have the patient sign the Patient Authorization and the Patient Assistance Program (PAP) Consent for Patient (if applicable). For Zykadia and Farydak specialty pharmacy submission only, patient signature is not mandatory.
2. **Insurance Information (Section 2).** Please include a copy of the front and back of the patient’s insurance card(s).
3. **Patient Financial Information (Section 3).** This section only needs to be completed if you believe the patient could be eligible for the Patient Assistance Program (PAP). For patient assistance consideration, please attach proof of income, i.e., wage stubs, employer statement of income, tax returns, etc.
4. **Physician Information (Section 4).** Complete with all relevant information and best contact person. Be sure to sign the Physician Authorization and Patient Assistance Program (PAP) Consent for Physician (if applicable).
5. **Pharmacy Preference (Section 5).** Choose your patient’s preferred pharmacy (if applicable).
6. **Prescription Information (Section 6).** Please complete the selected prescription information for your patient. Ensure that all necessary prescriber signatures are included.

Fax completed forms to: 1.888.891.4924. (NOTE: follow instructions on enrollment form for enrolling patients on Zykadia and Farydak through a specialty pharmacy.) Questions? Call 1.800.282.7630, Monday through Friday, 9:00 am to 8:00 pm EST.

**REIMBURSEMENT ASSISTANCE**

**Patient Assistance NOW Oncology (PANO)**

PANO (oncologyaccessnow.com) helps patients and healthcare providers with questions about insurance verification and other reimbursement issues including,

* Benefits investigations
* Prior authorizations
* Assistance with denials and appeals.

Providers can download and complete the Novartis Service Request Form at: hcp.novartis.com/globalassets/approved_onc-1112163-novartis-universal-enrollment-form-gsk-update-digital1.pdf and, following the directions above, fax it to: 1.888.891.4924 (NOTE: follow instructions on enrollment form for enrolling patients on Zykadia and Farydak through a specialty pharmacy.) Questions? Call 1.800.282.7630.

**Oncology Reimbursement Hotline**

By calling 1.800.282.7630, providers and patients can receive assistance in resolving reimbursement issues and concerns, including:

* **Insurance verification.** Program staff verify patients’ medical benefits, helps determine insurance coverage, and clarify co-payment obligations.
Novartis

- **Denials and appeals.** Program staff can assist you and your patient with the appeals process.
- **Referrals to co-pay cards.**
- **Alternative funding searches.** Program staff can search for possible assistance for patients with insufficient medical benefit coverage or no drug coverage and refer to other sources of funding that could help alleviate or reduce costs.
- **Referrals to patient assistance** for low-income uninsured patients.
- **Help finding pharmacies that stock Novartis medication.** Program staff can also overnight an emergency supply, and find other ways to get your patient their Novartis medicine.

The Reimbursement Hotline and Novartis Pharmaceuticals Corporation do not guarantee success in obtaining reimbursement, nor do they submit appeals on behalf of providers or patients. Third-party payment for medical products and services is affected by numerous factors, not all of which can be anticipated or resolved by Reimbursement Hotline staff.

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**Active Listening 101**

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

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

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

**Retention**—take notes if necessary.

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

**Active Listening Tactics**

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

**Barriers to Active Listening**

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

Source. ACCC Financial Advocacy Network. accc-cancer.org/FAN
Oncology-related products: Aromasin® (exemestane tablets), Bavencio® (avelumab) Injection (co-marketed with EMD Serono, Inc.), Bosulif® (bosutinib) tablets, Camptosar® (irinotecan HCI injection), Ellence® (epirubicin hydrochloride injection), Emcyt® (estramustine phosphate sodium capsules), Ibrance® (palbociclib), Idamycin® (idarubicin hydrochloride for injection, USP), Inlyta® (axitinib) tablets, Sutent® (sunitinib malate), Torisel® (temsirolimus) injection, Xalkori® (crizotinib) capsules, Zinecard® (dexrazoxane for injection)

**Patient and Reimbursement Assistance Website**
pfizerrxpathways.com

**PATIENT ASSISTANCE**

**Pfizer Oncology Together**

At Pfizer Oncology Together, we’re committed to working alongside healthcare professionals so that no patient goes without the Pfizer Oncology medication you’ve prescribed—regardless of their insurance coverage.

We offer access and reimbursement services to overcome barriers and we have a range of offerings to provide patients with financial support.

We’ll work with your patients to help find the right financial support, regardless of insurance coverage. There’s assistance for:

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

We also offer personalized in-office support to help office staff navigate access and reimbursement issues. Resources supporting this initiative are in development. Please reach out to your Pfizer Representative for additional details.

- For live personalized support, call 1.877.744.5675 Monday to Friday, 8:00 AM to 8:00 PM ET
- To get started, fax completed enrollment form to 1.877.736.6506
- To learn more, visit PfizerOncologyTogether.com

**Pfizer RxPathways**

For more than 25 years, Pfizer has offered a number of assistance programs to help eligible patients access their prescription medicines. Now, to answer patients’ changing needs and make our services more accessible, we’ve combined our existing programs into one program called Pfizer RxPathways. Formerly Pfizer Helpful Answers, Pfizer RxPathways is a comprehensive assistance program that provides eligible patients with a range of support services, including insurance counseling, co-pay assistance, and access to medicines for free or at a savings.

**Pfizer Savings Card**

This card will provide patients with a 50 percent savings off the cost of their Pfizer Oncology medicine. You may call Pfizer patient support at 1.877.744.5675 for assistance on how to obtain this savings card. Certain eligibility criteria are required.

**Services for Uninsured Patients**

Uninsured patients may be able to get certain specialty medicines...
for free if they cannot secure insurance coverage. To apply for free medicine, patients and their prescribers must download and complete the Group B application at: http://www.pfizer-rxpathways.com/sites/default/files/attachment/0401%20RxPathwaysGroupB_081816.pdf. The application, along with any other required documents should be faxed to: 800.708.3430 or mailed to: Pfizer RxPathways, P.O. Box 66976, St. Louis, MO 63166-6976.

If patients require immediate assistance with their specialty medicines, they or their prescribers should call 1.877.744.5675, Monday through Friday, 8:00 am to 8:00 pm EST.

To be eligible for free specialty medicines, uninsured patients must:
• Be prescribed a Pfizer specialty, or “Group B,” medicine. To view these medicines, click “View Group B Medicine List” on the Pfizer RxPathways website (http://pfizerrxpathways.com/en/see-how-we-help).
• Have no prescription coverage to pay for their Pfizer medicines.
• Meet certain income limits that vary by medicine and household size.
• Live in the United States, Puerto Rico, or the U.S. Virgin Islands.
• Be treated as an outpatient.

After applying or contacting Pfizer RxPathways, a Pfizer RxPathways counselor will first work with uninsured patients to find and apply for insurance options that may help them access their Pfizer specialty medicines (e.g., state pharmaceutical assistance programs, Medicaid, Medicare Part D, and low-income subsidies). During this time, eligible patients will be given up to a 90-day supply of free medicine. If eligible patients cannot secure insurance coverage, they will continue to get free medicine through Pfizer RxPathways for up to 12 months.

Within two business days, patients will be notified of their enrollment status over the phone. If accepted, patients will then receive a letter containing their enrollment term and next steps on how to receive their free specialty medicine(s). For more information on the eligibility requirements, application, and enrollment process, see the Group B application: http://www.pfizer-rxpathways.com/sites/default/files/attachment/0401%20RxPathwaysGroupB_081816.pdf.

Services for Underinsured Patients
If patients have prescription coverage, but still cannot afford their Pfizer specialty medicines, they may be able to get them for free. To be eligible for free specialty medicines, patients without enough health insurance coverage must:
• Be prescribed a Pfizer specialty, or “Group B,” medicine. To view these medicines, click “View Group B Medicine List” on the Pfizer RxPathways website (http://pfizerrxpathways.com/en/see-how-we-help).
• Have prescription coverage, but not enough to pay for their Pfizer medicines.
• Meet certain income limits that vary by medicine and household size.
• Live in the United States, Puerto Rico, or the U.S. Virgin Islands.
• Be treated as an outpatient.

To apply for free medicine, patients and their prescribers must download and complete the Group B application (http://www.pfizer-rxpathways.com/sites/default/files/attachment/0401%20RxPathwaysGroupB_081816.pdf) and mail or fax it (see address and fax number above) to Pfizer RxPathways along with any other required documents. If patients require immediate assistance with their specialty medicines, they or their prescribers should call 1.877.744.5675, Monday through Friday, from 8:00 am to 8:00 pm EST to start the process.

After applying to or contacting Pfizer RxPathways, a Pfizer RxPathways counselor will first work with underinsured patients to find and apply for other ways to help patients with their co-pay. Other sources of help could come from co-pay foundations, Medicare Part D, low-income subsidies, and even co-pay card programs. If other funding cannot be secured, patients may be eligible to receive their Pfizer specialty medicines for free through Pfizer RxPathways.

Within two business days, patients will be notified of their enrollment status. If accepted, they will receive a letter that contains their enrollment term and next steps on how to receive their free specialty medicine(s). Medicines will typically be shipped to a patient’s home, or to a prescriber’s office.
In some cases, patients who apply for free medicine and have private insurance coverage may instead receive co-pay assistance through Pfizer RxPathways. Instead of having free medicine shipped to them, these patients will receive a Pfizer RxPathways co-pay card to use at their local pharmacy to cover the entire cost of their co-pay. (NOTE: Pfizer RxPathways Co-Pay Assistance is not health insurance. For a complete list of participating pharmacies call 1.877.744.5675.) For more information on the eligibility requirements, application, and enrollment process, see the Group B application (http://www.pfizer-rxpathways.com/sites/default/files/attachment/0401%20RxPathwaysGroupB_081816.pdf). Patients who participate in any federal or state programs, such as Medicaid or Medicare, are not eligible for co-pay assistance. However, these patients may be eligible to receive their medicine for free through Pfizer RxPathways. Terms and conditions apply.

**Pfizer Co-Pay One Card**

Commercially insured (commercial, private, employer and healthcare exchange patients) patients qualify for co-pay One’s offer – maximum of $10 out of pocket.

- The Pfizer Co-Pay One card enables patients with commercial, private, employer and Healthcare exchange insurance to fill their prescription with a maximum out of pocket cost of $10.
- Patients must live in the US or Puerto Rico and be 18 years of age or older to qualify.
- Patients may receive up to $25,000 in savings annually. Limits, terms and conditions apply. This offer is only available at participating pharmacies. This offer is not health insurance. No membership fees. To register and see the full terms and conditions, go to: www.PfizerCoPayOne.com/pharmacist.

**My Pfizer Brands**

My Pfizer Brands is a program that helps patients receive prescription savings on the Pfizer medications they have been prescribed. Many people, even those with prescription coverage, may save with this program. Terms and conditions apply. If the product is available as a generic, patients may pay less with other offers or by receiving the generic. See full terms and conditions on each respective Pfizer brand medication website. The card will be accepted only at participating pharmacies. The card is not health insurance. No membership fees. Maximum annual savings of $400 to $10,000. For more information, call 1.866.341.9100 or write to Pfizer, PO Box 29387, Mission, KS 66201-9618.

Regardless of income or employment status, patients may qualify for the My Pfizer Brands program if:

- They pay for prescriptions with insurance at the pharmacy (this means they are self-insured or have prescription coverage through their employer or their spouse’s employer)
- They pay out-of-pocket (cash) for their prescriptions at the pharmacy
- They do not purchase prescriptions through Medicare, Medicaid, or a federal or state program
- They are not a resident of a state where this program is prohibited by law. (Please check your brand’s website for specific terms and conditions.)

To verify eligibility, select brand-name product from those listed in the keyboard located on the My Pfizer Brands home page (mypfizerbrands.com) then click through to the available savings offer. If patients are not eligible, there may be other ways they can save on their prescriptions through Pfizer RxPathways, Pfizer’s patient assistance program. Learn more at: PfizerRxPathways.com.

**Insurance Counseling**

If insured or underinsured patients need help understanding their coverage and reimbursement options for certain Pfizer specialty medicines, Pfizer RxPathways can help by offering:

- **Reimbursement support.** A Pfizer RxPathways counselor will research and verify benefits, outline coverage options and policies, and explain the prior authorization process to patients and their prescribers.
- **Appeals process information.** If a claim is underpaid or denied, Pfizer RxPathways will investigate it and provide patients with information on the appeals process.
Specialty pharmacy referral. For patients prescribed Bosulif, Ibrance, Inlyta, Sutent, or Xalkori (crizotinib), Pfizer RxPathways will refer them to a retail or specialty pharmacy that will verify their benefits and help to fill their prescriptions.

To receive insurance counseling for certain specialty medicines, patients can call 1.877.744.5675, Monday through Friday, 8:00 am to 8:00 pm EST. Patients can also download and submit the Group B application to begin the process. For more information on the eligibility requirements, application, and enrollment process, see the Group B application: http://www.pfizer-rxpathways.com/sites/default/files/attachment/0401%20RxPathwaysGroupB_081816.pdf.

PfizerPro (pfizerpro.com) offers physicians the support they need to help improve their practice and the lives of their patients, including:
- Clinical trial listings. Search the database of ClinicalTrials.gov for available clinical trials by keyword, trial phase, location, and more.
- Digital product presentations. These self-guided, online learning sessions are available for certain Pfizer products and are designed to leave providers with a clearer understanding of the Pfizer product discussed. The presentations feature case studies, mechanism of action videos, efficacy and safety information, and more, all of which can be viewed at your own pace from either your desktop or tablet device.
- Grants and fellowships. Pfizer seeks to cooperate with healthcare delivery organizations and professional associations to narrow professional practice gaps in areas of mutual interests through support of learning and change strategies that result in measurable improvement in competence, performance, or patient outcomes.
- Hispanic/Latino learning series are PowerPoint presentations designed to educate healthcare professionals and other key stakeholders on cultural competency for Hispanic/Latino populations.
- Pfizer medical information. Have a medical question? Submit a medical question, chat live about Pfizer prescription medicines, and more.
- Pfizer patient-reported outcomes is a resource for up-to-date versions and translations of many available measures used to assess patient-reported outcomes. It offers current information on validated measures developed by Pfizer in various therapeutic areas, including CV/metabolic, neuroscience, oncology, pain, sexual health, urology, and women’s health.
- Pfizer Responsible Disposal Advisor assists institutional facilities in properly disposing of unused medicine. The site is now available to healthcare facilities and providers. Answers to your product disposal questions are only a click away.
- Pfizer samples. Eligible healthcare professionals can sign in or register for PfizerPro, choose from eligible samples or savings cards, and submit their requests. PfizerPro members can also call 1.888.736.8220 for more information and to request samples. (NOTE: Not all Pfizer products are available for sampling through this program.)
- Vaccine ordering. Pfizer is committed to the prevention of life-threatening diseases. For over a century, Pfizer and its legacy companies have played a critical role in technological developments against diseases such as pneumococcal pneumonia. This is where you can order vaccines for your practice.
**PATIENT ASSISTANCE**

**YOU&i Access™ Instant Savings Program**

Patients with commercial insurance and who meet eligibility requirements will pay no more than $10 per month for Imbruvica. (NOTE: Month refers to a 30-day supply. Subject to a maximum benefit, 12 months after activation or 12 monthly fills [one-year supply]. This program is not valid for patients enrolled in Medicare, Medicaid, or other state or federal healthcare programs. For these patients, foundation support may be available.) The program can also provide information on independent foundations that may be able to provide patients with additional financial support. (NOTE: The Johnson & Johnson Patient Assistance Foundation, Inc. may be able to help uninsured individuals who are unable to pay for their Imbruvica medication. Contact a JJPAF program specialist at 1.800.652.6227 from 9:00 am to 6:00 pm EST, or visit the foundation website at jjpaf.org to see if your patient might qualify for assistance.)

**YOU&i™ Start Program**

For patients experiencing coverage decision delays the YOU&i™ Start Program may be able to provide access to Imbruvica. Eligible new patients who have been prescribed Imbruvica for an FDA-approved indication, and who are experiencing an insurance coverage delay greater than five business days, can receive a free, 30-day supply of the drug. If the decision delay persists, an additional free, 30-day supply may be provided. The free product is offered to eligible patients without any purchase contingency or other obligation.

**REIMBURSEMENT ASSISTANCE**

**Imbruvica YOU&i™ Support Program**

This personalized support program from Pharmacyclics, Inc., and Janssen Biotech, Inc., includes information on access and affordability, nurse call support, and resources for patients being treated with Imbruvica. Healthcare providers can help enroll patients in this program before they start taking Imbruvica. For more information, call 1.877.877.3536, Monday through Friday, 8:00 am to 8:00 pm EST. Enroll online at: imbruvica.com/reg or download the enrollment form at: imbruvica.com/docs/librariesprovider3/default-document-library/enrollment_form.pdf?sfvrsn=6. The Imbruvica YOU&i Support Program provides:
- Rapid (2 business days) benefits investigation
- Information about the prior authorization process
- Information about the insurance appeals process
- Help connecting to a specialty pharmacy (List of specialty pharmacies can be found here: imbruvica.com/docs/librariesprovider3/default-document-library/specialty_pharmacies.pdf?sfvrsn=8).

**Nurse Call & Support Resources**

In addition to the services outlined above, the Imbruvica. Patients can have ongoing tips, tools, and other resources sent via email or to their home address. New Imbruvica patients will also receive a Patient Starter Kit.
Sandoz, Inc.

Oncology-related product: Zarxio™ (filgrastim-sndz)

Patient and Reimbursement Assistance Website
sandozonesource.com

PATIENT ASSISTANCE

Sandoz One Source™
Sandoz One Source is a comprehensive program designed to help simplify and support patient access for those prescribed Zarxio. Sandoz One Source offers a variety of customized services for patients, including:

• Comprehensive insurance verifications
• Prior authorization support, when required by the insurance company
• Billing and coding information
• Claims tracking information
• Denials/Appeals information
• General payer policy research.

Sandoz One Source is available to assist patients with:

• Information on external resources and support
• Sandoz One Source Commercial Co-Pay Program eligibility.

Download an enrollment form for patient assistance at: sandozonesource.com. For patient assistance program, complete Sections 1-6, and Section 8. For reimbursement assistance, enrollment in the Sandoz One Source Co-pay Program, and/or information on external resources, complete sections 1-7:

Section 1: Patient information

Section 2: Insurance information. Include policy information for both your patient’s primary and secondary insurance (as applicable). It helps to include a copy of the front and back of the patient’s insurance card(s). If your patient has no insurance, check the “No Insurance” box.

Section 3: Treatment & prescribing information. Primary and secondary ICD/Dx are required. Remember to enter drug name in the first row of this section.

Section 4: Prescriber information. Include office/primary contact person.

Section 5: Patient authorization & signature.

Section 6: Prescriber authorization.

Section 7: Commercial co-pay program. Skip this section if applying for the patient assistance program.

Section 8: Patient consent/signature & financial information. Complete only if you believe the patient could be eligible for patient assistance. For patient assistance consideration, patients may sign consent for real-time income projector or may opt to include proof of income documentation. The enrollment form is also available online via the Sandoz One Source Provider Portal. To access the Provider Portal visit: sandozonesource.com. Questions? Call 844.SANDOZ1 (844.726.3691), 9:00 am to 8:00 pm EST, Monday through Friday.

Sandoz One Source Co-Pay Program
The Sandoz One Source Co-pay Program is available for all eligible, commercially insured patients who have been prescribed Zarxio. There is no income eligibility requirement for this program. Under this program, patients pay $0 for their
first dose or cycle, and are responsible for a $10 out-of-pocket cost for subsequent doses or cycles, subject to a maximum benefit of $10,000 annually.

The Sandoz One Source Co-pay Program is not insurance. It is available only to patients with commercial insurance. Cash-paying patients, uninsured patients, and patients with federal or state-funded insurance are not eligible for this program. The program not available in states where it is prohibited by law. Patients must be prescribed Zarxio for an FDA-approved indication. Patients can participate in the program for up to 12 months or until age 65, whichever comes first. Other terms and conditions apply.

To enroll in the Sandoz One Source Co-pay Program patients must complete the Sandoz One Source enrollment form described above. Patients should complete Sections 1-7 of the form. To enroll, or to learn more about the program restrictions and eligibility requirements visit: www.sandozonesource.com, or call: 844.SANDOZ1 (844.726.3691), 9:00 am to 8:00 pm EST, Monday through Friday.

**REIMBURSEMENT ASSISTANCE**

Sandoz One Source offers a variety of reimbursement assistance services for patients and providers. For reimbursement assistance, complete the Sandoz One Source enrollment form, Sections 1-7, found at: www.sandozonesource.com. Reimbursement services include:

- Comprehensive insurance verifications
- Prior authorization support, when required by the insurance company
- Billing and coding information
- Claims tracking information
- Denials/Appeals information
- General payer policy research.

You can download the enrollment form, or enroll your patients online via the Sandoz One Source Provider Portal. Questions? Call 844.SANDOZ1 (844.726.3691), 9:00 am to 8:00 pm EST, Monday through Friday.
PATIENT ASSISTANCE

SeaGen Secure™ Patient Assistance Program

SeaGen Secure offers an Adcetris Co-insurance Assistance Program for uninsured and underinsured patients who have been prescribed Adcetris. Once an enrollment form (https://seagensecure.com/assets/docs/USP-BVP-2015-0153(2)_SeaGen_Secure_PAP_Form_v07_clickable.pdf) has been completed, fax it to: 855.557.2480. It is important that each field is filled out completely and accurately to ensure timely processing of the application. If you have any questions, please call 855.4SEAGEN (855.473.2436), option 1, to speak with a reimbursement counselor.

Benefits Investigation

Once the enrollment form is received, a benefits investigation is conducted to determine an individual patient’s coverage for treatment. It is SeaGen Secure’s priority to make sure providers have patient-specific coverage information before starting patients on therapy with Adcetris, so they will fax a summary of the patient’s Adcetris-related benefits within two business days of receiving the completed request. If patient coverage for Adcetris is confirmed:

- Refer to sample claims form (https://seagensecure.com/assets/docs/Sample_CMS_1500_ADCETRIS.pdf) for billing guidance.
- If patients need help paying co-insurance, they will be assessed for eligibility for the SeaGen Secure Co-Insurance Assistance Program or referred to an independent foundation.

NOTE: To be eligible for the Co-Insurance Assistance Program, patients must have coverage for Adcetris through a commercial insurer, be at least 18 years old, and be seeking treatment for a labeled indication.

If patient does not have coverage for Adcetris:

- If the patient is insured, SeaGen Secure will assist with an appeal. If the appeal is unsuccessful, the patient will be assessed for eligibility for patient assistance.
- If the patient is uninsured, the patient will be assessed for eligibility for the SeaGen Secure Patient Assistance program.

REIMBURSEMENT ASSISTANCE

SeaGen Secure reimbursement services include:

- **Billing and coding support.** Trained reimbursement counselors provide payer-specific billing and coding requirements to assist with the billing process.
- **Prior authorization assistance.** If it is determined that Adcetris treatment requires prior authorization, SeaGen Secure can determine which forms and
processes are needed to secure the authorization. Additionally, SeaGen Secure can track the prior authorization claim once it is submitted.

- **Appeal assistance and claims tracking.** If an Adcetris prior authorization or claim is denied (or partially paid), SeaGen Secure will work to determine the reason for the denial and the steps for an appeal. SeaGen Secure will also provide a sample Letter of Medical Necessity (https://seagensecure.com/assets/docs/ADCETRIS_Sample_LMN_Appeal.pdf). Medical Information may be able to assist with any additional data requests. After SeaGen Secure assists with an appeal and the documentation is submitted to the payer, they offer claims tracking to ensure the payer receives the appeal and addresses it. Claims tracking ensures that the provider is aware of claims payment and/or any payer delays in processing.

- **General payer and policy research.** Many payers have established Adcetris policies. Contact SeaGen Secure at 855.473.2436, option 1, from 9:00 am–8:00 pm EST, Monday through Friday, to inquire about a specific payer’s policy or obtain a copy of a current policy.

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### Tips for Filing Claims

**For Electronic Claims DO...**

- Verify, file, and keep all transmission reports.
- Track clearinghouse claims to ensure successful transmission.
- Ensure your computer software is consistent with the clean claims rules.
- Verify that your software correctly prints the CMS-1500 claim form.
- Call your software vendor, if needed, to address the above two items.

**For Paper Claims DO...**

- Use only original claim forms (printed in red drop-out ink).
- Avoid folding claims, if possible.
- Resist using terms such as “refiled claim,” “second request,” or “corrected claim.”
- Avoid handwritten claims.
- Use all UPPERCASE letters.
- Stay inside the lines of each block.
- Ensure claims are printed darkly.

**For Paper Claims DON’T...**

- Use any punctuation or decimals.
- Send unnecessary attachments.
- Use staples or paperclips.
- Attach “post-it” notes.
- Mark up the claim with highlighters.
- Use circles or additional markings.
- Attach labels or stickers.
- Add notes or instructional assistance.

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Source: ACCC Financial Advocacy Network. accc-cancer.org/FAN
Oncology-related product: Lonsurf® (trifluridine and tipiracil)

Taiho Oncology Patient Support
Taiho Oncology Patient Support offers the following services:

- **Co-pay support** for eligible, privately insured patients. Such patients can receive a Taiho Oncology Patient Support Co-pay Card for help with out-of-pocket expenses for Lonsurf.
- **Patient Assistance Program.** Taiho Patient Support will research financial assistance options for patients with no insurance coverage, insufficient prescription coverage, or insufficient resources to pay for treatment with Lonsurf. Eligible patients may receive Lonsurf at no cost based on assistance, financial, and medical criteria.
- **Alternate funding support.** Taiho Patient Support will also refer eligible, publicly insured patients to nonprofit foundations that may be able to offer them co-pay assistance.

To enroll in Taiho Oncology Patient Support simply download the enrollment form in English at: taihopatientsupport.com/Home/ViewPef or Spanish at: taihopatient support.com/Home/ViewPefSp and fax the completed form to 1.844.287.2559. Questions? Call 844-TAIHO-4U (844.824.4648) Monday through Friday, 8:00 am to 8:00 pm EST. Or visit: taihopatientsupport.com.

REIMBURSEMENT ASSISTANCE
Taiho Oncology Patient Support
Taiho Oncology Patient Support will quickly investigate each patient’s coverage for Lonsurf and help them get access to the Lonsurf treatment they have been prescribed. Taiho Oncology Patient Support offers the following services to help improve access to Lonsurf, and to make the treatment process as simple and smooth as possible:

- **Access and reimbursement support,** including benefit investigations, assistance with prior authorizations to meet payer requirements, and claims appeals assistance if coverage is denied.
- **Specialty pharmacy prescription coordination,** including prescription triage, coordination with the in-network specialty pharmacy, self-dispensing practice, or hospital retail pharmacy, and claims appeals assistance if coverage is denied.
- **Personalized nurse support** is available for treatment plan adherence upon request. Taiho Oncology Patient Support treatment plan adherence services are available as needed to support patient care, including refill reminders.

To enroll in Taiho Oncology Patient Support simply download the enrollment form in English at: taihopatientsupport.com/Home/ViewPef or Spanish at: taihopatient support.com/Home/ViewPefSp and fax the completed form to 1.844.287.2559. Questions? Call 844-TAIHO-4U (844.824.4648) Monday through Friday, 8:00 am to 8:00 pm ET. Or visit: taihopatientsupport.com.
**PATIENT ASSISTANCE**

**Ninlaro 1Point**
This comprehensive support program offers an array of access and coverage services for patients and their healthcare providers. A dedicated case management team helps patients and providers navigate coverage requirements for Ninlaro, streamline product access, and connect to helpful resources. Services include the:
- Ninlaro Patient Assistance Program
- Ninlaro Co-Pay Assistance Program
- Ninlaro RapidStart Program.

**Ninlaro Patient Assistance Program**
The Ninlaro Patient Assistance Program provides free medication to eligible patients who do not have prescription drug or health insurance coverage. If patients qualify for the program, Ninlaro will be delivered to them free of charge. To apply for the Patient Assistance Program, providers must submit a completed and signed Patient Assistance Program Application and a valid prescription for Ninlaro. Patients must sign the form and submit the required household verification. If patients are approved for this program, they and their doctor will be notified and a 1-month supply of Ninlaro will be mailed to them. Each month, the provider must confirm that the patient is still being treated with Ninlaro and requires another month’s supply. Qualified patients may be enrolled for up to 1 year. Get started or to learn more by calling 1.844.N1POINT (1.844.617.6468) and selecting option 2, Monday through Friday, 8:00 am-8:00 pm EST. Or download the enrollment form at: https://www.ninlarohcp.com/pdf/NINLARO1Point-PAP-Application.pdf and fax the completed form to: 1.844.269.3038.

**Ninlaro Co-Pay Assistance Program**
Eligible, commercially insured patients could pay as little as $25 per monthly prescription of Ninlaro, subject to a maximum benefit of $25,000 annually. Patients must meet eligibility requirements, however, there is no income limit for this program. This offer is valid for up to 13 prescription fills of Ninlaro per enrollment year. This savings program covers out-of-pocket expenses greater than $25 per monthly prescription. Maximum value $25,000 annually. Co-pay cards can be renewed every 12 months. This offer is not valid with any other program, discount, or incentive involving Ninlaro. This offer may be rescinded, revoked, or amended without notice. No reproductions. This offer is void where prohibited by law, taxed, or restricted. Get started or to learn more by calling 1.844.N1POINT (1.844.617.6468) and selecting option 2, Monday through Friday, 8:00 am to 8:00 pm EST. Patients can also enroll by contacting their designated specialty pharmacy. After patients are enrolled, they will receive a letter in the mail from Ninlaro 1Point, containing their co-pay card.

**Ninlaro RapidStart Program**
The RapidStart Program can provide a 1-cycle (the number of pills prescribed in a 28-day period)
supply of Ninlaro for patients who experience a delay in insurance coverage determination of at least 7 business days. Terms and conditions apply. Physicians must submit a completed enrollment form and a valid prescription for Ninlaro to Ninlaro 1Point on behalf of their patient. Patients must have been prescribed Ninlaro for an FDA-approved indication and be new to Ninlaro therapy. Patients who have Medicare Part D or commercial insurance coverage may be eligible for this program. Get started or to learn more by calling 1.844.N1POINT (1.844.617.6468) and selecting option 2, Monday through Friday, 8:00 am to 8:00 pm EST. Or download the enrollment form at: https://www.ninlarohcp.com/1point-program and fax the completed form to: 1.844.269.3038.

The Velcade Patient Assistance Program

If patients do not have any insurance coverage, they may be eligible to participate in the Velcade Patient Assistance Program. If patients qualify for the program, Velcade will be delivered free of charge to their treating physician. Patient eligibility is based on three factors:
1. Household income
2. Treatment setting
3. Velcade prescribed for a use that is medically appropriate.

Patients who do not have insurance coverage for Velcade must apply for assistance through their healthcare professionals. To demonstrate eligibility, they must complete an enrollment form and provide income documentation, as well as health insurance information. It is strongly recommended that you enroll patients into the Patient Assistance Program prior to the start of their treatment with Velcade. All enrollment forms must be received within six months of the first treatment. The enrollment form is available online at: velcade.com/files/pdfs/VELCADE_VRAP_Enrollment_Form.pdf. You can also obtain an enrollment form by calling 1.866.VELCADE (1.866.835.2233) Monday through Friday, 8:00 am-8:00 pm EST. Fax completed forms to: 800.891.9843. Learn more online at: velcade.com/Files/PDFs/VRAP_and_Patient_Assistance.pdf or by calling 1.866.VELCADE (1.866.835.2233) and choosing option 2.

REIMBURSEMENT ASSISTANCE

Ninlaro 1Point

This comprehensive support program offers an array of access and coverage services for patients and their healthcare providers. A dedicated case management team delivers personalized services that help patients and providers navigate coverage requirements for Ninlaro, streamline product access, and connect to helpful resources. Services include:
• Benefit verification and prior authorization assistance
• Assistance with appealing a payer denial
• Ninlaro Co-Pay Assistance Program enrollment for eligible, commercially insured patients
• Specialty pharmacy referral and coordination
• Referral to alternative funding sources and third-party foundations
• Connection to support services, including referrals for transportation services, legal support, and national and local organizations for counseling
• Ninlaro RapidStart Program for patients with insurance-related coverage delays.

The Velcade Reimbursement Assistance Program

Dedicated (VRAP) case managers help providers and patients:
• Verify patient’s insurance coverage.
• Provide support during the appeals process in the event that a claim is denied (NOTE: VRAP case managers do not file claims or appeals on behalf of patients and cannot guarantee that patients will be successful in obtaining reimbursement).
• Identify alternate and supplemental insurance coverage options.
• Provide co-payment foundation support information.
• Screen and enroll eligible patients into the Velcade Patient Assistance Program.
• Connect patients to transportation assistance.

The enrollment form is available online at: velcade.com/files/pdfs/VELCADE_VRAP_Enrollment_Form.pdf. Fax completed forms to: 800.891.9843. Learn more online at: velcade.com/Files/PDFs/VRAP_and_Patient_Assistance.pdf or by calling 1.866.VELCADE (1.866.835.2233) and choosing option 2.
option 2. Dedicated case managers are available Monday through Friday, 8:00 am to 8:00 pm EST.

**Resources for Healthcare Professionals**


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**Patient Assistance Checklist for Uninsured Patients**

- I have received the chemotherapy order written by the physician?  
- 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  
  If no, state reasons why:

- Does the patient need drug(s) that are not available through a drug replacement program?  
  - YES  
  - NO  
  If yes, identify which drugs:

- Is Foundation funding assistance available for any of these drug(s)?  
  - YES  
  - NO  
  If yes, identify Foundation(s) and drug(s):

- I have completed all the necessary forms and paperwork for these Foundation funding program(s).  
  - YES  
  - NO  
  If no, state reasons why:

- 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  
  If no, state reasons why:

- 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 AND REIMBURSEMENT ASSISTANCE

TOGETHER with TESARO™

TOGETHER with TESARO is a patient resource program dedicated to supporting patients. The program offers a suite of solutions to address medication access and affordability throughout each patient’s experience. TESARO’s expert case management team facilitates a seamless process to ensure TESARO patients get the individualized support needed.

Principles of the Program

TOGETHER with TESARO is based on 4 primary principles: commitment, the suite of solutions, seamless execution, and evolution. The program assists with access issues so that patients can focus on treatment goals and daily life. A team of access and affordability experts is available to help oncology practices and patients gain access to the TESARO medication they require. TOGETHER with TESARO will continue to evolve and grow to meet provider and patient needs.

Enrollment

With the patient’s consent, enrollment begins when providers complete and submit a simple enrollment form. Enrollment forms can be obtained in print or digitally through a case manager, area manager, or https://www.togetherwithtesaro.com. Enrollment initiates a comprehensive benefits investigation with written findings sent to the prescriber’s office. The report explains coverage status, prior authorization requirement, and out-of-pocket costs for the patient. This is a free service for all patients enrolled in TOGETHER with TESARO.

TOGETHER with TESARO™ Suite of Solutions

TOGETHER with TESARO offers a suite of solutions to address medication access and affordability, including coverage support, Patient Assistance Program (PAP), Commercial Co-Pay Assistance Program and referrals to independent co-pay foundations and patient advocacy organizations, depending on patient eligibility.

- **Coverage Support:** Includes benefits investigation, prior authorization, and appeals services.
- **Patient Assistance Program (PAP):** Provides product to eligible uninsured and underinsured patients who have demonstrated financial hardship. Financial eligibility requirements apply.
- **Commercial Co-Pay Assistance Program:** Reduces out-of-pocket costs for commercially insured patients. The virtual card can be initiated by enrolling in an online portal, https://www.activatethecard.com/tesaro, which can also be found on https://www.togetherwithtesaro.com. Card numbers are registered and activated upon enrollment completion.
- **Referrals to Independent Co-Pay Foundations:** Includes assistance with finding other sources of financial support based on the patient’s eligibility for these programs and services.
Patient Assistance Checklist for Medicare Only Patients

☑️ I have received the chemotherapy order written by the physician?
☑️ I have verified the patient’s insurance coverage?
☑️ I have verified that the drug(s) are indicated for the patient’s diagnosis?
☑️ I have obtained prior authorization, if needed?
☑️ I have identified the patient’s responsibility (an estimate in dollars) for treatment costs?
☑️ I have met with the patient to assess his or her ability to pay for treatment?
☑️ Based on this meeting, does patient need drug replacement? ☐ YES ☐ NO

☑️ If yes, is a replacement drug program available? (Note: an appeal must to be made to receive drugs.) ☐ 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  If no, state reasons why:

☑️ Does the patient need drug(s) that are not available through a drug replacement program? ☐ YES ☐ NO  If yes, identify which drugs:

☑️ Is Foundation funding assistance available for any of these drug(s) or to help with other treatment-related costs? ☐ 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  If no, state reasons why:

☑️ Does the patient qualify for charity care 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  If no, state reasons why:

☑️ 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

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Source. ACCC Financial Advocacy Network. accc-cancer.org/FAN
Oncology-related therapeutic products: Bendeka™ (bendamustine hydrochloride) for Injection, Synribo® (omacetaxine mepesuccinate) for Injection, Treanda® (bendamustine HCl) for Injection, Trisenox® (arsenic trioxide) for Injection.

Oncology-related supportive care products: Actiq® (oral transmucosal fentanyl citrate) [C-II], Fentora® (fentanyl buccal tablet) [C-II], Granix™ (tbo-filgrastim) Injection.

Patient and Reimbursement Assistance Websites

tevacares.org

tevacore.com

PATIENT ASSISTANCE

The Teva Cares Foundation

The Teva Cares Foundation is a conglomeration of Patient Assistance Programs designed to improve patient access to Teva medications and ensure that cost is not a barrier to care. Through these programs, the Teva Cares Foundation is able to provide certain Teva medications at no cost to patients in the United States who meet certain insurance and income criteria. Eligibility is based on a patient’s income and prescription insurance status, and varies depending on the Teva medication that has been prescribed. To determine if your patient qualifies, review the Teva Cares Foundation Patient Assistance Programs eligibility requirements online at: tevacares.org/DoIQualify.aspx or call 877.237.4881, Monday through Friday, 9:00 am to 7:00 pm EST. Then download the appropriate enrollment application for the Teva medication you have prescribed at: tevacares.org/DownloadApplication.aspx. Completed applications should be faxed to the number provided at the top of the form. (NOTE: The fax number may differ depending on the Teva medication.)

If your patient does not meet the eligibility requirements for the Teva Cares Foundation Patient Assistance Programs, Teva may offer a reimbursement assistance program or other type of program to assist your patient. For more information, please call 888.TEVA.USA (838.2872). Some patients may be eligible for assistance from other programs. For a listing of these other assistance programs go to: tevacares.org/OtherResources.aspx.

REIMBURSEMENT ASSISTANCE

CORE

CORE (Comprehensive Oncology Reimbursement Expertise) provides patients and providers with a reimbursement support program, as well as online tools to help make it easier to understand and navigate reimbursement. The CORE Hotline (1.888.587.3263) is a service provided by Teva Oncology to help physicians and their patients understand the complexities of reimbursement and where CORE fits in. Reimbursement consultants are available 9:00 am to 8:00 pm EST, Monday through Friday, to provide assistance with the following:

- Benefit verification and coverage determination
- Pre-certification and prior authorization support

TABLE OF CONTENTS
Patient Assistance Checklist for Medicaid Patients

- Coverage guidelines and claim requirements of payers
- Personalized support through the claims and appeals process
- Templates for letters of medical necessity
- Referral to the appropriate Teva Cares Foundation Patient Assistance Program.

Download the CORE enrollment form at: tevacore.com/PDF/Enrollment%20Form.PDF. Fax the completed form to 866.676.4073. Providers can also create an account and enroll their patients online at: https://eprescribe.iassist.com/?style=tevaoncology.

I have received the chemotherapy order written by the physician?

✓ I have verified the patient’s insurance coverage?

✓ I have verified that the drug(s) are indicated for the patient’s diagnosis?

✓ I have obtained prior authorization, if needed?

✓ I have identified the patient’s responsibility (an estimate in dollars) for treatment costs?

✓ I have met with the patient to assess his or her ability to pay for treatment?

Based on this meeting, does patient need drug replacement?

☑ YES ☐ NO

If yes, is a replacement drug program available? (Note: an appeal must to be made to receive drugs.)

☑ 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.

☑ YES ☐ NO

If no, state reasons why:

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
Other Patient Assistance Programs & Resources

Agingcare.com
agingcare.com

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

BenefitsCheckUp*
benefitscheckup.org

A free service of the National Council on Aging (NCOA), a non-profit service and advocacy organization. Many adults over 55 need help paying for prescription drugs, healthcare, utilities, and other basic needs. There are over 2,500 federal, state, and private benefits programs available to help. BenefitsCheckUp asks a series of questions to help identify benefits that could save patients money and cover the costs of everyday expenses. After answering the questions, patients receive a personalized report that describes the programs that may help them.

CancerCare*
cancercare.org

CancerCare provides limited financial assistance to people affected by cancer. As a non-profit organization, funding depends on the sources of support CancerCare receives at any given time. If CancerCare does not currently have funding to assist you, their professional oncology social workers will always work to refer you to other financial assistance resources. Check: cancercare.org periodically for funding updates.

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 $17,820 (if single) and $24,030 (if married). If they live in Alaska or Hawaii, they may still get help even if their income is higher than these limits.
- Patients have resources less than $13,640 (if single) and $27,250 (if married).

If patients meet the guidelines, they will have low or no deductibles, low or no premiums, no coverage gap, and will pay much less for prescriptions. At the same time, patients can start the application process for the Medicare Savings Programs that could increase their monthly income by about $121.80. Patients will also find out if there are other benefits programs that can save them money. Apply online at: www.benefitscheckup.org/cf/continue.cfm. For more information go to: benefitscheckup.org.

Here’s how to apply:
1. Call 800.813.HOPE (4673) and speak with a CancerCare social worker to complete a brief interview, 9:00 am to 7:00 pm ET, Monday through Thursday, and 9:00 am to 5:00 pm ET on Friday.
2. If patients are eligible to apply, we will:
- Mail the patient an individualized barcoded application
- Request documentation to verify the patient’s income.

Other Patient Assistance Programs & Resources
3. Patients must submit a completed application. Here are some tips:

- Print clearly—illegible applications cannot be processed.
- Fill in each blank space in the application. Use “no,” “none,” or “0” as appropriate—do not leave any blank responses.
- Have a medical oncology healthcare provider complete all sections of the Medical Information Section and provide a signature and date. Patients cannot complete this section.
- Make sure patients use the correct CancerCare mailing address and fax number listed on the application.

NOTE: CancerCare’s financial assistance does not cover basic living expenses such as rent, mortgages, utility payments, or food.

**CancerCare Co-payment Assistance Foundation**  
cancercarecopay.org

CancerCare Co-payment Assistance Foundation (CCAF) helps people afford the cost of co-payments for chemotherapy and targeted treatment drugs. This assistance is provided free of charge to ensure patient access to care and compliance with prescribed treatments. CCAF offers a seamless, same-day approval process through a state-of-the-art online platform. Patients will always know if they have been approved on the same day they apply. This allows immediate access to the full array of CancerCare support services, including telephone, online, and in-person counseling, support groups, information and resource referrals, publications, education, and financial assistance with treatment-related expenses such as transportation and child care.

In order to be eligible for assistance, patients must complete and sign an application and HIPAA Authorization form, as well as provide proof of income. CCAF will review your application and forms on a first-come, first-served basis to the extent that funding is available.

NOTE: as a non-profit organization, CCAF cannot guarantee that funding will always be available for a particular diagnosis. If unable to provide co-payment assistance, however, they will refer patients to other organizations that may be able to help.

To qualify for assistance, patients must meet the criteria below:

- **Financial.** Individuals or families with an adjusted gross income of up to four times the Federal Poverty Level may qualify for assistance. CCAF may also consider the cost of living in a particular city or state. Income verification is required as part of the application process.
- **Medical.** Patients must be diagnosed with one of the cancer types covered by CCAF (check the CCAF website for an up-to-date list of the types of cancers for which assistance is currently available). The treating physician must submit a verification form confirming diagnosis and medications. In addition, the physician must complete and sign our physician verification form. Patients must currently be undergoing chemotherapy or prescribed and/or using a targeted treatment drug when they apply to CCAF, and at the time of approval.
- **Insurance.** Patients must be covered by private insurance or an employer-sponsored health plan, or they must have Medicare Part B, Medicare Part D, or a Medicare Advantage Plan (Medicare C).
- **Other criteria.** Patients must be receiving treatment in the United States. Patients must be a U.S. citizen or legal resident.

NOTE: if patients have private insurance, please contact the drug company that manufactures their medication before you contact CCAF, as the company may offer a program that can help. Patients who are uninsured (do not have any insurance or medical plan that covers their prescription medicines), are not eligible for co-payment assistance. However, we encourage you to contact us at: 866.55.COPAY (866.552.6729), 9:00 am to 7:00 pm EST, Monday through Thursday, and 9:00 am to 5:00 pm EST on Friday, so that we can refer you to other organizations or patient assistance programs.

Eligible individuals will receive an application packet with instructions on how to apply for assistance. Co-payment specialists are available to answer questions about this process. Or patients can enroll online at: [http://portal.cancercare](http://portal.cancercare)
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, through:
1. Facilitating communication and collaboration among member organizations
2. Educating patients and providers about existing resources and linking to other organizations that can disseminate information about the collective resources of the member organizations
3. Advocating on behalf of cancer patients who continue to bear financial burdens associated with the costs of cancer treatment and care.

Because CFAC is a coalition of organizations, it cannot respond to individual requests for financial assistance. To find out if financial help is available, use the CFAC database at: cancerfac.org. Search by cancer diagnosis or specific type of assistance or need (i.e., general living expenses, transportation, childcare).

Co-Pay Relief
copays.org

The Patient Advocate Foundation (PAF) Co-Pay Relief Program (CPR) provides direct financial support to qualified patients, including those insured through federally administered health plans such as Medicare, assisting them with prescription drug co-payments, co-insurance, and deductibles required by the patient’s insurer. CPR call counselors work directly with the patient as well as with the provider of care to obtain necessary medical, insurance and income information to advance the application quickly. Upon approval, payments may be made to:
• The pharmacy
• The healthcare provider
• The patient directly.

Eligibility requirements:
• Patients must be insured and insurance must cover the medication for which they seek assistance.
• Patients must have a confirmed diagnosis of the disease or illness for which they seek financial assistance.
• Patients must reside and receive treatment in the United States.
• The patient’s income must fall below the income guidelines of the fund under which they are requesting financial assistance. All funds have income guidelines of either 300 percent, 400 percent, or less of the Federal Poverty Guideline with consideration of the Cost of Living Index and the number in the household.

NOTE: Patients will be informed immediately upon application if they qualify for assistance.

The CPR Program offers four points of entry:
1. Patients may apply via the
   Patient Online Application Portal available 24 hours a day.
2. Medical providers may apply on behalf of their patients via the Provider Online Application Portal available 24 hours a day.
3. Pharmacies may apply on behalf of their patients via the Pharmacy Online Application Portal available 24 hours a day.
4. The program offers personal service to all patients through the use of an Approval Specialist, personally guiding patients through the enrollment process toll free at 866.512.3861, Option 1.

Good Days
mygooddays.org

Good Days has a mission to ensure no one has to choose between getting the medication they need and affording the necessities of everyday living. Good Days helps patients suffering from chronic diseases by providing financial support to patients who cannot afford the medications they need. Services include:
• Direct Financial Assistance for patients who cannot afford their medication. Good Days offers a same-day approval process, so patients know on the same day that they apply whether or not they have been approved. If approved, patients are given enough funding to cover their treatments for the balance of the calendar year.
• Premium Assistance to help patients find the insurance coverage that is right for them.
• Travel Assistance through the Good Days Travel Concierge
Program, which can help with transport, lodging and ancillary travel costs for patients who must travel to receive treatment.

Please note, because Good Days is a non-profit charitable organization, it cannot guarantee that funding for a specific disease state will be available. However, if unable to provide financial help, Good Days will refer patients to outside organizations that may be able to offer assistance instead.

For a list of covered diseases and medications go to: http://www.mygooddays.org/for-patients/diseases-and-medications-covered/. Enrollment applications can be downloaded online at: https://www.mygooddays.org/wp-content/uploads/2017/03/Internet-Application_v20170321.pdf (English) or https://www.mygooddays.org/wp-content/uploads/2017/03/Internet-Application_v20170321_Spanish.pdf (Spanish). (Please note: Enrollment applications may change from year to year.) Or providers and patients can apply online at: http://patientsandpros.mygooddays.org/.

Questions? Call 877.968.7233, Monday through Friday, 8:00 am-5:00 pm CST.

HealthWell Foundation
healthwellfoundation.org

The HealthWell Foundation reduces financial barriers to care for underinsured patients with chronic or life-threatening diseases by providing financial assistance to eligible individuals to cover the cost of co-insurance, co-payments, healthcare premiums, and deductibles for certain medications and therapies. If patients have some healthcare coverage, either through a private insurance plan or a federal or state-funded program such as Medicare or Medicaid, but still cannot afford the out-of-pocket costs associated with their medical treatment, HealthWell may be able to help.

With the patient’s permission, providers, pharmacy representatives, and patient advocates can apply on behalf of a patient in two ways:
1. Apply online using the HealthWell provider portal at: https://healthwellfoundation.secure.force.com/
2. Apply by phone at: 800.675.8416.

NOTE: Providers, pharmacies, and social workers are strongly encouraged to use the Provider Portal to apply so that patients can readily access HealthWell hotline care managers. Before beginning the application process, have the following information ready:
✓ Patient contact information (name, address, telephone number, Social Security number, date of birth).
✓ Patient insurance and prescription information and ID (i.e., insurance and policy information and prescription card(s)
✓ Patient income information (total household income, total household size)
✓ Prescribing physician information (name, address, telephone number, fax number, and contact name)
✓ Fund to which the patient is applying for assistance
✓ Type of assistance the patient is applying for (co-pay or premium).

NOTE: not all funds offer premium assistance.

The HealthWell Foundation provides instant approval for patients applying online or via phone. (Online applications can take up to one business day to process; patients and providers who apply over the phone can expect to know of their approval status within 10 to 15 minutes.) If approved, HealthWell will send an approval letter with the enrollment period dates and grant amount to the patient. The approval letter will provide the patient with a Reimbursement Request Form based on the type of assistance requested and instructions for submitting the reimbursement OR a pharmacy card (fund appropriate). In addition, HealthWell will fax a copy of the approval letter to the provider as long as their fax number was provided.

NOTE: The HealthWell Foundation randomly selects patients for income audits and confirmation of diagnosis. It is very important for patients to understand that if they receive a letter from HealthWell at any time requesting income documentation, they must reply right away. If they don’t, payments on their grant will stop or their...
HealthWell Pharmacy Card will be de-activated. In addition, the patient will have to submit income documentation to HealthWell for any and every new grant moving forward. Individuals applying on behalf of a child for the Pediatric Assistance Fund will not receive immediate grant approval. For more information on the Pediatric Assistance Fund application process visit: healthwellfoundation.org/pediatric-assistance-fund.

When a patient applies and is approved for assistance, the grant start date can be up to 30 days prior to the application date. All active grant recipients are welcome to re-enroll at the end of their grant cycle (one year) as long as assistance is still required and the individual still meets the program criteria and funding is available. Patients can begin the re-enrollment process no more than 3-4 weeks in advance of the end date of their current grant.

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

The Leukemia & Lymphoma Society
lls.org

The Leukemia & Lymphoma Society (LLS) Co-Pay Assistance Program helps patients pay their insurance premiums and meet co-pay obligations. LLS can also help providers and patients find additional sources of financial support. The LLS Co-Pay Assistance Program offers financial help toward:

- Blood cancer treatment-related co-payments
- Private health insurance premiums
- Medicare Part B, Medicare Plan D, Medicare 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 Puerto Rico and be medically and financially qualified
✓ Have medical and/or prescription insurance coverage
✓ Have an LLS Co-Pay Assistance Program covered blood cancer diagnosis confirmed by a provider (See a list of covered diagnoses here: http://www.lls.org/support/financial-support/co-pay-assistance-program).

Apply online at:
https://cprportal.lls.org/

You can also apply or get more information about the LLS Co-Pay Assistance Program, by calling 877.557.2672 and speaking with a co-pay specialist who will provide personalized service throughout the application process.

NeedyMeds
needymeds.com

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

1. Click on the first letter of the name of your medicine in the alphabet bar.
2. Click on the name of your medicine to find out if there is a Patient Assistance Program (PAP) available. If there is an active program available, a PAP icon will appear under the drug name.
3. Click on the PAP icon to access the eligibility and contact information for the program(s). In some cases, the program application form can be printed from the NeedyMeds website. Applications should be faxed or mailed directly to the PAP, not to NeedyMeds.
4. 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.
5. If an application form is available through a PAP, look for it in the Program Applica-
tions list. Look for all of your medications, not just the most expensive ones.

**Applications Assistance:**
If you need help filling out your applications, see our list of organizations that provide application assistance for free or a small fee here: [http://www.needymeds.org/local-programs](http://www.needymeds.org/local-programs). These organizations can help with such things as finding a program for your prescription medication, completing the application forms, and working with physicians who must sign the forms. 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 your 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 offered by various drug companies and may offer a rebate, discount or even a free trial size of a medication. Offers for prescription medications require a doctor’s prescription. Offers can be found three ways: under Brand Name Drugs if a coupon icon appears under the drug name then click on the icon. They can also be found on the Coupons, Rebates & More page of the NeedyMeds website. Use the alphabet bar to find the medicine. Or do a category search for coupons by diagnosis or symptoms.

- **NeedyMeds Drug Discount Card** provides savings of up to 80% on many prescription medications. The card is free and available to everyone. There is no registration and your entire family can use the same card. Download a card and learn more about its benefits. Information on other drug discount cards are also available on the NeedyMeds website.

- **Diagnosis-Based Assistance:** [needymeds.org/copay_branch.taf](http://needymeds.org/copay_branch.taf).
  There are many government and private-funded programs that help with costs associated with a specific diagnosis. They may cover many types of expenses, including drugs, insurance co-pays, office visits, transportation, nutrition, medical supplies, child, or respite care. Some cover one specific diagnosis, while others cover whole categories (such as all types of cancers) or even all chronic medical illnesses. 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. NeedyMeds has compiled a database of diagnosis-based assistance programs that you or your patient can search. It’s best to search by the type of diagnosis. Other ways to search for assistance are by looking for programs that serve a specific geographical area. If you know the name of a specific program about which you want more information, you can also search by name of program.

**Assistance with Government Programs:**
Every state has programs to help needy families and individuals with the cost of healthcare. NeedyMeds has compiled a database of these state programs. The programs are available via the organization website. You can search these programs by clicking on a state, the District of Columbia, Puerto Rico, or Guam. Programs and their guidelines vary from state to state. NeedyMeds has also has a list of Medicaid Sites with a clickable map where you can learn more about Medicaid in your state, as well as general information on Medicare.

For all help line questions, send emails to [info@needymeds.org](mailto:info@needymeds.org) or call our toll-free number: 1.800.503.6897.

**Partnership for Prescription Assistance**
[pparx.org](http://pparx.org)

The Partnership for Prescription Assistance (PPA) helps qualifying uninsured and underinsured patients connect to the right assistance programs so that they can get the medicines they need for free or nearly free. The Partnership for Prescription Assistance will help you find the program that’s right for your patient, free of charge.

**Step 1.** Tell us what medicines your patient takes. Go to: [www.pparx.org/gethelp/select-therapies](http://www.pparx.org/gethelp/select-therapies). Type the name of the medicine into the box and click the search button. Once the search is complete you can add one or more prescription drugs from your search to the My Medicines list, which appears on the right side of the page. Repeat this process until you have entered and selected all of the medicines.
Step 2. Tell us about your patient. Provide basic information about the patient and the type of drug coverage (if any) he or she currently has. Answer short questions, such as the patient’s residency, age, and household income, to see which patient assistance programs they may qualify for. You must answer all questions marked with an asterisk on this page for your patient to be considered. If you need assistance, please call 1.888.477.2669 Monday through Friday, from 9:00 am to 5:00 pm EST.

Step 3. Get your patient’s results. See which prescription assistance programs your patient may be eligible for and select the ones you would like to apply to.

Step 4. Complete the application process. Print, complete, and mail applications to each program your patient is applying to. You may download the applications directly from your computer or device or have them emailed to you.

PPA offers other resources, including:

- Searchable list of Patient Assistance Programs: pparx.org/prescription_assistance_programs/list_of_participating_programs
- A list of discount drug card programs at: pparx.org/prescription_assistance_programs/savings_cards
- Information about Medicare prescription drug coverage at: pparx.org/prescription_assistance_programs/medicare_drug_coverage.

Have recent natural disasters affected your patient’s ability to get access to their prescription medicines? Download the natural disaster worksheet: pparx.org/sites/default/files/Natural%20Disaster%20Worksheet_Final.pdf and PPA may be able to match your patient with a program to help them regain access to their medicines.

Patient Access Network Foundation
panfoundation.org

The Patient Access Network Foundation (PAN) facilitates access to medical treatment for patients with chronic, rare, or life-threatening illness. Providers and their patients can apply for assistance by calling 1.866.316.7263, between 9:00 am and 5:00 pm ET Monday through Friday, or start the application online through the Pan Foundation Provider Portal: https://providerportal.panfoundation.org/

In order for patients to qualify for co-payment assistance with the Patient Access Network Foundation, they must meet the following eligibility criteria:

- Patient must be getting treatment for the disease named in the assistance program to which he or she is applying
- Patient is insured and insurance covers the medication for which the patient seeks assistance
- The medication or product must be listed on PAN’s list of covered medications
- Patient’s income must be below a designated percentage of the Federal Poverty Level, depending on individual fund requirements
- Patient must reside and receive treatment in the U.S. (U.S. citizenship is not a requirement.)

Step 1. Log into the correct Pan Foundation Portal (i.e., “Provider Portal,” “Patient Portal,” or “Pharmacy Portal”) to begin the application process.

Step 2. Select the appropriate disease fund for your patient. Select your patient’s primary insurance type from the drop-down list. Then, select the name of the medication for which you are applying for assistance.

Step 3. You will need to access to the following information for the patient:

Demographic information
- First and last name
- Social Security number or Alien Number
- Phone number
- Street address and email address.
Income Information
Documentation of adjusted gross income applicable to the patient and all members of the patient’s household. Such documentation may include:
- Tax forms (1040, 1040 EZ)
- Social Security statements (1099)
- Retirement income documentation (e.g., IRA and pensions)
- Other income sources (e.g., alimony, child support, rental income).

Insurance and Co-payment Information
- Health insurance card(s)
- Details regarding assistance that patient may be receiving from other co-pay or co-insurance assistance organizations.

NOTE: Patients should be prepared to share co-pay or co-insurance obligations for the medications relevant to the disease fund for which they are applying.

Step 4. You will need to access to the following information for the provider:
- First name
- Last name
- Phone number
- Facility address
- Email address.

Step 5. Review the application to make sure the information entered is correct and then submit the application online using the PAN Foundation Portal. For more information or to apply over the phone call 1.866.316.7263, between 9:00 am and 5:00 pm EST.

Other Patient Assistance Programs and Resources

Patient Advocate Foundation
patientadvocate.org

The Patient Advocate Foundation (PAF) is a national non-profit organization that provides professional case management services to Americans with chronic, life-threatening, and debilitating illnesses. PAF case managers, assisted by doctors and healthcare attorneys, serve as an active liaison between the patient and their insurer, employer, and/or creditors to resolve insurance, job retention, and/or debt crisis matters relative to their diagnosis. PAF seeks to safeguard patients through effective mediation assuring access to care, maintenance of employment, and preservation of their financial stability. PAF offers services by telephone, email, or web chat to patients in need that fall under the scope of our services. Professional staff members offer assistance via telephone, email, or live web chat to patients in need who fall under the scope of PAF’s services. Available patient services from Patient Advocate Foundation include:

Case management. Free one-on-one assistance with a professional case manager to help patients, caregivers, or providers resolve healthcare issues. Case managers are available to assist patients, caregivers, and their providers who face debilitating, chronic, or life-threatening disease. Call toll free at 1.800.532.5274.

MedCare program. The MedCareLine is a division of Patient Advocate Foundation staffed with a team of nurses and case managers who provide individualized case management services to a specific population of patients, caregivers, and providers.

Financial aid fund division. 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.

Co-Pay Relief Program. Operating as an independent division within PAF, the Co-Pay Relief Program offers co-pay assistance for insured applicants meeting disease and income eligibility guidelines to help patients afford the cost of pharmaceutical medications and treatments.

Partnership programs. PAF works in conjunction with many nonprofit and corporate partners, including but not limited to, American Cancer Society, Susan G. Komen, and Cancer Treatment Centers of America to meet the needs of patients across the United States.

Outreach & support programs. PAF performs community-based educational and outreach programs geared towards increasing access to quality healthcare for underserved populations. PAF also works to educate patients about resources focused on disease prevention and screening. Contact PAF to see when they will be in your area next.
Questions? Contact Patient Advocate Foundation at: 800.532.5274.

RxAssist
rxassist.org

RxAssist offers a comprehensive resource center for patients, healthcare providers and patient advocates who are seeking free and low cost medications to help manage chronic diseases. The RxAssist database contains eligibility information and applications for over 150 pharmaceutical company patient assistance programs. The database can help you find out whether a drug is available, which pharmaceutical company program offers the drug, and how to apply for the medication. RxAssist also provides practical tools, news, and articles for patients and healthcare providers alike.

Using RxAssist

Step 1. In order to use the database, you must register either as a provider or patient. If you are already registered, login. Click the “Search Database” tab or find the search box in the Provider Center or Patient Center pages.

Step 2. Choose whether you want to search by drug name or company name. Or conduct a “multiple drug” search, which allows you to search for a drug by either the generic or brand name, and to choose between the Patient Assistance Programs database, which searches the charitable programs offered by pharmaceutical companies as well as RxOutreach and Xubex, or the Generics Retail Programs database, which searches generic drug programs offered through retail pharmacies.

To search for a medication by brand name or generic name, select “search by drug name.” Then, enter either the complete name of the medication, or the first few letters. If you type in the full name, the name must be spelled correctly in order for the database to find that medication. If you are unsure how to spell a drug name, type in as many letters as you know to be correct. If you type only the first letter, the results will include all generics and brand names that begin with that letter.

To search a company name, select “search by company name,” then type the company’s name into the search term box. To search the RxOutreach program select the “search by RxOutreach” button and follow the same instructions as those above for drug name. When searching by RxOutreach, the results will only include medications available through this program.

Step 3. If you would like to search for multiple drugs, click the advance search button. Then, enter the items in the search boxes that pop up.

Step 4. After you have entered information in the search box, if the database finds a match a search results page will appear. (If there is only one program available for a medication, you will be taken directly to the program details page.)

Step 5. Click the underlined hyperlink of the medication you want in the search results page, and you will be taken to the program details page.

Step 6. The program details page includes eligibility criteria and information on how to apply to the program. If an application is available for a program, you will see “Application Forms and Instructions” to the right with links to download the application.

Step 7. If an application is available online, you can either open (download) the application, type information directly onto the application on the screen and print it out, or print out the application and fill it out by hand. If there is no application online, use the phone number provided at the top of the program details page to call the company for information on how to get an application.

NOTE: RxAssist only includes medications that are available through patient assistance programs. If your medication is not listed, it most likely means that the medication is not available through a patient assistance program. If you believe that the program does exist, please contact RxAssist by emailing: info@rxassist.org. If a patient assistance program for the medication you have prescribed is not available, you or a patient advocate may contact the manufacturer of the medication directly to see if the medication could be sent to your patient.
RxAssist Prescription Discount Card
Patients can save up to 80 percent off the cash price of their medications using the RxAssist Prescription Discount Card at their local pharmacy. 21 of 25 most common meds are cheaper with the card than a $10 co-pay. This card:

- Is completely free and never expires
- Works for all FDA-approved prescription medications
- Supports RxAssist.org.

Learn more at: rxassist.org/patients/patient-assistance-center.

RxHope™ rxhope.com

Healthcare providers and their staff can set up accounts online to order free medications for their patients through the RxHope automated patient assistance online system. If you would like to create a free account for one healthcare provider, visit: rxhope.com/Prescriber/Set upAccount.aspx. (NOTE: Each account is valid for use by one healthcare provider only. If multiple members of your office staff wish to utilize the RxHope automated patient assistance online system, each staff person must set up a separate account.) To set up your free account and place orders online the following criteria are required:

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

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

Rx Outreach® rxoutreach.org

Rx Outreach is a fully-licensed non-profit mail order pharmacy that ships medication directly to patients’ homes. To make this process simple and cost-effective, Rx Outreach typically ships a 90 or 180-day supply of the needed medication. Patients who meet eligibility requirements can use Rx Outreach regardless of whether they use Medicare, Medicaid, or other health insurance. To be eligible to use Rx Outreach, patients must meet income requirements, which differ depending on household size:

- **1-person household**: Less than $35,640/year. (Alaska: less than $44,520/year; Hawaii: less than $41,010/year.)
- **2-person household**: Less than $48,060/year. (Alaska: less than $60,060/year; Hawaii: less than $55,290/year.)
- **3-person household**: Less than $60,480/year. (Alaska: less than $75,600/year; Hawaii: less than $69,570/year.)
- **4-person household**: Less than $72,900/year. (Alaska: less than $91,140/year; Hawaii: less than $83,850/year.)
- **More than 4-person household**: For each additional person in the house, add $12,420/year. (Alaska: add $15,540/year; Hawaii: add $14,280/year.)

Providers and patients can enroll in the program by following the steps below:

1. Determine patient eligibility using criteria above.
2. See if the patient’s drug is listed on the RxOutreach Medication’s List: rxoutreach.org/find-your-medications.
3. Create a simple account by providing your email address and selecting a password. Verify the email address provided.
4. Enroll in Rx Outreach. To enroll, you’ll need to provide the following information:
   - Name and contact information for provider and patient
   - Patient date of birth
   - Patient Social Security or Green Card number (required to order Controlled Substance medications only)
   - Information on patient allergies and current medications
   - Patient income and household size information
   - For faster service, you can include credit card information for payment at this time.

5. Follow Rx Outreach guidelines, found at http://rxoutreach.org/wp-content/uploads/current/Overview.pdf, when writing patient’s prescription. It is important that the patient’s prescription is written according to these guidelines.
6. Calculate the cost of your medication(s) by filling out the worksheet found at [http://www.rxoutreach.org/](http://www.rxoutreach.org/), using the information provided here: [rxoutreach.org/find-your-medications](http://www.rxoutreach.org/).

7. Fill out and sign the Rx Outreach form. Patients will need to submit a separate form for each member of their household who orders medication. Medications can be sent directly to the patient’s home, or to the provider’s office. To obtain additional forms call 1.888.RXO.1234 (888.796.1234). Monday through Friday, 7:00 am to 5:30 pm CST or visit the Rx Outreach website.

8. Submit prescription, payment and form to Rx Outreach. Payment can be made with personal checks, money orders, or credit cards (only Visa, MasterCard, or Discover). Patients are asked not to send cash. Patients should send payment for the total cost of their medication(s) along with completed Rx Outreach form and prescriptions. (NOTE: If patient has health insurance, they cannot use their insurance to help pay the Rx Outreach fee.) Prescriptions and payment may be faxed to 1.800.875.6591. Faxed prescriptions are only accepted from a healthcare provider’s office or facility. Patients or providers can also mail prescriptions and payment to: Rx Outreach, P.O. Box 66536, St. Louis, MO, 63166-6536. Credit or debit card payment can also be submitted online or over the phone. Once payment and prescription are received, please allow 24 to 48 hours for processing.

For more information, go to: [rxoutreach.org](http://www.rxoutreach.org/) or call 1.888.RXO.1234 (1.888.796.1234), Monday through Friday, 7:00 am to 5:30 pm CST.

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### Tips for Assisting Patients in Applying to Patient Assistance Programs

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

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

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

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

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

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Source. ACCC Financial Advocacy Network. accc-cancer.org/FAN
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/Coincurrence 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).