ASSOCIATION OF COMMUNITY CANCER CENTERS

2019

Patient Assistance & Reimbursement Guide

ACCC
Association of Community Cancer Centers

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2019

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by Natasha Gomes

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The ACCC Patient Assistance & Reimbursement Guide was printed in January 2019. This publication is updated four times a year. Visit **accc-cancer.org/PatientAssistanceGuide** to download and print the most up-to-date information on cancer drug assistance and reimbursement programs.

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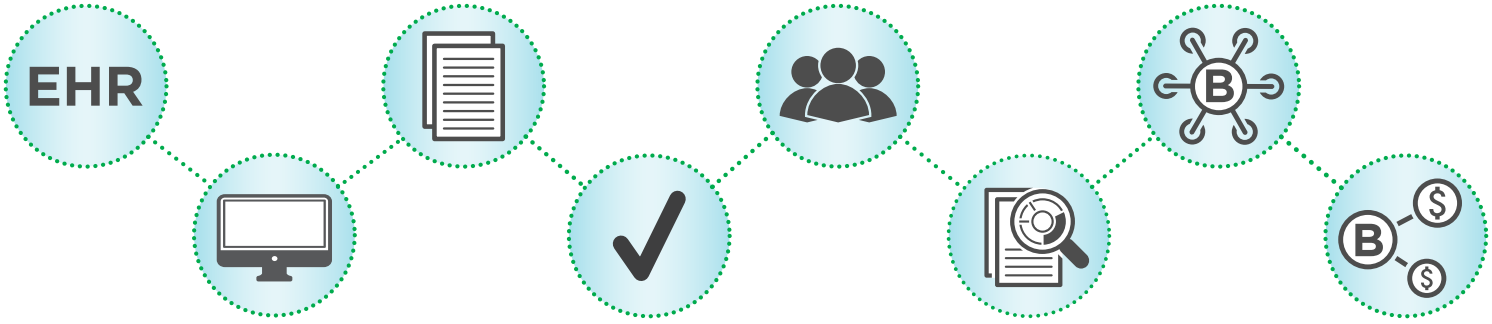
BY NATASHA GOMES

FINANCIAL TOXICITY
Navigation Process Improvement

Improving patient flow by optimizing EHRs



Finances are often a major concern for patients dealing with a cancer diagnosis. In 2017 DuPage Medical Group, Downers Grove, Ill., directed more attention and resources toward our financial navigation department to assist patients in minimizing out-of-pocket expenses. Adding financial navigators to the conversation and communication process helps bridge the gap for a patient deciding whether to start or continue treatment, as financial navigators provide patients with exceptional, personalized care and guidance throughout the course of their treatment. This also eases the burden on our clinical staff by allowing them to focus on their areas of expertise.

DuPage Medical Group is the largest physician-owned group in Illinois, with more than 700 physicians, 115 locations, and 6 infusion sites that average 700 scheduled appointments per week. Medical oncology and radiation oncology services are staffed by 11 physicians and more than 100 clinical staff. With a team of only 4 financial navigators supporting all specialties, much is expected of our financial navigation team. However, optimizing our electronic health record (EHR) has allowed us to manage this heavy caseload.

Leveraging our Epic EHR to better support financial navigation of patients along the care continuum, DuPage Medical Group is able to:

- Capture patients from the time an order for treatment is placed
- Develop communications with oncology and infusion patients
- Follow up on patient accounts
- Track billing to co-pay assistance programs and foundations.

Since implementing this process in June 2017, DuPage Medical Group has tripled patient enrollment in co-pay and foundation assistance programs, helping reduce patient expenses by $1.4 million. The following outlines our new workflow for patient financial navigation and offers guidance for cancer programs seeking to implement a financial assistance pathway.

Financial Navigator Intake Process

Physician orders a new or updated treatment/therapy plan through EHR

Order routed to Health Plan Services work queue to begin prior authorization

Mirrored work queue created for financial navigator to access authorized referral, sorted by patient last name

Financial navigator reviews patients with authorized referrals for co-pay or foundation assistance

Financial navigator transfers patient to personal work queue and removes patient from mirrored work queue

Financial navigator uses two account statuses to track patient in EHR and track patient's co-pay or foundation enrollment

EHR routes account based on status code to biller work queue

Biller handles patient submittal to co-pay or foundation assistance for reimbursement

CAPTURING PATIENTS FROM THE TIME OF ORDER

Once it has been determined that a patient needs to start a treatment/therapy plan, an order is placed by the physician's office through a module in the EHR called Beacon. That order is then routed to our Health Plan Services work queue to start the prior authorization process. In addition to the work queue for Health Plan Services, we created a work queue for financial navigators so that they can view the same information that our Health Plan Services department sees. By creating this mirrored work queue, our financial navigation team can review all patients with authorized referrals to determine if patients qualify for co-pay/foundation assistance and begin the enrollment process. Financial navigators will transfer this patient to their personal work queue and change the referral flag to "benefits verified," removing the patient from both the Health Plan Services and the mirrored queue.

DEVELOPING A WORKFLOW FOR FINANCIAL NAVIGATORS

It was determined that best practice for managing patients was to develop an alpha split process based on patient last name to assign patients to a financial navigator who would serve as the liaison for the patient and clinical staff. Regardless of physician and location, each patient has a designated financial navigator to assist with any billing questions or financial concerns. Assigning patients to a financial navigator provides a single point of contact and streamlines the administrative process. Through the EHR, patients are entered into their financial navigator's work queue, eliminating the use of spreadsheets for tracking and allowing financial navigators to easily provide backup for each other. Activity codes were built into the EHR for patient account notes, and financial navigators have assigned activity codes along with smart phrases (a series of questions) so that the note is standardized yet comprehensive. Reports can be pulled by management for tracking purposes, to monitor enrollment, for use of activity codes and letters, and to follow up with billing questions, ensuring that each patient has been reviewed. Each activity code can also show an attached status code to ensure that patients are routed appropriately to the billing work queue.

FINANCIAL NAVIGATOR RESPONSIBILITIES

Financial navigators use two account statuses: one to track patients in the EHR, and one for Patient Accounts to know if a patient has an active co-pay foundation enrollment. While not all patients qualify for co-pay programs or foundation assistance, we assign a status code and track all patients anyway. In the background, the EHR will route that status code to a work queue assigned to our biller, who handles submittal to co-pay programs and foundations for reimbursement.

For patients who do not qualify, we use another status code so we know the patient is in active treatment but does not currently qualify for any assistance. Even if patients do not qualify for assistance, we still want to be available to assist with billing questions and payment arrangements and to monitor foundation funds in the event that one opens up for which a patient qualifies.

Financial navigators monitor and review all patients in their work queue who are in active treatment. A reminder date can be set to review each patient's account (usually every 30 days) to make sure the patient is not receiving any denials and that payment arrangements are current. The following financial navigation work queues are built in the EHR:

- ***Financial navigator work queue.*** Based on alpha split (total of four work queues) to monitor and review all patients for oncology/infusion.
- ***Oncology/Infusion closed foundations.*** Patients that are in active treatment, but the foundation is closed. A work queue is created for closed foundations, notifying a financial navigator if/when they open again. At that point, we can access the work queue and try to assist those patients. A specific activity code denotes that a fund in which the patient was enrolled has been closed.
- ***Oncology review work queue.*** We added all J codes (and some Q codes) for oncology and infusion

patients that have a self-pay balance. In the event an enrollment is missed, this catch-all work queue will capture a patient and add them.

Financial navigators will try to contact the patient via phone and introduce themselves, explaining that co-pay/foundation assistance may be available. We also have walk-in availability by appointment or by phone. DuPage Medical Group social workers work closely with the patient, and in the event of financial need, they will notify financial navigators that the patient needs assistance through a message pool in the EHR. By streamlining this process, patients have greater communication options for assistance. Since creating a staff messaging pool and financial navigation flyer, we have seen an increase in patient interaction with DuPage Medical Group financial navigators.

If a financial navigator cannot reach the patient by phone, we built a Welcome Letter in the EHR that introduces the financial navigator. When this letter is selected, financial navigators can personalize it with their own name and contact information. Our financial navigators are knowledgeable in all aspects of a patient's account. They can follow up on insurance denials and billing questions, set up payment plans, and answer patient questions. This provides patients with one point of contact for all their billing needs. Other patient letters created directly in the EHR for patients include:

- ***Commercial co-pay card letter.*** Enrollment eligibility and rules for co-pay programs through drug manufacturer(s).
- ***Foundation assistance letter.*** Requesting income information (in the event we cannot contact the patient).
- ***Radiation oncology letter.*** Assistance is limited for our radiation patients, but we still want to be a resource for any billing questions and assist in setting up payment arrangements.
- ***Biller letter.*** Explains that we have designated a biller to handle claim and explanations of benefits (EOBs) submittal to co-pay/foundation assistance programs.

TRACKING AND BILLING CO-PAY AND FOUNDATION PAYMENTS

We have one biller for the submittal of claims and EOBs that works with co-pay and foundation programs for reimbursement. The biller will review the financial navigator enrollment note based on what drops into the biller work queue. This work queue was designed to catch all patients that have been enrolled into co-pay or foundations and allows the biller to focus solely on reimbursement.

Tracking payments from co-pay and foundation used to be a challenge. Prior to having a payment code built into the EHR for co-pay assistance and foundation payments, all payments were bundled into a standard insurance payment code used by the Payment Post department. Without the payment code, use of a spreadsheet was necessary to track payments.

Our EHR has payment codes for site payments, insurance payments, co-pay payments, and several other codes for account adjustment. The big question was: Why not create a specific payment code for co-pay assistance and foundation payments? We determined that a payment code specific to these co-pay and foundation payments would be a benefit. From 2015 through 2017, a spreadsheet showed all the data that had to be manually added by our biller to reflect these payments. Demonstrating revenue through that spreadsheet was very helpful in establishing the need for a separate payment code in the EHR.

By working with the manager of the payment post department, we created a separate, specific payment code for co-pay and foundation payments, allowing management to report on and track an average of $30,000 in payments per week through the EHR. This data was very exciting, and in February of 2018, the code was activated in the EHR. By creating this code, we can justify an additional FTE financial navigator or biller in the future and demonstrate the value in assisting with minimizing out-of-pocket expenses for our cancer patients.

We are still tracking co-pay assistance and foundation payments on a spreadsheet just to make sure the process is going smoothly between payment post and our biller, but the numbers match. Our goal is to eliminate the spreadsheet by the end of 2018, and rely solely on EHR reporting on this specific code.

As for billing to co-pay assistance programs and foundations, the biller can fax and upload claims and EOBs for reimbursement. Follow-up is done via phone or portal, based on the setup of the drug manufacturer or foundation. There is a designated work queue for patients enrolled into a co-pay or foundation assistance program. Our biller works closely with financial navigators if a re-enrollment needs to be updated. The biller also uses two activity codes: one for when the co-pay assistance program or foundation is billed, and another when a payment is received. The biller always checks to make sure that the appropriate payment code is being used.

GOING FORWARD

In June 2017 DuPage Medical Group began the process of maximizing its EHR use for financial navigation. From January through June 2018, we have tripled our enrollments in patient co-pay assistance and foundation assistance programs, and we've already exceeded what was collected in co-pay and foundation payments for all of 2017. Our EHR has supported our vision and needs, and we are continuing to work with IT and other departments to bridge any gaps in communications and workflow processes to provide a better experience for the patient. ❙

Natasha Gomes serves as a team lead financial navigator at DuPage Medical Group, Downers Grove, Ill. She has more than four years of experience with oncology and infusion financial navigation and has worked within DuPage Medical Group for 13 years. Gomes graduated from Lewis University with a BS in business administration. Gomes wishes to thank her financial navigation team for their contributions — Celeste, Delorse, Sheria, and Liza.

OUR PROGRAM AT-A-GLANCE

The integrated oncology program at DuPage Medical Group provides comprehensive care for patients with all types of cancer from the time of screening through diagnosis, treatment, and recovery support. DuPage Medical Group has been granted Accreditation with Commendation from the Commission on Cancer (CoC) and is the only CoC-accredited freestanding cancer center in Illinois. DuPage Medical Group is staffed by board-certified physicians that specialize in radiology, surgical oncology, urologic oncology, medical oncology, radiation oncology, and plastic surgery who work closely with dedicated nurse navigators and genetic counselors.

Flowchart

STEP 1. Provider writes chemotherapy order for patient.

STEP 2. Chemotherapy order is sent to finance staff.

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

No Insurance	Identify if patient qualifies for any programs (SSDI, Medicaid, etc.). Identify if replacement drugs are available.	Fill out forms for all programs. Complete forms for companies that have a replacement program if patient qualifies.	Identify if foundation funding is available for any drugs not replaced.	Fill out forms for foundation funding that is available.
Medicaid Program	Verify benefits.	Verify drugs are indicated for diagnosis and authorize if necessary.	Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.	Identify patient's responsibility.
Medicare Only	Verify benefits.	Verify drugs are indicated for diagnosis.	Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.	Identify patient's responsibility.
Medicare & Supplemental	Verify benefits.	Verify drugs are indicated for diagnosis.	Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.	Identify patient's responsibility; if none, start treatment.
Medicare & Secondary	Verify benefits.	Verify drugs are indicated for diagnosis and authorize secondary insurance if necessary.	Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.	Identify patient's responsibility.
Medicare Advantage	Verify benefits.	Verify drugs are indicated for diagnosis and authorize secondary insurance if necessary.	Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.	Identify patient's responsibility.
Other Government Programs	Verify benefits.	Verify drugs are indicated for diagnosis and authorize secondary insurance if necessary.	Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.	Identify patient's responsibility.
Managed Care	Verify benefits.	Verify drugs are indicated for diagnosis and authorize secondary insurance if necessary.	Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.	Identify patient's responsibility.
Commercial & Insurance Exchanges	Verify benefits.	Verify drugs are indicated for diagnosis and authorize secondary insurance if necessary.	Identify if replacement drugs are available if necessary; will need to appeal to receive drugs.	Identify patient's responsibility.

Identify if patient qualifies for charity care within the clinic or institution and complete paperwork.	Create payment plan for any balance (if available) or collect balance.				
Collect out-of-pocket costs.					
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.		
If patient has responsibility, identify if foundation assistance is available.	Fill out forms for foundation funding that is available.	If patient qualifies, send in EOB and/or anything else to help verify amount for foundation to pay.	If any balance, create payment plan for any balance (if available) or collect balance.		
Identify if foundation assistance is available.	Fill out forms for foundation funding that is available.	If patient qualifies, send in EOB and/or anything else to help verify amount for foundation to pay.	If any balance, create payment plan for any balance (if available) or collect balance.		
Identify if foundation assistance is available.	Fill out forms for foundation funding that is available.	If patient qualifies, send in EOB and/ or anything else to help verify amount for foundation to pay.	If any balance, create payment plan for any balance (if available) or collect balance.		
Identify if foundation assistance is available.	Fill out forms for foundation funding that is available.	If patient qualifies, send in EOB and/or anything else to help verify amount for foundation to pay.	If any balance, create payment plan for any balance (if available) or collect balance.		
Identify if manu-facturer 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 manu-facturer assistance is available and fill out forms if applicable.	If no manufacturer assistance, then identify if foundation assistance is available.	Fill out forms for foundation funding that is available.	If patient qualifies for manufacturer or foundation assistance, send in EOB and/or anything else to help verify amount owed.	Process payment using co-pay card or whatever form of payment the program has.	If any balance, create payment plan (if available) or collect balance from patient.

Supporting Patients Through Their Journey on Jakafi® (ruxolitinib)

IncyteCARES (**C**onnecting to **A**ccess, **R**eimbursement, **E**ducation and **S**upport) 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:

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- Insurance benefit verification
- Information about prior authorizations
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EDUCATION & SUPPORT

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- Patient Welcome Kit

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- Access to patient advocacy organizations for counseling and emotional support resources

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Oncology Drug Database

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

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

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

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

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

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IMMUNO-ONCOLOGY INSTITUTE

As immunotherapy for cancer continues to evolve, ACCC adapts to meet the changing needs of the oncology community.

The ACCC Immuno-Oncology Institute is the only initiative dedicated to educating multidisciplinary teams to go beyond a clinical understanding of IO and tackle real-world implementation issues.

With the care of patients on immunotherapies now extending beyond the cancer team, the ACCC Immuno-Oncology Institute is at the forefront of developing critical education to empower healthcare professionals across care delivery settings.

Access resources at the intersection of science, business, operations, and policy to support all facets of immunotherapy integration at

accc-cancer.org/immunotherapy

The **Association of Community Cancer Centers (ACCC)** is the leading education and advocacy organization for the multidisciplinary cancer team. ACCC is a powerful network of 24,000 cancer care professionals from 2,100 hospitals and practices nationwide. ACCC is recognized as the premier provider of resources for the entire oncology care team. For more information, visit accc-cancer.org or call 301.984.9496. Follow us on Facebook, Twitter, and LinkedIn, and read our blog, ACCCBuzz.

The **ACCC Immuno-Oncology Institute** is the leader in optimizing the delivery of cancer immunotherapies for patients by providing clinical education, advocacy, research, and practice management solutions for cancer care teams across all healthcare settings.

Association of Community Cancer Centers

The ACCC Immuno-Oncology Institute is supported by Bristol-Myers Squibb (charitable donation); EMD Serono; Kite, a Gilead Company; and Merck & Co, Inc. (educational grant).

AbbVie, Inc.

Oncology-related products: Lupron Depot® (leuprolide acetate for depot suspension)

Patient and Reimbursement Assistance Website
abbvie.com/patients/patient-assistance.html

PATIENT ASSISTANCE

myAbbVie Assist

Assistance for Uninsured or Underinsured Patients

myAbbVie Assist provides free medicines to qualifying patients. myAbbVie Assist reviews all applications on a case-by-case basis. Participation in the program is free; the program does not collect any fees from people seeking its assistance. Patients may be eligible to receive free Lupron Depot if they:

- Have been prescribed Lupron Depot
- Have limited or no health insurance coverage
- Live in the United States
- Are being treated by a licensed U.S. health care provider on an outpatient basis
- Demonstrate qualifying financial need based on a combination of insurance coverage, household income, and out-of-pocket medical expenses. myAbbVie Assist will evaluate insurance coverage and out-of-pocket medical expenses during the application process.

If you meet the requirements above, patients should work with their healthcare provider to submit a program application. Download the application (abbvie.com/content/dam/abbvie-dotcom/uploads/PDFs/pap/Lupron-Application-approved.pdf), follow the instructions on the first page, and submit all requested information.

This program is part of the AbbVie Patient Assistance Foundation, a separate legal entity from AbbVie.

Amgen, Inc.

Oncology-related products: Aranesp® (darbepoetin alfa), Blincyto® (blinatumomab), Imlygic® (talimogene laherparepvec) suspension for intralesional injection, Kanjinti™ (trastuzumab-anns) Kyprolis® (carfilzomib) for injection, Neulasta® (pegfilgrastim), Neulasta® Onpro® (pegfilgrastim) injection kit, Neupogen® (filgrastim), Nplate® (romiplostim), Prolia® (denosumab), Sensipar® (cinacalcet), Vectibix® (panitumumab), Xgeva® (denosumab)

Patient and Reimbursement Assistance Websites
amgenassist360.com
amgenfirststep.com

PATIENT ASSISTANCE

Co-pay Assistance Support

Amgen offers co-pay coupon programs for Blincyto, Imlygic, Kyprolis, Neulasta, Neulasta Onpro, 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; $5 out-of-pocket cost for subsequent dose or cycle. Maximum benefit of $10,000 per patient per calendar year. (For Kyprolis: maximum benefit of $20,000 per patient per calendar year; for Prolia: $25 out-of-pocket for subsequenct dose or cycle, maximum benefit of $1,500 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: amgenfirststep.com/login. 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 ET.

Uninsured Patients

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

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

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

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

To apply, visit amgensafetynetfoundation.com/how-to-apply.html, select the appropriate medication, complete the Patient Application, and fax the completed application and prescription form to 1.866.549.7239.

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

Questions? Contact 1.888.762.6436, Monday through Friday, 9:00 am to 8:00 pm ET.

Amgen Assist 360™

Amgen Assist 360™ Nurse Ambassadors are there to support your treatment plan and help patients and caregivers find the resources that are most important to them so that they can stay focused on their treatment. Nurse Ambassadors are there to support, not replace, treatment plans and do not provide medical advice or case management services. They can:

- Help patients with insurance benefit verification and put them in touch with programs that may help them afford their prescribed medication
- Refer patients to independent nonprofit organizations that may provide assistance with treatment-related travel costs such as gas, tolls, parking, airfare, and lodging
- Help patients get in touch with independent nonprofit organizations that may provide community resources, local support groups, and counseling services.

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

REIMBURSEMENT ASSISTANCE

Amgen Assist 360™

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

- Insurance verifications
- Prior authorizations
- Billing and claims support and updates
- Local payer information

Amgen provides information as a courtesy only. It is not intended to be comprehensive or instructive. Coding and coverage policies can change without warning. The healthcare professional is solely responsible for determining coverage, coding, and reimbursement. Amgen does not guarantee coverage or reimbursement. Visit amgenassist360.com/hcp/patient-support/amgen-access-specialist for more.

At the Benefit Verification Center, providers can electronically submit, store, and retrieve benefit verifications for all patients currently on an Amgen product or determine regional coverage specifics with the Local Payer Wizard tool. They can assist with benefit verification support, including sending a summary of benefit letters, prior authorization details, and follow-up appeals assistance. To register your practice, visit amgenassistonline.com.

Array BioPharma

Oncology-related products: Braftovi® (encorafenib) capsules, Mektovi® (binimetinib) tablets

Patient and Reimbursement Assistance Website
braftovimektovi.com/hcp/financial-support/

PATIENT ASSISTANCE

Array ACTS®

Array is committed to helping patients access its medicines, regardless of their insurance coverage. Array can assist in providing financial support to:

- Commercially insured patients
- Government-insured patients
- Under- and uninsured patients.

To enroll in Array ACTS, download the enrollment form (braftovimektovi.com/assets/pdfs/array_acts_enrollment_form.pdf) and fax the enrollment form and prescription separately to 1.877.299.9226. An Array ACTS case manager will contact you upon receipt of a completed application.

Array Co-Pay Savings Program

Eligible commercially insured patients may pay as little as $0 per month supply of Braftovi + Mektovi. To activate the Co-Pay Savings Program, visit qv.trialcard.com/array and begin the enrollment process. In order to be eligible for the Array Co-Pay Savings Program, the patient must not have government-funded health insurance (e.g., Medicare, Medicaid, or any other federal or state program) and must be taking Braftovi + Mektovi for an FDA-approved indication.

Array Patient Assistance Program

Under- and underinsured patients may be eligible for free medicine provided through the Array Patient Assistance Program. To be eligible for this program, insured patients must have exhausted all other forms of patient assistance and meet financial criteria. Insured and uninsured patients must also meet certain eligibility criteria. Call 1.866.ARRAYCS (1.866.277.2927) for more information.

Independent Co-pay Assistance Foundations

Array ACTS can provide referrals to independent co-pay assistance foundations for eligible patients who are commercially or government-insured. Array does not influence or control the operations or eligibility criteria of any independent co-pay assistance foundation and cannot guarantee co-pay assistance after a referral. There may be other foundations to support the patient's disease state.

REIMBURSEMENT ASSISTANCE

Array ACTS™

Array ACTS provides a range of support services to help eligible patients, including:

- Benefits investigation and verification
- Prior authorizations and appeals support.

To enroll in Array ACTS, download the enrollment form (braftovimektovi.com/assets/pdfs/array_acts_enrollment_form.pdf) and fax the enrollment form and prescription separately to 1.877.299.9226. An Array ACTS case manager will contact you upon receipt of a completed application. Patients and healthcare providers are responsible for completing and submitting enrollment forms and coverage or reimbursement documentation. Array makes no representation or guarantee concerning coverage or reimbursement of any service or item.

For more information on Array ACTS and all available assistance programs, please call 1.866.ARRAYCS (1.866.277.2927).

Astellas Pharma US, Inc.

Oncology-related products: Tarceva® (erlotinib) tablets (co-marketed with Genentech, Inc.), Xospata® (gilteritinib) tablets, Xtandi® (enzalutamide) capsules

Patient and Reimbursement Assistance Website
astellaspharmasupportsolutions.com

PATIENT ASSISTANCE

Astellas Pharma Support Solutions℠

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

Xospata Support Solutions℠

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

Xospata Quick Start+® Program

The Xospata Quick Start+ Program provides a one-time, 7-day supply of Xospata at no cost to eligible patients who experience an insurance-related delay. To be eligible, patients must:

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

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

Xospata Copay Card Program

The Xospata Copay Card Program is for eligible patients who have commercial prescription insurance. The Program parameters are as follows:

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

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

The Program is not valid for patients whose prescription claims are reimbursed, in whole or in part, by any state or federal government program, including but not limited to Medicaid, Medicare, Medigap, Department of Defense (DoD), Veterans Affairs (VA), TRICARE, Puerto Rico Government Insurance, or any state patient or pharmaceutical assistance program.

Xtandi Support Solutions℠

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

Xtandi Quick Start+™ Program

The Xtandi Quick Start+ Program provides a free, one-time, 14-day supply of Xtandi to new patients who experience a delay in insurance coverage. Overnight shipping is offered directly to the patient. In

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

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

Xtandi Patient Savings Program

The Xtandi Patient Savings Program is for eligible patients who have commercial prescription insurance. The program parameters are as follows:
- Patients can pay as little as $0 per prescription
- Co-pay assistance is available for up to 12 refills during a 12-month period after enrollment (the "Enrollment Period")
- The program covers up to a maximum of $25,000 during an Enrollment Period
- There are no income requirements.

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

The program is not available to patients 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, Medigap, DoD, VA, TRICARE, Puerto Rico Government Insurance, or any state patient or pharmaceutical assistance program.

Astellas Patient Assistance Program

The Astellas Patient Assistance Program provides Xtandi and Xospata at no cost to patients who meet the program eligibility requirements. The patient may be eligible if they meet the following criteria:
- Patient is uninsured or has insurance that excludes coverage for Xtandi or Xospata
- Patient has a verifiable shipping address in the United States
- Patient has been prescribed Xtandi or Xospata for an FDA-approved indication
- Patient meets program financial eligibility requirements.

To enroll a patient in the Astellas Patient Assistance Program, complete the Xtandi or Xospata Support Solutions enrollment process. If the patient is eligible, the patient and provider will be notified, and the prescription will be shipped directly to the patient's home.

REIMBURSEMENT ASSISTANCE

Astellas Pharma Support Solutions℠

Benefits Verification

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

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

Prior Authorization

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

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

AstraZeneca

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

Patient and Reimbursement Assistance Websites
astrazenecaspecialtysavings.com
MyAccess360.com

PATIENT ASSISTANCE

AstraZeneca has a commitment to providing affordable access to its medications and wants to ensure that cost is not a barrier when a physician has determined that an AstraZeneca medication is appropriate for a patient.

Patient Savings Programs for Calquence, Faslodex, Imfinzi, Iressa, Lumoxiti, 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 1.844.ASK.A360 (1.844.275.2360).

AstraZeneca Access 360™ Program

The AstraZeneca Access 360™ program provides personal support to connect patients to affordability programs and streamline access and reimbursement for AstraZeneca's medicines. Our reimbursement counselors help 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
- Providing eligibility requirement information and enrollment assistance for specialty Patient Savings Programs
- Referring patients to patient assistance programs
- Connecting to nurse assistance or educational support programs, if applicable (not for all medicines).

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

The AZ&Me™ Prescriptions Savings Programs

The AZ&Me™ Prescriptions Savings Programs are designed to help qualifying people without insurance and those in Medicare Part D who are still having trouble affording their AstraZeneca medications. There are two programs:

- AZ&Me Prescription Savings program for people without insurance

- AZ&Me Prescription Savings program for people with Medicare Part D.

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

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 temporary enrollment and medication supply 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 a certain level
- Patient must be a legal U.S. 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.

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 temporary enrollment and medication supply 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 a certain level
- 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 U.S. resident
- Patient must not be eligible for Medicaid in their state of residence
- Patients with Medicare Part B coverage may also be eligible. Please call 1.800.AZandMe (1.800.292.6363) for more information.

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 total household income.

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

For more information, please visit azandmeapp.com or call 1.800.AZandMe.

Bayer HealthCare Pharmaceuticals

Bayer HealthCare Pharmaceuticals, Inc.

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

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

PATIENT ASSISTANCE

Xofigo Access Services

Uninsured Patients

Xofigo Access Services may provide Xofigo free of charge for eligible patients who are uninsured or who are insured but do not have coverage for Xofigo. You must apply for assistance on your patient's behalf by submitting a completed application, including a signed patient authorization. Visit https://hcp.xofigo-us.com/patient-financial-assistance for more information. 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.

Fax a completed application, including the signed patient authorization, to 1.855.963.4463. Call an Access Counselor at 1.855.6XOFIGO (1.855.696-3446), Monday through Friday, 9:00 am to 7:00 pm ET, if you have any questions or to obtain more information.

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

$0 Commercial Copay Assistance Program

Your patient may be eligible for copayment/coinsurance assistance if your patient has a private commercial plan that covers Xofigo. Patients approved for assistance will not have to pay anything to access Xofigo. Eligibility criteria include:

- Patient has private commercial insurance
- Residency in the United States, including the District of Columbia, Puerto Rico, Guam, or the U.S. Virgin Islands.

To apply, fax a completed patient assistance application including the signed patient authorization to Xofigo Access Services at 1.855.963.4463. Once approved, your patient receives an approval letter with a commercial copay/coinsurance identification (ID) card.

Medicare beneficiaries and patients with other government insurance who need help paying for treatment with Xofigo are not eligible for copay assistance through the Xofigo Access Services commercial copay/coinsurance assistance program. If your patient needs assistance with cost-share requirements, they may be eligible for copay or coinsurance assistance through an independent copay/coinsurance assistance foundation. Xofigo Access Services Access Counselors can verify your patients' coverage for Xofigo and provide information about any available foundation.

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.

Visit nexavar-us.com/co-pay-assistance/ or stivarga-us.com/getting-and-paying/REACH/ for more information.

Privately Insured Patients

- No monthly cap
- Up to $25,000 per year
- Enroll at: zerocopaysupport.com
- Obtain BIN & Group # and provide to your pharmacist.

Call 1.866.581.4992 for more information on enrolling online.

Government Insured

- Information on Part D prescription drug plans
- Financial assistance may be available through independent charitable organizations.

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

Uninsured/Underinsured

- Patient Assistance Program (PAP)
- Eligibility requirements apply
- Up to 12 months of free drug for qualified patients.
- Financial assistance may be available through independent charitable organizations.

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

Aliqopa Resource Connections

The ARC Patient Support Program offers comprehensive access, reimbursement support, and patient assistance services:

- The Bayer Patient Assistance Program provides Aliqopa free of charge for eligible patients who are uninsured or underinsured. In order to qualify for assistance, patients must meet certain eligibility criteria.
- The Temporary Patient Assistance Program is for patients whose coverage is delayed or who experience a temporary lapse in coverage for Aliqopa.
- The Aliqopa $0 Co-Pay Program is for eligible patients with commercial insurance. Patients must not be enrolled in a government-sponsored program and must meet certain other eligibility criteria to qualify for this program. If approved, the patient may pay as little as $0, with a maximum benefit of $25,000 per year.
- Referrals to independent assistance foundations for publicly insured patients and those requiring travel assistance may be provided.

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

REIMBURSEMENT ASSISTANCE

Xofigo Access Services

Xofigo Access Services provides 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 7:00 pm ET, Monday through Friday. You can also access these services online 24/7 through the Xofigo Access Services Provider Portal: xofigoaccessonline.com.

REACH®

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

Visit https://www.nexavar-us.com/co-pay-assistance/ or https://www.stivarga-us.com/getting-and-paying/REACH/ for more information.

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.

Aliqopa Resource Connections

The ARC program provides support for prescribers, office staff, patients, and caregivers through the access and reimbursement process. Access Counselors are available to provide the following support services:

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

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

Boehringer Ingelheim Pharmaceuticals, Inc.

Oncology-related product: Gilotrif® (afatinib)

Patient and Reimbursement Assistance Website
patientservices.gilotrifhcp.com

PATIENT ASSISTANCE

Gilotrif Patient Services

Provided by Accredo for non-dispensing accounts and Solutions Plus for dispensing accounts, Gilotrif Patient Services offers a range of services to help alleviate financial concerns around access for Gilotrif. Insurance coverage should not be a barrier to cancer treatment—we will explore multiple options to help a variety of patients afford their treatment.

Non-dispensing accounts can enroll in Accredo by calling 844.569.2836 or by downloading the prescription and enrollment form at patientservices.gilotrifhcp.com/sites/default/files/accredo_prescription_and_enrollment_form.pdf. Fax the completed form to 888.454.8488.

Dispensing pharmacies can apply to Solutions Plus by calling 1.877.814.3915, 8:30 am to 6:00 pm ET or by downloading the application at patientservices.gilotrifhcp.com/sites/default/files/solutions_plus_enrollment_form.pdf. Fax the completed form to 1.866.240.4556.

Co-pay Assistance Program

The Co-pay Assistance Program ensures the maximum out-of-pocket cost is no more than $0 per month (subject to a maximum monthly benefit of $5,500 and a maximum annual benefit of $25,000) for commercially insured U.S. resident patients. No income eligibility or additional paperwork is required.

Bridge Program

Eligible patients experiencing more than a 5-day payer approval delay can receive a 15-day supply of Gilotrif at no cost to the patient for the FDA-approved indications. Gilotrif Patient Services ensures the maximum out-of-pocket cost is no more than $0 per month (subject to a maximum monthly benefit of $5,500 and a maximum annual benefit of $25,000) for commercially insured U.S. resident patients.

Gilotrif Dose Exchange™

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

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

The Boehringer Ingelheim Cares Foundation Patient Assistance Program

The BI Cares Patient Assistance Program is a charitable program provided by the Boehringer Ingelheim Cares Foundation, an independent nonprofit organization, to improve patients' health and lives. The program provides Gilotrif free of charge to uninsured and underinsured U.S. patients who meet eligibility requirements. To be eligible, patients must:

- Be a resident with a physical address within the United States or U.S. Territory
- Have no health insurance coverage or not enough coverage to obtain the medication
- Not have access to alternate sources of coverage or funding for Gilotrif
- Meet household income guidelines established by BI Cares.

To submit an application, patients must complete Sections 1-4 of the application (boehringer-ingelheim.us/sites/us/files/files/gilotrif_pap_application-fillable.pdf) including signatures, and healthcare providers must complete

Sections 5-7 including an original signature. Fax the complete application to 1.855.297.5905. For more information, visit boehringer-ingelheim.us/our-responsibility/patient-assistance-program or call 1.855.297.5904, Monday through Friday, 8:30 am to 6:00 pm ET.

REIMBURSEMENT ASSISTANCE

Gilotrif Patient Services

Coverage and Access Assistance

Upon receipt of the Gilotrif Patient Services enrollment form, patient specialists investigate and verify coverage for patients within 2 business days. Patient specialists communicate prior authorization requirements for payers and assist with the reimbursement process.

For dispensing pharmacies, Boehringer Ingelheim Reimbursement and Access Managers provide appeals support upon prior authorization denial, help facilitate requests for additional information from Boehringer Ingelheim, and provide assistance with ordering Patient Support Kits.

Communication Skills 101

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

Tips for Effective Speaking

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

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

Bristol-Myers Squibb

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

Patient and Reimbursement Assistance Website
bmsaccesssupport.com

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 Assistance Program

This program 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 the co-pay for each dose of a BMS medication covered by this program. 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. Note: Absent a change in Massachusetts law, effective January 1, 2020, Massachusetts residents will no longer be able to participate in this program.

Enrollment is simple. The provider completes the application through BMS Access Support in one of the following ways:

- Download the enrollment form on your computer and fax to 1.888.776.2370.
- Enroll online with our secure portal: MyBMSCases.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 ET, Monday through Friday.

Assistance for Uninsured Patients

For patients without prescription drug insurance, or for patients who 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 for applicable medication
- Live in the United States, Puerto Rico, or U.S. Virgin Islands
- Are being treated by a U.S.-licensed physician as an outpatient
- Have a yearly income that is at or below 300% of the Federal Poverty Level. Medications that are injected and certain medications may be subject to higher limits.

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 Verification

BMS Access Support can conduct a benefits review. This will typically determine what is covered by the patient's insurance plan, whether there are any restrictions, and how much money the patient may have to pay to get their medication. A benefits review will identify whether prior authorization is required. For enrolled patients, benefits may also be reverified.

Prior Authorization

A Prior Authorization (PA) is a verification from your doctor that states that your medication is medically necessary. Your insurance company may require a PA before they will cover certain medications. BMS Access Support can provide information about this requirement. A PA is not necessary in all cases.

Claims Appeals

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

To start a benefits review or schedule a call with a care coordinator, visit bmsaccesssupport.bmscustomerconnect.com/overview-services.

Celgene Oncology

Oncology-related products: Abraxane® (paclitaxel protein-bound particles, for injectable suspension) (albumin-bound), Idhifa® (enasidenib), Pomalyst® (pomalidomide), Revlimid® (lenalidomide), Thalomid® (thalidomide), Vidaza® (azacitidine for injection)

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 per prescription with a maximum benefit of $10,000 per enrollment period.

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

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
- 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®

There are three simple ways to enroll in Celgene Patient Support®. Choose the way that is easiest:

- Patients can be enrolled in Celgene Patient Support® online at celgenepatientsupport.com
- Patients can be enrolled over the phone 1.800.931.8691, Monday to Thursday, 8:00 am to 7:00 pm ET, and Friday, 8:00 am to 6:00 pm ET (translation services available)
- Download the English or Spanish enrollment form at celgene patientsupport.com and return it to us by e-mail at patientsupport@celgene.com or fax it to us at 1.800.822.2496.

Coherus BioSciences

Oncology-related products: Udenyca® (pegfilgrastim-cbqv)

Patient and Reimbursement Assistance Website
coheruscomplete.com

PATIENT ASSISTANCE

Coherus COMPLETE™

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

Coherus COMPLETE Co-Pay Assistance Program

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

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

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

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

Patient Assistance Program

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

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

To enroll, visit login.coherus complete.com and follow the instructions.

REIMBURSEMENT ASSISTANCE

Coherus COMPLETE™

Coherus COMPLETE can assist provider offices with benefits verification. The Coherus COMPLETE Provider Portal (login.coherus complete.com) provides a single repository for all programs with streamlined electronic services to ease the administrative burden:

- Customized pre-populated data fields
- Electronic upload of patient documentation
- Electronic signatures expedite consents
- Real-time tracking of approval status
- Fewer errors that delay benefits
- Improves communication with Patient Access Specialists by providing secure, direct access

Insurance Benefit Verification
- Provides comprehensive product-specific coverage assessments
- Determines insurance eligibility based on a patient's benefit plan and payer policy.

Comprehensive Prior Authorization (PA) Services
- Identifies payer PA requirements
- Assists in PA submissions
- Provides pre-populated payer and pharmacy PA forms when necessary
- Tracks PA determinations with payers.

Coding and Billing Support
- Provides product-specific coding support
- Assists with claims submission questions.

Claims and PA Appeals Support
- Provides payer guidance for PA or claims denials
- Provides guidance on the appeal submission process
- Monitors the appeal request.

Alternative Funding Support
- Investigates alternative financial support through independent foundations for eligible patients.

Eisai Co., Ltd

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

Patient and Reimbursement Assistance Website
eisaireimbursement.com

PATIENT ASSISTANCE

The Eisai Patient Assistance Program

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

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

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

$0 Co-Pay Program

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

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

Enrollment in the $0 Co-Pay Program is automatic if the patient is receiving Lenvima from Accredo or Biologics and is required when receiving Lenvima from another source. Complete and submit the Lenvima Intake Form (lenvima.com/pdfs/specialty-pharmacy-intake-form.pdf) or call 1.866.61.EISAI (1.866.613.4724) for more information.

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

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

Step 2: If the patient is determined to be eligible, they will be sent a Welcome Letter for the Halaven $0 Co-Pay Program stating they are eligible for benefits.

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, 2019, and to all other patients through March 31, 2020. For patients prescribed Halaven, this offer is available to MA residents through June 30, 2019, and to all other patients through November 20, 2019.

REIMBURSEMENT ASSISTANCE

The Eisai Assistance Program

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

For Halaven, agents can provide information relating to payer-specific policies for coverage, information regarding billing and coding requirements, and answer questions regarding financial assistance options. Call 1.866.61.EISAI (1.866.613.4724) Monday through Friday, 9:00 am to 6:00 pm ET for all billing, coding, coverage, and financial assistance questions.

For Lenvima, specialists will complete a full benefit investigation to understand the patients' insurance coverage. If needed, specialists can also discuss options for financial assistance to help patients access Lenvima. Contact 1.866.61.EISAI (1.866.613.4724) Monday through Friday, 9:00 am to 6:00 pm ET.

Eli Lilly and Company

Lilly | ONCOLOGY

Oncology-related products: Alimta® (pemetrexed for injection), Cyramza® (ramucirumab), Erbitux® (cetuximab), Lartruvo® (olaratumab), Portrazza® (necitumumab) , Verzenio® (abemaciclib)

Patient and Reimbursement Assistance Website
LillyPatientOne.com

FOR PATIENTS

Lilly PatientOne

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

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

Lilly PatientOne Co-Pay Program

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

Eligibility criteria:

- Patient must be aged 18 years or older
- Patients must be residents of the United States or Puerto Rico
- Patients must be treated with Alimta, Cyramza, Erbitux, Lartruvo, or Portrazza for an FDA-approved indication
- Patients must be commercially insured.

Ineligible:

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

Patient Enrollment Steps:

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

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

Have any questions? Call a Lilly Field Reimbursement Manager at 1866.4PatOne (1.866.472.8663), Monday through Friday, 9:00 am to 7:00 pm ET.

Donations to Charitable Organizations

Lilly donates medicines to charitable organizations, including the Lilly Cares Foundation, a separate nonprofit organization that helps qualified people in need receive Lilly medicines at no cost. Learn more

at www.lillycares.com or by calling Lilly Cares at 1.800.545.6962, Monday through Friday, 8:00 am to 5:00 pm ET.

Independent Patient Assistance Program Foundations

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

Verzenio Savings Card

The Verzenio Savings Card is available to eligible commercially insured patients. Eligible patients can receive the first 3 months of Verzenio free. After the first 3 months, patients pay no more than $10 per month thereafter for up to 12 months of Verzenio with a $25,000 annual cap.

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

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

REIMBURSEMENT ASSISTANCE

Lilly PatientOne

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 forms can also be found at lillypatientone.com/financial-assistance)
- Upon request provide status updates for appeals that have been filed for eligible Lilly Oncology products.

Lilly PatientOne program specialists are available Monday through Friday, 9:00 am to 7:00 pm ET. Call 1.866.4PatOne (1.866.472.8663). Learn more at lillypatientone.com.

Verzenio Continuous Care™ Program

The Verzenio Continuous Care Program provides patient support throughout their metastatic breast cancer journey, offering access and assistance and ongoing services.

The Verzenio Continuous Care Program may help eligible patients minimize co-pay or out-of-pocket costs by providing the following services (the program is not a guarantee of coverage):

- A benefits investigation
- Guidance through the specialty pharmacy process
- Identification of savings opportunities.

Ongoing services:

- Reiterating Verzenio treatment information (like dosing and adverse events) that providers outlined in their office
- Guiding patients back to the provider office if they are experiencing side effects or have questions regarding their treatment
- Connecting patients to relevant disease state content and Verzenio information.

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

MyRightDose Exchange Program

With MyRightDose, your patient can continue their Verzenio therapy at the appropriate dose for them without the hassle of delays and at no cost. Medication is shipped to the patient as early as 48 hours after receipt of the enrollment form. Medication is available at no cost for up to three separate dose reductions of between 5 and 28 days of therapy per exchange to any patient prescribed Verzenio for an FDA-approved indication Additional terms and conditions apply.

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

EMD Serono, Inc. and 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 a CoverOne Enrollment Form on the CoverOne Enrollment Portal (coverone.com/en/portal/log-in.html) prior to treatment or fax the completed form and proof of income to 1.800.214.7295 prior to treatment.

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

NOTE: The CoverOne patient assistance program is a philanthropic program for patients in need, and is not contingent on any past or future commercial sale 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 completing a CoverOne Enrollment Form on the CoverOne Enrollment Portal (coverone.com/en/portal/log-in.html) prior to treatment or faxing a completed 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 may be eligible for a $0 co-pay for each treatment for Bavencio, up to a maximum of $30,000 per year. Once the annual co-pay assistance limit is reached, enrolled patients are responsible for paying all co-pays and any balance not covered by CoverOne.

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

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

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:

- 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.

Enroll through the CoverOne Enrollment Portal, or fax a completed CoverOne Enrollment Form to 1.800.214.7295 to request services.

Active Listening 101

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

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

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

Retention—take notes if necessary.

Response—respond both verbally and non-verbally.

Active Listening Tactics

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

Barriers to Active Listening

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

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

Exelixis, Inc.

Oncology-related products: Cabometyx® (cabozantinib) tablets, Cometriq® (cabozantinib) capsules

Patient and Reimbursement Assistance Websites
ease.us
cometriq.com/hcp/access/

PATIENT ASSISTANCE

Cabometyx Exelixis Access Services®

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

- The EASE Co-pay program ensures that eligible commercially insured patients pay $0 per month for a maximum benefit of $25,000 per year. Additional restrictions and eligibility rules apply. Visit activatethecard.com/7311 to enroll eligible patients.
- The EASE Patient Assistance Program helps eligible patients who cannot afford their drug costs receive Cabometyx free of charge. Additional restrictions and eligibility rules apply.
- The Cabometyx Quick Start Program helps your newly prescribed eligible patients quickly receive their therapy if they experience a payer decision delay of 5 days or more. Limited to on-label indications. Additional restrictions may apply.
- At your request, EASE can provide support with benefits investigations (BIs), prior authorization (PA) assistance, and appeals support and follow-up.

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

EASE Dose Exchange Program

The EASE Dose Exchange Program can help ensure the continuity of your patient's care by providing a lower dose when a dose adjustment is required. Patients receive a one-time supply of Cabometyx to help them transition to a lower dose; 15 days of free product are provided in the event a dose reduction is required. Additional restrictions and eligibility rules apply. To apply, download the EASE Dose Exchange Form (cabometyxhcp.com/downloads/DoseExchangeForm.pdf) and fax it to 1.844.901.EASE (1.844.901.3273).

Cometriq Exelixis Access Services

Exelixis Access Services (EASE) is a personalized support program that provides information about how patients can afford Cometriq treatment. Specialists at EASE are available by phone to help with:

- Ordering Cometriq
- Financial assistance
- Information about Cometriq.

Exelixis Access Services is designed to minimize financial barriers to therapy for commercially insured patients. Funding specialists are available to assist in enrolling eligible patients into available patient assistance programs.

- The Co-pay Assistance Program provides help with out-of-pocket costs for patients who meet the program's eligibility requirements.
- The Patient Assistance Program provides Cometriq free of charge to patients who do not have insurance coverage and who meet eligibility requirements.

- Alternative funding investigation provides assistance with identification of alternate funding for people who do not qualify for our sponsored programs.

For more information and to enroll in EASE for Cometriq, call 1.855.253.EASE (1.855.253.3273).

REIMBURSEMENT ASSISTANCE

Cometriq Exelixis Access Services

Exelixis Access Services has dedicated oncology support specialists to assist healthcare professionals, including:

- Benefit coverage specialists to support benefit investigations, prior authorizations, appeals, and delivery coordination
- Appeals specialists to assist with further authorization requirements.

For more information, call 1.855.253.EASE (1.855.253.3273).

Insurance Verification Form

Update ❑ New ❑ Patient Name: _____

ID/SSN #: _____ Patient Insurance ID _____

Group Policy # _____ Insurance Company: _____

Primary Insurance? _____ Secondary? _____ Tertiary? _____

Authorization/referral # _____

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: _____

❑ Part A ❑ Part B Medicare HMO? _____

Medicare Supplement? ❑ Yes ❑ No Medigap Plan? _____

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

Genentech, Inc.

Genentech
A Member of the Roche Group

Oncology-related products: Alecensa® (alectinib) capsules, Avastin® (bevacizumab), Cotellic® (cobimetinib) tablets, Erivedge® (vismodegib), Gazyva® (obinutuzumab), Herceptin® (trastuzumab), Herceptin Hylecta™ (trastuzumab and hyaluronidase-oysk), Kadcyla® (ado-trastuzumab emtansine), Perjeta® (pertuzumab) for injection, Polivy™ (polatuzumab vedotin-piiq), Rituxan® (rituximab), Rituxan Hycela® (rituximab and hyaluronidase human), Tarceva® (erlotinib), Tecentriq® (atezolizumab), Venclexta® (venetoclax), Zelboraf® (vemurafenib) tablets

Patient and Reimbursement Assistance Website
genentech-access.com

PATIENT ASSISTANCE

Genentech Access Solutions

The Genentech Patient Foundation

The Genentech Patient Foundation gives free Genentech medicine to people who don't have insurance coverage or who have financial concerns. Patients will get free Genentech medicine if they:

- Do not have insurance or coverage for their Genentech medicine and their household makes less than $150,000 per year
- Have insurance, can't afford their out-of-pocket costs, have used all available financial assistance, and meet certain income requirements (found online at gene.com/patients/patient-foundation/see-if-you-qualify).

To get started, fax the completed Enrollment Form (gene.com/download/pdf/Genentech_Patient_Foundation_Enrollment_Form.pdf) to 833.999.4363. Once an eligibility determination has been made, both the patient and prescriber will be contacted to discuss the application outcome and any next steps.

Genentech BioOncology® Co-pay Assistance Program

This co-pay card helps patients pay for prescription medication costs. Qualified patients must:

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

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

To get started, call 855.MYCOPAY (855.692.6729) or visit Copay AssistanceNow.com.

Referrals to Co-pay Assistance Foundations

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

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

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

REIMBURSEMENT ASSISTANCE

Genentech Access Solutions

Benefits Investigation

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

- Treatment is covered
- Prior authorization is required
- Treatment is denied.

A BI can be initiated once the Prescriber Service Form and the Patient Consent Form are submitted. Forms can be found by going to genentech-access.com, selecting the prescribed medication, and selecting the "Forms and Documents"section.

Prior Authorization Assistance

Access Solutions can help you identify if a prior authorization (PA) is necessary and offer resources as to obtain it. PA support can be provided once the Prescriber Service Form and the Patient Consent Form are submitted.

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

Appeals

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

If a plan issues a denial:

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

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

My Patient Solutions™

My Patient Solutions is an online tool to help you enroll and manage your Genentech Access Solutions service requests. Features of My Patient Solutions:

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

To register, visit genentech-access.com and follow the instructions. For assistance, call 866.422.2377, Monday through Friday, 9:00 am to 8:00 pm ET.

Heron Therapeutics

Oncology-related products: Cinvanti® (aprepitant) injectable emulsion, Sustol® (granisetron) extended-release injection

Patient and Reimbursement Assistance Website
heronconnect.com

PATIENT ASSISTANCE

Heron Connect™

Heron Therapeutics is committed to making a difference in patients' lives with innovative products and a suite of support services. Heron Connect provides support programs that meet the needs of patients and providers. Our access solutions include:

- Convenient access for eligible patients through $0 copay, deductible assistance up to $200 per treatment, and patient assistance programs
- Comprehensive support for practices to assist with patient benefit coordination
- Dedicated reimbursement counselors to help with patient enrollment, appeals, product access, and more
- The Heron Commitment Program™, which helps mitigate the financial burden of qualifying claim denials when programs are met.

For more information on Heron Connect, call 1.844.HERON11 (1.844.437.6611), Monday through Friday, 8:00 am to 8:00 pm ET.

Heron Connect Copay Assistance Program

Commercially insured patients can benefit from $0 out-of-pocket costs for Cinvanti or Sustol with the availability of copay assistance from Heron Therapeutics. When applicable, patients may also be eligible for deductible assistance up to $200 per treatment. Limitations apply.

Offer not valid as follows: (a) patients covered under Medicare, Medicaid, or any federal or state program; (b) where plan covers treatment for the patient for the entire cost of the prescription drug. Patients pay $0 per copay per dose per 12-month calendar period. When applicable, deductible assistance up to $200 per treatment will be covered. For cash-paying patients, the program will cover $150 per prescription up to $1,800 per calendar year. Eligibility is for 12 months, after which patient will need to reapply for continued assistance.

To verify benefits and enroll your patients, download and complete the Insurance Verification and Program Enrollment Form (heronconnect.com/pdfs/Insurance-Verification-and-Program-Enrollment-Form.pdf) and fax the form to 1.844.504.8652. Practices that verify benefits directly can use simplified registration at heroncopay.com. Those practices can also complete a one-time Practice Copay Assistance Program Enrollment Form (heronconnect.com/pdfs/Practice-Copay-Assist-Program-Enroll-Form.pdf). Once the practice enrollment form is complete, individual patients can be enrolled by completing the Patient Copay Assistance Program Registration Form (heronconnect.com/pdfs/Patient-Copay-Assist-Program-Registration-Form.pdf). Fax forms to 1.844.504.8652.

Heron Connect Patient Assistance Program

Eligible patients may choose to enroll in the Heron Connect Patient Assistance Program (PAP). This program is for patients with financial hardship who meet program eligibility criteria to receive Heron medications at no cost. Heron Therapeutics reserves the right, at its sole discretion, to discontinue the Heron Connect Patient Assistance Program or change the qualifications at any time. All patient information remains confidential. Product supply for the program depends on availability.

To verify benefits and enroll your patients, complete the Insurance Verification and Program Enrollment Form (heronconnect.com/pdfs/Insurance-Verification-and-Program-Enrollment-Form.pdf).

Fax the form along with the prescription for the Heron medication to 1.844.504.8652.

Heron Commitment Program™

Heron Therapeutics is dedicated to ensuring patients and providers have access to Heron medications. The Heron Commitment Program helps mitigate the economic burden of denials; in the event of a qualifying claim denial, the program will credit your practice for the cost of the administered medication when program requirements are met. More information on this program is available at heronconnect.com/pdfs/Heron-Commitment-Program-Information-Sheet.pdf.

The Heron Commitment Program and the other product support programs offered by Heron Therapeutics do not impose any purchase obligation at any time or in any manner. Use of Cinvanti and/or Sustol may be discontinued at any time, without penalty. A qualifying claim denial can be reviewed for the Heron Commitment Program when, for a patient covered under commercial insurance, the following criteria have been met, and documentation confirms: (a) the verification of benefits, conducted by the provider and/or Heron Connect, meets all of the payer criteria and/or policy requirements, (b) the submitted claim for the Heron product is denied, and (c) the claim has been denied again by the commercial payer after the first level of appeals process has been followed.

To enroll your practice, complete a one-time Heron Commitment Program Enrollment Form (heronconnect.com/pdfs/Heron-Commitment-Program-Practice-Enrollment-Form.pdf) and fax the form to 1.844.504.8652.

REIMBURSEMENT ASSISTANCE

Heron Connect™

Heron Connect services provide the access solutions you need:

- ***Dedicated reimbursement counselors.*** Your counselor will be a single point of contact for your practice to help patients with enrollment in Heron Connect programs and insurance verification; assist with prior authorization, appeals, billing, reimbursement, and coding; track outcomes; and provide other services to support patients and help them secure product coverage.
- ***Prior authorization and appeals support.*** Sample forms and letters are available online at heronconnect.com.
- ***Drug replacement.*** In the event that the Heron medication is determined to be unfit for patient use or has expired, Heron Therapeutics will replace the affected units. Call Heron Connect for more information at 1.844.HERON11 (1.844.437.6611). Determination will be made by the manufacturer of the drug.
- ***Product information.*** Call if you have a clinical inquiry or would like to report an adverse event related to the Heron medication.

For more information on Heron Connect, call 1.844.HERON11 (1.844.437.6611), Monday through Friday, 8:00 am to 8:00 pm ET.

Incyte Corporation

Oncology-related products: Jakafi® (ruxolitinib) tablets

Patient and Reimbursement Assistance Website
incytecares.com

PATIENT ASSISTANCE

IncyteCARES

IncyteCARES (Connecting to Access, Reimbursement, Education and Support) is designed to help eligible patients gain access to Jakafi. IncyteCARES provides a single point of contact through an oncology-certified nurse. IncyteCARES nurses work one-on-one with patients to identify ongoing support, resources, and referrals to help meet their needs during treatment with Jakafi. Specifically, IncyteCARES nurses can help eligible patients with:

- Reimbursement support
- Delivery coordination
- Financial assistance options
- Temporary access for coverage delays
- Connection to support resources
- Ongoing education and support

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

Completed hard-copy forms should be faxed to 1.855.525.7207. Once the IncyteCARES program receives the completed enrollment form, the program will:

- Confirm the patient's drug coverage for Jakafi
- Coordinate their Jakafi prescription with the appropriate specialty pharmacy
- Determine if the patient qualifies for any financial assistance
- Provide ongoing education and support.

For additional help, call an IncyteCARES registered nurse at 1.855.4.JAKAFI (1.855.452.5234).

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. In addition, patients insured through Medicare, Medicaid, TRICARE, and healthcare exchange plans are not eligible. An Incyte CARES nurse can help determine if patients qualify for patient assistance. For additional help, call an IncyteCARES registered nurse at 1.855.4.JAKAFI (1.855.452.5234).

Co-pay/Coinsurance Assistance

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 healthcare 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 $11,977 per month and $25,000 per year. 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. This offer expired for Massachusetts residents on July 1, 2017.

If you have any questions, please call 1.855.4.JAKAFI (1.855.452.5234).

Temporary Access

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

Referral to an Independent Nonprofit Organization

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.

INOs 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:

- Support 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.

For more information, call 1.855.4.JAKAFI (1.855.452.5234).

Ipsen Biopharmaceuticals, Inc.

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

Patient and Reimbursement Assistance Website
ipsencares.com

PATIENT ASSISTANCE

IPSEN CARES®

The IPSEN CARES® (Coverage, Access, Reimbursement & Education Support) program was designed to simplify the process of applying and getting coverage for Ipsen medications, as well as related care, for adult patients, pediatric patients, and their parents. Eligible patients may save on out-of-pocket prescription costs for certain Ipsen products. Patients and providers can call 866.435.5677, Monday through Friday, 8:00 am to 8:00 pm ET, to begin the enrollment process. You can also enroll patients online at: ipsencaresportal.biologicsinc.com/Account/Login or download the drug-specific enrollment form from ipsencares.com and fax the signed and completed form to 1.888.525.2416. IPSEN CARES offers the following services for patients:

- Help minimize delays or interruptions in treatment
- Provide financial assistance, including copay assistance or free medication to eligible patients
- 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 Copay Program

The Somatuline Depot Copay Program is available to eligible commercially insured and uninsured patients by enrolling in IPSEN CARES. Most eligible patients pay no copay subject to a maximum annual benefit of $20,000. Program exhausts after 12 months, 13 injections, or a maximum annual benefit of $20,000, whichever comes first. The maximum copay benefit per prescription for cash-paying patients is $1,666.66, subject to the $20,000 annual maximum. Patients must enroll annually to receive continued benefit. For more information, visit ipsencares.com/somatuline-patient-support or call 866.435.5677.

Onivyde Copay Program

The Onivyde Copay Program is available to eligible commercially insured and uninsured patients by enrolling in IPSEN CARES. Patients pay $0 per order up to a maximum annual copay benefit of $20,000. For patients with government-provided insurance, IPSEN CARES may be able to offer the contact information for independent nonprofit foundations that may be able to offer financial assistance. The maximum copay benefit per prescription for cash-paying patients is $1,666.66, subject to the $20,000 annual maximum. For more information, visit ipsencares.com/onivyde-patient-support or call 866.435.5677.

Patient Assistance Program

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

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

REIMBURSEMENT ASSISTANCE

IPSEN CARES

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

- ***Benefits Verification:*** IPSEN CARES will help determine patient's coverage, restrictions (if applicable), and copayment 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 ET.

2018–2019 Federal Poverty Guidelines*

Family Size	100%	133%	138%	250%	400%
1	$12,140	$16,146	$16,753	$30,350	$48,560
2	$16,460	$21,892	$22,715	$41,150	$65,840
3	$20,780	$27,637	$28,676	$51,950	$83,120
4	$25,100	$33,383	$34,638	$62,750	$100,400
5	$29,420	$39,129	$40,600	$73,550	$117,680
6	$33,740	$44,874	$46,561	$84,350	$134,960
7	$38,060	$50,620	$52,523	$95,150	$152,240
8	$42,380	$56,365	$58,484	$105,950	$169,520

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

Janssen Biotech, Inc.

Oncology-related products: Balversa™ (erdafitinib), Darzalex® (daratumumab), Doxil® (doxorubicin HCl liposome injection), Erleada® (apalutamide), Procrit® (epoetin alfa), Sylvant® (siltuximab), Yondelis® (trabectedin), Zytiga® (abiraterone acetate)

Patient and Reimbursement Assistance Website
JanssenCarePath.com

PATIENT ASSISTANCE

Janssen CarePath

Janssen CarePath is your one source for resources focused on access, affordability, and treatment support for your patients. The Care Coordinator team supports all prescribed Janssen medications. Janssen CarePath can help make it easier for you and your patients to get the resources you both may need.

Access Support

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

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

Affordability Support

Janssen CarePath can help find affordability assistance for patients with that may be available for patients taking Janssen medications. Janssen CarePath

- Support for patients using commercial or private insurance
- Support for patients using government insurance
- Support for patients without insurance coverage
- Patient Account and Provider Portal for convenient online enrollment of eligible patients into Savings Programs.

Treatment Support

Janssen CarePath provides additional support to patients, including:

Education tools

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

Adherence tools

- Personalized reminders
- Access to the Care4Today® Connect Mobile App.

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

Call a Janssen CarePath Care Coordinator at 877.CarePath (877.227.3728), Monday through Friday, 9:00 am to 8:00 pm ET. Multilingual phone support is available.

Janssen CarePath Savings Program

Janssen CarePath Savings Program can help eligible patients with their out-of-pocket costs for their Janssen medication. Depending on their health insurance plan, savings may apply toward co-pay, co-insurance, or deductible. Patients may be eligible if they are using commercial or private health insurance to cover a portion of their medication costs for the Janssen medication. There is no income requirement. This program is not available to individuals who use any state or federal government-subsidized healthcare program to cover a portion of medication costs, such as Medicare, Medicaid, TRICARE, Department

of Defense, or Veterans Administration. Patients confirm that they will not seek reimbursement from any of these programs or from pharmaceutical patient assistance foundations and accounts such as a Flexible Spending Account (FSA), Health Savings Account (HSA), or Health Reimbursement Account (HRA).

Janssen CarePath Savings Program for Erleada

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

Janssen CarePath Savings Program for Zytiga

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

Janssen CarePath Savings Program for Darzalex

Eligible patients will pay $5 per infusion, with a $20,000 maximum program benefit per calendar year. Program provides a rebate to patients for out-of-pocket medication costs for Darzalex. Program does not cover cost to give patients their infusion. To learn more about the Janssen CarePath Savings Program for Darzalex, including full eligibility requirements, visit JanssenCarePath.com/Darzalex.

Janssen CarePath Savings Program for Yondelis

Eligible patients will pay $5 per infusion, with a $20,000 maximum program benefit per calendar year. Program provides a rebate to patients for out-of-pocket medication costs for Yondelis. Program does not cover cost to give patients their infusion. To learn more about the Janssen CarePath Savings Program for Yondelis, including full eligibility requirements, visit JanssenCarePath.com/Yondelis.

Other Affordability Options

For patients using government insurance or patients without insurance coverage, Janssen CarePath can provide information about independent resources that may be able to help with out-of-pocket medication costs:

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

†Independent co-pay assistance foundations have their own rules for eligibility. We cannot guarantee a foundation will help your patient. We have no control over these independent foundations and can only refer the patient to a foundation that supports their disease state. We do not endorse any particular foundation.

JanssenPrescriptionAssistance.com provides information on affordability programs and information about independent foundations† that may have funding available to help patients with medication costs for Janssen medications.

Or call Janssen CarePath at 877-CarePath (877-227-3728) to speak with a Care Coordinator about affordability programs that may be available.

Johnson & Johnson Patient Assistance Foundation

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

REIMBURSEMENT ASSISTANCE

Janssen CarePath Provider Portal

Janssen CarePath understands that navigating payer processes and finding cost support options may seem complicated at times. That's why we've created an enhanced Provider Portal experience. The Janssen CarePath Provider Portal gives healthcare providers and pharmacies 24-hour online access to:

- Request benefits investigations
- Review the status of benefits investigations
- Enroll your eligible, commercially insured patients in the Janssen CarePath Savings Program
- View savings program transactions for enrolled patients
- Receive notifications when new information is available or action is required on the Portal.

Create a Provider Portal account at JanssenCarePathPortal.com.

Janssen CarePath Patient Account

Patients can create a Janssen CarePath Account at MyJanssenCarePath.com where they can:

- Check their insurance coverage for Janssen medications
- Check eligibility and enroll in the Janssen CarePath Savings Program
- Manage Savings Program transactions
- Sign up for treatment reminders.

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

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.

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

Kite Pharma

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

Patient and Reimbursement Assistance Website
kitekonnect.com

PATIENT AND REIMBURSEMENT ASSISTANCE

Kite Konnect™

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

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

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

How to Check for Patient Understanding

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

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

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

Merck

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

Vaccine: Gardasil®9 (Human Papillomavirus 9-valent Vaccine, Recombinant)

Patient and Reimbursement Assistance Websites
merckaccessprogram.com
merckhelps.com

PATIENT ASSISTANCE

Merck Access Program

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

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

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

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

Merck Patient Assistance Program

The Merck Patient Assistance Program provides product free of charge to eligible individuals, primarily the uninsured who, without assistance, could not afford needed Merck medicines. A single application may provide up to 1 year of product free of charge to eligible individuals, and an individual may reapply as many times as needed.

Eligibility criteria include:

- Patient is legal resident of the United States or U.S. territories
- Patient does not have insurance or other coverage for your prescription medicine
- Patient meets income requirements.

Sometimes exceptions need to be made based on the patient's individual circumstances. If the patient does not meet the prescription drug coverage criteria, their income meets the program criteria, and there are special circumstances of financial and medical hardship that apply to their situation, they can request an exception be made.

To enroll, patients and providers must complete the Patient Assistant Program Enrollment Form (merckhelps.com/docs/MPAP_Enrollment_Form_CORP-1083762-English.pdf in English, merckhelps.com/docs/MPAP_Enrollment_Form_Spanish.pdf in Spanish) and mail it to the address on the form. If you have any questions about the Merck Patient Assistance Program including the status of an application, please call 1.800.727.5400, Monday through Friday, 8:00 am to 8:00 pm ET.

The Merck Co-pay Assistance Program for Keytruda

The Merck Co-pay Assistance Program offers assistance to eligible patients who need help affording Keytruda. Co-pay assistance may be available for patients who:

- Are a resident of the United States (including Puerto Rico)
- Have private health insurance that covers Keytruda under a medical benefit program
- Have been prescribed Keytruda for an FDA-approved indication

- Meet financial eligibility requirements as set forth in the terms and conditions (found at merckaccessprogram-keytruda.com/hcp/the-merck-copay-assistance-program/)
- Meet all other criteria of the program.

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

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

Merck Vaccine Patient Assistance Program for Gardasil®9

The Merck Vaccine Patient Assistance Program provides vaccines free of charge to eligible individuals, primarily the uninsured who, without assistance, could not afford needed Merck vaccinations. Eligibility criteria include:

- Patient is legal resident of the United States or U.S. territories and is 19 to 26 years of age
- Patient does not have insurance or other coverage for your prescription medicine
- Patient meets income requirements.

Sometimes exceptions need to be made based on the patient's individual circumstances. If the patient does not meet the prescription drug coverage criteria, their income meets the program criteria, and there are special circumstances of financial and medical hardship that apply to their situation, they can request an exception be made.

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

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

REIMBURSEMENT ASSISTANCE

Merck Access Program

Benefit Investigations

MAP can contact insurers to request coverage and benefits information. Visit the specific product site for additional resources.

Prior Authorizations

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

Appeals

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

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

Mylan

Oncology-related products: Fulphila® (pegfilgrastim-jmdb) injection

Patient and Reimbursement Assistance Website
mylanadvocate.com

PATIENT ASSISTANCE

MYLAN ADVOCATE™

MYLAN ADVOCATE provides access support for Fulphila and Fulphila's associated services. Services include insurance benefits verification, coding information, and field reimbursement support. MYLAN ADVOCATE can also identify solutions such as copay assistance for commercially insured patients, patient assistance for qualified patients who cannot afford their medication, and contact information for other resources, such as third-party charitable foundations, as appropriate.

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

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

MYLAN ADVOCATE Co-Pay Assistance Program

The MYLAN ADVOCATE Co-Pay Assistance Program is open to both new and existing eligible patients who are residents of the U.S. or Puerto Rico and who have commercial insurance. This co-pay assistance program can be used to reduce the amount of an eligible patient's out-of-pocket expense for Fulphila up to the full amount of the patient's out-of-pocket expense per prescription up to $10,000 per 12-month period.

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

REIMBURSEMENT ASSISTANCE

MYLAN ADVOCATE™

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

- ***Coding and billing information.*** Mylan can provide information about applicable coding for Fulphila and its administration. (Note: Coding information is provided for informational purposes only; the physician must determine the appropriate code for each patient and payer.)
- ***Insurance coverage verification.*** Mylan can help check patient insurance plan enrollment status.
- ***Benefit investigation.*** Mylan can assist in researching patient-specific insurance

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

- ***Prior authorization/reauthorization assistance and tracking.*** Mylan can assist in checking PA requirements, submission details, and track status, as well as provide offices with payer-specific forms.
- ***Coverage/claim appeal assistance and tracking.*** Mylan can verify appeal requirements and track the status and resolution of appeals.
- ***Field reimbursement support.*** A reimbursement expert from your area can visit your cancer program for live educational programs on coverage and reimbursement information or to assist with questions related to Fulphila access.

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

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

Novartis Pharmaceuticals Corporation

Oncology-related products: Afinitor® (everolimus) tablets, Afinitor Disperz® (everolimus) tablets for oral suspension, Arzerra® (ofatumumab) injection, Exjade® (deferasirox) tablets for oral suspension, Farydak® (panobinostat) capsules, Femara® (letrozole) tablets, Gleevec® (imatinib mesylate) tablets, Jadenu® (deferasirox) tablets, Kisqali® (ribociclib) tablets, Kymriah® (tisagenlecleucel) suspension for IV infusion, Mekinist® (trametinib) tablets, Odomzo® (sonidegib), Piqray® (alpelisib), 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, Zykadia® (ceritinib) capsules

Patient and Reimbursement Assistance Websites
hcp.novartis.com/access
https://www.patient.novartisoncology.com

PATIENT ASSISTANCE

The Novartis Patient Assistance Foundation

This foundation provides assistance to patients experiencing financial hardship and/or 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
- Not have private or public prescription coverage. (NOTE: Exception process exists.)

Questions? Contact the Novartis Patient Assistance Foundation at: 1.800.277.2254, or go online to: https://www.patient.novartisoncology.com. There are two ways to enroll in the program:

- Enroll online by visiting pharma.us.novartis.com/info/patient-assistance/patient-assistance-enrollment.jsp, selecting the appropriate Novartis medication from the drop down menu, and following the instructions
- Call 1.800.277.2254 to enroll by phone.

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 medic tions listed below:

- Afinitor
- Exjade
- Gleevec
- Jadenu
- Kisqali
- Mekinist
- Piqray
- Promacta
- Rydapt
- Sandostatin LAR Depot
- Tafinlar
- Tasign
- Tykerb
- Votrient
- Zykadia.

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.

Independent Charitable Foundations

There are a variety of independent charitable foundations that may be

able to provide additional assistance. Select your condition at http://www.patient.novartisoncology.com/financial-assistance/private-insurance/ to see a list of some of the foundations that may be able to help.

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

Kymriah Cares™

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

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

REIMBURSEMENT ASSISTANCE

Patient Assistance Now Oncology (PANO)

Novartis Oncology is committed to helping patients get the medicines they need. Getting access to medications can sometimes be difficult or confusing. Patient Assistance Now Oncology (PANO) offers tools and support designed specifically to help make that process easier, including:

- Insurance benefits verification, including information on denial of coverage and/or appeals
- Patient Support Counselors who are able to provide information in over 160 languages
- Patient Navigators who provide 1-on-1 support specific to a patient's medication (varies by medication)
- Free trial of medication or free access programs (varies by medication; this offering is for approved uses/indications only)
- Dedicated case managers with a private extension for you to reach them directly when needed
- A combination of PANO case managers and/or field reimbursement managers are available to help depending on the complexity of a patient's case.

To enroll your patient, visit hcp.novartis.com/access. To learn more, call 1.800.282.7630.

Pfizer, Inc.

Oncology-related products: Aromasin® (exemestane tablets), Bavencio® (avelumab) injection (co-marketed with EMD Serono, Inc.), Besponsa® (inotuzumab ozogamicin), Bosulif® (bosutinib) tablets, Camptosar® (irinotecan HCl injection), Daurismo™ (glasdegib), Ellence® (epirubicin hydrochloride injection), Emcyt® (estramustine phosphate sodium capsules), Ibrance® (palbociclib), Idamycin PFS® (idarubicin hydrochloride for injection), Inlyta® (axitinib) tablets, Lorbrena® (lorlatinib), Mylotarg™ (gemtuzumab ozogamicin), Sutent® (sunitinib malate), Talzenna® (talazoparib), Torisel® (temsirolimus) injection, Trazimera™ (trastuzumab-qyyp), Vitrakvi® (larotrectinib) (co-marketed with Loxo Oncology Inc.), Vizimpro® (dacomitinib), Xalkori® (crizotinib) capsules, Zinecard® (dexrazoxane for injection), Zirabev™ (bevacizumab-bvzr)

Patient and Reimbursement Assistance Website
pfizeroncologytogether.com

PATIENT ASSISTANCE

Pfizer Oncology Together™

Pfizer Oncology Together offers personalized assistance to help your patients get the treatment you've prescribed. Their support complements the care patients receive in your office and goes beyond financial assistance and treatment information. From connecting patients to third-party organizations that help patients get to treatment-related appointments to finding local patient support events and programs—Pfizer here to help.

Pfizer offers access and reimbursement services to help your patients get Pfizer medication, including benefits verification, prior authorization assistance, and appeals assistance. Pfizer will 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.

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

Pfizer Oncology Together Co-Pay Savings Program

Commercially insured patients may qualify for the Pfizer Oncology Together Co-Pay Savings Program. Through the Pfizer Oncology Together Co-Pay Savings Card, patients pay a $0 co-pay per eligible monthly prescription for select Pfizer medications. The maximum annual benefit is $25,000.

The card is not valid for prescriptions that are eligible to be reimbursed, in whole or in part, by Medicaid, Medicare, TRICARE, or other federal or state healthcare programs, as well as the Government Health Insurance Plan available in Puerto Rico. For more information, call 1.877.744.5675 or visit pfizeroncologytogether.com and select the medication.

Pfizer Patient Assistance Program

Eligible patients may receive up to a 90-day supply of medication for free while applying for Medicaid. If patients do not qualify for Medicaid, they may be able to get a 1-year supply of medication for free through

the Pfizer Patient Assistance Program, or at a savings through the Pfizer savings Program. Patients must meet eligibility requirements and reapply as needed.

To qualify for free medicine, patients must:

- Have been prescribed an eligible Pfizer medicine
- Live in the United States or a US territory
- Have no prescription coverage or not enough coverage to pay for their Pfizer medicine
- Meet certain income limits (income limits vary by product and household size).

The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation. The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc. with distinct legal restrictions. For more information, call 1.877.744.5675 or visit pfizeroncologytogether.com and select the medication.

Support from Independent Charitable Organizations

For Medicare or government-insured patients, Pfizer can assist in searching for financial support that may be available from independent charitable foundations. These foundations exist independently of Pfizer and have their own eligibility criteria and application process. Availability of support from the foundations is determined solely by the foundations. If independent charitable foundation support is not available, Pfizer may be able to help insured patients receive Pfizer medications for free through the Pfizer Patient Assistance Program.

REIMBURSEMENT ASSISTANCE

Pfizer Oncology Together

Pfizer Oncology Together wants to help you and your staff find solutions for access and reimbursement issues that may arise. Pfizer will assist with handling benefits verification, offering prior authorization and appeals assistance, and coordinating with specialty pharmacies.

- ***Benefits verification:*** Pfizer can conduct a benefits verification to determine the patient's health insurance coverage, including co-pay responsibility and out-of-pocket cost for eligible Pfizer medication.
- ***Prior authorization:*** Pfizer will coordinate with the insurer to determine all prior authorization requirements, where and how to submit requests, and typical turnaround times. Pfizer will also follow up with the payer on behalf of the patient and track the process until a final outcome is determined.
- ***Appeals assistance:*** If your patient's claim is denied, Pfizer can work with you to review the reason for the denial and help you better understand the appeals process. Once the appeal is submitted, Pfizer will follow up with the payer on behalf of the patient and track the process until a final outcome is determined.
- ***Pharmacy coordination:*** Pfizer provides support in identifying specialty pharmacy options, or you and your staff can continue to work directly with specialty pharmacies.

To get started, fax a completed enrollment form to 1.877.736.6506 or call 1.877.744.5675, Monday through Friday, 8:00 am to 8:00 pm ET.

Pharmacyclics, LLC

Oncology-related products: Imbruvica® (ibrutinib)

Patient and Reimbursement Assistance Website
imbruvica.com/youandi

PATIENT ASSISTANCE

YOU&i™ Instant Savings Program

Through this program, patients with commercial insurance and who meet eligibility requirements will pay no more than $10 per prescription for Imbruvica. This program is not valid for patients enrolled in Medicare, Medicaid, or other state or federal programs. Maximum limit of $24,600 per calendar year. To enroll in the program, visit https://sservices.trialcard.comCoupon/YouAndI/. For more information, call 1.877.877.3536, Monday through Friday, 8:00 am to 8:00 pm ET.

For patients with federally funded Medicare, Medicaid, or commercial insurance, YOU&i can also provide information on independent foundations that may be able to provide patients with additional financial support.

The Johnson & Johnson Patient Assistance Foundation, Inc., may be able to provide access to Imbruvica to uninsured patients who lack the financial resources to pay for them. Contact a JJPAF program specialist at 1.800.652.6227, 9:00 am to 6:00 pm ET, or visit the foundation website at jjpaf.org to see if they might qualify for assistance.

YOU&i™ Start Program

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

REIMBURSEMENT ASSISTANCE

YOU&i™ Support Program

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

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

To learn more about the YOU&i Support Program, call 1.877.877.3536, Monday through Friday, 8:00 am to 8:00 pm ET.

Nurse Call & Support Resources

The You&i Support Program has nurses who are available to support patients with:

- A resource-filled Starter Kit designed for new patients containing disease information, tips on building a medication routine, adherence tools, and more
- Nurse call support personalized to patients' preferences for frequency and method of contact
- Referrals of patients seeking medical advice back to their healthcare providers.

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

Puma Biotechnology

Oncology-related product: Nerlynx® (neratinib)

Patient and Reimbursement Assistance Website
nerlynx.com/access-and-support

PATIENT ASSISTANCE

Puma Patient Lynx™

Puma Patient Lynx is designed to provide patients with the support needed throughout their course of treatment. The following support services are available to patients prescribed Nerlynx:

Patient Assistance Program: For patients who are uninsured and meet certain financial qualifications, Nerlynx can be provided for free through the Patient Assistance Program. Please call reimbursement specialists at 1.855.816.5421 for more information. Referrals can also be made to nonprofit foundations for patients who are not commercially insured and are in need of financial support.

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

Nerlynx Quick Start: The Nerlynx Quick Start program provides a 21-day supply of Nerlynx at no charge for eligible patients experiencing a delay in coverage through health insurance. Patients must reside in the United States or its territories.

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

Supportive Care Voucher Program: The voucher program provides a 3-month supply of certain products used for antidiarrheal treatment to eligible patients. Patients can access the voucher provided in their Starter Kits with their first shipment of Nerlynx from a specialty pharmacy, or contact a Puma Biotechnology Clinical Specialist Sales Representative for more information.

Nurse Call Center: The nurse call center is an additional resource for patients and healthcare providers. Registered nurses are available to speak with patients and healthcare providers to answer questions about NERLYNX. The call center is open 24 hours a day, 7 days a week for your convenience. Please call our nurses at 1.855.816.5421 for more information.

Text Message Support Program: Patients can sign up to receive medication reminders and motivational messages to support treatment adherence. Message and data rates may apply. Message frequency determined by user. Text HELP to 90803 for help and STOP to 90803 to cancel. Go to carespeak.com/terms for terms and privacy. Call 1.855.816.5421 for more information.

Mentor Program: The Nerlynx Mentor Program connects women who have questions with women who know what it's like to experience Nerlynx. This free program is available to all women with early-stage HER2+ breast cancer who are considering Nerlynx or who have been prescribed Nerlynx. Call 1.855.816.5421 for more information.

REIMBURSEMENT ASSISTANCE

Puma Patient Lynx™

For patients prescribed with Nerlynx, Puma Patient Lynx can conduct a benefits investigation, verify insurance approval or coverage, and assist with the submission of necessary documentation for patients requiring prior authorization.

For more information on the Puma Patient Lynx Support Program, call 1.855.816.5421, Monday through Friday, 9:00 am to 8:00 pm ET.

REGENERON
SCIENCE TO MEDICINE®

SANOFI GENZYME

Regeneron Pharmaceuticals, Inc., and Sanofi Genzyme

Oncology-related products: Libtayo® (cemiplimab-rwlc)

Patient and Reimbursement Assistance Website
libtayohcp.com/accessinglibtayo

PATIENT ASSISTANCE

LIBTAYO Surround™

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

LIBTAYO Surround Copay Program for Eligible Commercially Insured Patients

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

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

Patients are responsible for any out-of-pocket cost for Libtayo that exceeds the program assistance limit of $25,000 per year, in addition to non–product-specific expenses related to supplies, procedures, or physician-related services. To be eligible:

- Patients must have commercial or private insurance, which includes state or federal employee plans and health insurance exchanges. (Note: patients who do not have commercial or private insurance are not eligible.)
- Patients must be residents of the United States or its territories or possessions.
- Other restrictions apply.

There are two ways to enroll patients in the LIBTAYO Surround Copay Program:

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

LIBTAYO Surround Patient Assistance Program

The LIBTAYO Surround Patient Assistance Program helps eligible patients who are uninsured or who lack coverage for Libtayo receive Libtayo at no cost. Patient eligibility:

- Patients must be uninsured, lack coverage for Libtayo, or have Medicare Part B with no supplemental insurance coverage.
- Patients must be residents of the

United States or its territories or possessions.
- Patients must enroll in LIBTAYO Surround by signing Section 9 of the LIBTAYO Surround Enrollment Form (libtayohcp.com/-/media/EMS/Conditions/Oncology/Brands/LibtayoHCP/pdf/LIBTAYO%20Surround%20Enrollment%20Form_US-LIB-1001.pdf) and the Health Insurance Portability and Accountability Act of 1996 authorization in Section 10.
- Patients must have an annual gross household income that does not exceed the greater of $100,000 or 500% of the federal poverty level.
- Other restrictions apply.

LIBTAYO Surround facilitates the enrollment process. To assist patients who wish to enroll in this program, a LIBTAYO Surround Reimbursement Specialist is available to investigate the patient's eligibility criteria, notify the healthcare provider about the patient's eligibility, coordinate shipment of Libtayo to the healthcare provider's practice or other site of care, send confirmation of patient enrollment in the LIBTAYO Surround Patient Assistance Program, and contact the healthcare provider's office to coordinate future shipments.

Identification of Alternate Sources of Funding

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

To assist patients, a Reimbursement Specialist will:
- Identify alternate coverage programs for which patients may be eligible and explain the benefits they provide
- Answer questions about the application process for each program
- Provide patients with the appropriate program's contact information.

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

Once an alternate source is identified and the patient applies for assistance, a LIBTAYO Surround Reimbursement Specialist may be able to follow up with the patient and/or healthcare provider's office staff about the status of the application and communicate the result.

REIMBURSEMENT ASSISTANCE

LIBTAYO Surround™

LIBTAYO Surround™ provides assistance with the reimbursement process. To enroll, download the LIBTAYO Surround Enrollment Form (libtayohcp.com/-/media/EMS/Conditions/Oncology/Brands/LibtayoHCP/pdf/LIBTAYO%20Surround%20Enrollment%20Form_US-LIB-1001.pdf), make sure each field is complete and accurate, sign the form, and fax the completed form to 1.833.853.8362.

Upon enrollment, a Reimbursement Specialist can provide the following assistance:
- Benefits investigation, which addresses:
  - How the medication may be covered under the patient's health plan
  - Acquisition options for the patient's medication
  - The patient's eligibility for copay assistance
  - Any additional coverage information to facilitate the patient's access to medication.
- Prior authorization, appeal, and claims assistance.

Once the patient's coverage requirements have been verified, LIBTAYO Surround is available to provide ongoing support to facilitate approval of and reimbursement for Libtayo for eligible patients:
- Prior authorization support to review and explain payer requirements
- Appeal assistance when prior authorizations are denied
- Claims assistance to address questions as healthcare providers prepare claims and to review the status of claims with the patient's health insurer.

Sandoz, Inc.

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

Patient and Reimbursement Assistance Website
zarxio.com/resources/patient-support

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 is available to assist patients with:

- Benefit investigations
- Prior authorization support
- Appeals support
- Sandoz One Source Commercial Co-Pay Program eligibility
- Independent foundation information
- Patient assistance program
- Billing and coding support
- General payer policy information.

To enroll, visit qv.trialcard.com/zarxiohub or download and complete the enrollment form (zarxio.com/globalassets/zarxio7/resources/sandoz-one-source-enrollment-form.pdf) and fax it to 1.844.726.3691. Questions? Call 844.SANDOZ1 (844.726.3691), Monday through Friday, 8:00 am to 8:00 pm ET.

Sandoz One Source Co-Pay Program

The Sandoz One Source Commercial Co-Pay Program for Zarxio supports eligible, commercially insured patients with their out-of-pocket co-pay costs for Zarxio. Eligible patients may pay $0 out of pocket for their first dose or cycle of Zarxio and $0 out of pocket for subsequent doses or cycles up to a maximum annual benefit of $10,000. There is no income eligibility requirement for this program.

Maximum benefit of $10,000 annually. Prescription must be for an approved indication. This program is not health insurance. This programis for insured patients only; cash-paying or uninsured patients are not eligible. Patients are not eligible if prescription for Zarxio is paid, in whole or in part, by any state or federally funded programs, including but not limited to Medicare (including Part D, even in the coverage gap) or Medicaid, Medigap, VA, DOD, or TriCare, or private indemnity plans that do not cover prescription drugs, or HMO insurance plans that reimburse the patient for the entire cost of their prescription drugs, or where prohibited by law.

Co-Pay Program may apply to out-of-pocket expenses that occurred within 120 days prior to the date of the enrollment. Co-Pay Program may not be combined with any other rebate, coupon, or offer. Co-Pay Program has no cash value. Sandoz reserves the right to rescind, revoke, or amend this offer without further notice.

There are three ways to enroll:

1. Instruct your patients to enroll online at qv.trialcard.com/zarxio.
2. Submit an online Sandoz One Source enrollment form at qv.trialcard.com/zarxiohub.
3. Download and fax a completed Sandoz One Source enrollment form to 1.844.726.3695.

Questions? Call 1.844.SANDOZ1 (1.844.726.3691), Monday through Friday, 9:00 am to 8:00 pm ET.

REIMBURSEMENT ASSISTANCE

Sandoz One Source™

Sandoz One Source offers a variety of reimbursement assistance services for patients and providers, 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.

You can download the enrollment form, or enroll your patients online via the Sandoz One Source Provider Portal at zarxio.com/resources/patient-support. Call 1.844.SANDOZ1 (1.844.726.3691), Monday through Friday, 9:00 am to 8:00 pm ET with more questions.

Seattle Genetics

Oncology-related products: Adcetris® (brentuximab vedotin)

Patient and Reimbursement Assistance Website
seagensecure.com

PATIENT ASSISTANCE

SeaGen Secure™ Patient Assistance Program

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

There are three ways to enroll:

- Enroll online at seagensecure.com
- Complete the Patient Assistance/ Benefits Investigation Form (seagensecure.com/assets/docs/USP-BVP-2015-0124(3)_SeaGen_Secure_PAP_Form_v03_interactive.pdf) and fax it to 855.557.2480
- Call a SeaGen Secure case manager at 855.4SECURE (855.473.2873).

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

Coinsurance and Deductible Assistance

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

REIMBURSEMENT ASSISTANCE

SeaGen Secure reimbursement services include:

- Benefits investigation
- Prior authorization assistance
- Billing and coding assistance
- Claims and appeals assistance.

Benefits Investigation

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

If patients need help with cost sharing, they will be assessed for eligibility for assistance or referred to an independent foundation for co-pay assistance.

Claims and Appeals Assistance

SeaGen Secure Case Managers can help providers track claims to ensure they are being processed and paid on time. For insured patients with denied or underpaid claims, SeaGen Secure will assist with the appeal and assess for patient assistance.

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

Taiho Oncology

Oncology-related product: Lonsurf® (trifluridine and tipiracil) tablets

Patient and Reimbursement Assistance Websites
taihopatientsupport.com

PATIENT ASSISTANCE

Taiho Oncology Patient Support™

Taiho Oncology Patient Support offers the following services:

- ***Co-pay support*** for eligible, privately or commercially 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. They may also be eligible for the Patient Assistance program.

*As of May 1, 2018, The co-pay for all dose strengths of Lonsurf has been reduced from $30 to $0 per treatment cycle. This reduction is available to all patients with commercial prescription insurance coverage for Lonsurf.

There are three ways to enroll in Taiho Patient Support:

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

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 communication with patients about prescription status.
- ***Personalized nurse support*** is available for treatment plan adherence upon request.

Takeda Oncology

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

Patient and Reimbursement Assistance Websites
takedaoncology1point.com
velcade.com/paying-for-treatment

PATIENT ASSISTANCE

Takeda Oncology 1Point™

Takeda Oncology 1Point:

- Works with healthcare providers and insurance companies to help patients get started on their medication
- Identifies available financial assistance that may be right for patients
- Connects patients to additional support services and resources.

To enroll, download the Takeda Oncology 1Point Enrollment Form (takedaoncology1point.com/pdf/Takeda_Oncology_1Point_Enrollment_Form.pdf) and fax the completed and signed form along with a copy of the patient's insurance card and prescription to 1.844.269.3038.

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

Takeda Oncology Co-Pay Assistance Program

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

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

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

Takeda Oncology Patient Assistance Program

For patients who do not have insurance or who do not have insurance that covers their medication, they may be eligible to receive their medication through the Patient Assistance Program at no cost. To be eligible for the Patient Assistance Program, patients must meet certain clinical, financial, and insurance coverage criteria.

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

If the patient qualifies, they may be enrolled for up to 1 year. Upon enrollment, a Takeda Oncology 1Point case manager will notify the patient and their healthcare provider. A 1-month supply of their medication will be delivered to the patient at no cost. Each month a Takeda Oncology 1Point case manager will confirm with patient and provider that they are still being treated and are eligible to receive another month's supply of medication.

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), option 2, Monday through Friday, 8:00 am to 8:00 pm ET. Fax completed forms to: 800.891.9843. Learn more online at velcade.com or by calling 1.866.VELCADE (1.866.835.2233) and choosing option 2.

REIMBURSEMENT ASSISTANCE

Takeda Oncology 1Point™

Case managers at Takeda Oncology 1Point are a patient's connect to personalized support. Once a patient is enrolled in Takeda Oncology 1Point, the program:

- Works with the healthcare provider and insurance company to help determine if medication is covered.
- Works with the patient's pharmacy to arrange the delivery of medication
- Evaluates patient eligibility for available support and financial assistance programs (terms and conditions apply)
- Connects patients to a range of support services and additional resources, such as transportation assistance.

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

RapidStart Program

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

Velcade Reimbursement Assistance Program

The Velcade Reimbursement Assistance Program (VRAP) helps patients and providers navigate the reimbursement process. Call 1.866.VELCADE (1.866.835.2233), option 2, Monday through Friday, 8:00 am to 8:00 pm ET, to speak with a live Reimbursement Case Manager about insurance or coverage questions. The hotline accepts calls from patients, caregivers, physicians, and other healthcare professionals.

VRAP provides the following services to patients and providers:

- Insurance verification
- Claim appeals support (VRAP does not file claims or appeal claims for callers and cannot guarantee success in obtaining reimbursement)
- Identification of alternate and supplemental insurance coverage options
- Co-payment foundation support information
- Screening and enrollment of eligible patients into the Patient Assistance Program
- Transportation.

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), option 2, Monday through Friday, 8:00 am to 8:00 pm ET. Fax

completed forms to: 800.891.9843. Learn more online at velcade.com or by calling 1.866.VELCADE (1.866.835.2233) and choosing option 2.

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

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

TerSera Therapeutics

Oncology-related products: Varubi® (rolapitant) tablets, Zoladex® (goserelin acetate implant)

Patient and Reimbursement Assistance Website
terserasupportsource.com

PATIENT ASSISTANCE

TerSera Support Source

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

Co-Pay Assistance

The Zoladex and Varubi co-pay cards provide medical and pharmacy benefits for eligible patients. For eligible commercially insured patients, the cards carry a maximum benefit of $2,000 per calendar year. For Zoladex, eligible cash-paying patients will receive $500 off each one-month supply. You are not eligible if prescriptions are paid by any state or other federally funded programs, including but not limited to Medicare or Medicaid, Medigap, VA, DOD, or TRICARE, or where prohibited by law. Visit activatethecard.com/7526 to enroll for Zoladex, or visit activatethecard.com/7774 to enroll for Varubi.

Patient Assistance Programs

Zoladex

The challenges of dealing with a treatment can be made more difficult when a person lacks any form of insurance. TerSera is committed to helping eligible patients access Zoladex through the TerSera Therapeutics Patient Assistance Program. If patients qualify, they may get free TerSera medicine for up to 1 year. TerSera will send them an application for renewal once their enrollment ends. Medicines can be sent to the patient's home or the doctor's office; most medicines are sent in a 90-day supply. Patients may qualify for the program if they:

- Are a US Resident, or a Green Card or Work Visa holder
- Meet certain household income limits
- Do not have prescription drug coverage that helps pay for your TerSera medicines.

To apply, visit zoladexhcp.com/pdf/patient-assist-enroll_form.pdf. For more information, call 1.844.ZOLADEX (1.844.965.2339).

Varubi

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

REIMBURSEMENT ASSISTANCE

TerSera Support Source

TerSera Support Source provides a comprehensive suite of services to help patients get the treatment they deserve, including:

- Reimbursement information
- Prior authorization information
- Benefits investigation
- Appeals support.

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

Tesaro, Inc.

Oncology-related products: Zejula® (niraparib) capsules

Patient and Reimbursement Assistance Website
togetherwithtesaro.com

PATIENT ASSISTANCE

TOGETHER with TESARO™

TOGETHER with TESARO is a patient resource program that provides medication access and affordability services to patients taking Zejula. Our expert case management team facilitates a seamless process to ensure that patients and providers get the individualized support needed, including:

- Benefits investigation
- Prior authorization and appeals support
- Quick Start and Bridge Programs
- Commercial Co-pay Assistance Program
- Patient Assistance Program
- Referrals to patient advocacy and independent co-pay foundations.

There are three ways to enroll:

- Enroll your patient online by going to togetherwithtesaro.com and following the online portal instructions.
- Download the drug-specific enrollment form, complete it, and fax it to 1.800.645.9043.
- Contact a case manager (togetherwithtesaro.com/find-my-case-manager) or call 1.844.2TESARO (1.844.283.7276), Monday through Friday, 8:00 am to 8:00 pm ET to learn more or begin the enrollment process.

Commercial Co-pay Assistance Program

The TOGETHER with TESARO Commercial Co-pay Assistance Program may reduce out-of-pocket costs for commercially insured patients. The program reduces co-pay and/or coinsurance to $0 with a $26,000 annual maximum. The virtual card can be initiated and utilized by specialty pharmacies in Tesaro's limited distribution network or in-office dispensing sites.

The Commercial Co-pay Assistance Program is not retroactive. It can only be applied forward from the date of enrollment for 12 months and must be renewed a year after enrollment. Checks are sent biweekly directly to healthcare providers. To enroll, visit activatethecard.com/tesaro.

Quick Start and Bridge Programs

Providers can prescribe a 15-day supply of Zejula at no cost in the event of an insurance coverage delay. This will be provided only if there is a coverage-related delay at first dispense (Quick Start) or an interruption in coverage for patients already on treatment (Bridge) so that treatment can start or continue according to the patient's treatment plan. Terms and conditions apply. The program covers up to 5 refills pending resolution of related coverage delay.

Patient Assistance Program

The Patient Assistance Program provides product to eligible uninsured and underinsured patients who have demonstrated financial hardship. This program supports eligible patients who have a household income up to 500% of the current Federal Poverty Level. Patient signature is required on the Patient Consent for Patient Assistance Program Form found at togetherwithtesaro.com.

TOGETHER with TESARO can also refer patients to independent co-pay foundations which can assist patients in finding other sources of financial support based on their eligibility. For information, call 1.844.2TESARO (1.844.283.7276), Monday through Friday, 8:00 am to 8:00 pm ET.

REIMBURSEMENT ASSISTANCE

Benefits Investigation

TOGETHER with TESARO provides a benefits investigation for providers and patients at no cost. Once patient consent is obtained and the patient is enrolled in TOGETHER with TESARO, their case manager will look into specific coverage and benefits details and provide providers with the results. The patient may also separately ask for a benefit investigation or receive the requested results.

Prior Authorization and Appeals Support

TOGETHER with TESARO offers prior authorization/precertification facilitation and appeals support for denied claims. We cannot sign or submit prior authorizations or letters of appeal on your behalf, but we can support providers in the process. If the provider chooses to handle these independently, sample letters can be downloaded to assist in providing documentation and requests to the patient's health plan. For more information, visit togetherwithtesaro.com or call 1.844.2TESARO (1.844.283.7276), Monday through Friday, 8:00 am to 8:00 pm ET.

Patient Assistance Checklist for Medicaid 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.
❑ 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

TEVA Oncology

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 8:00 pm ET. Then download the appropriate enrollment application for the Teva medication you have prescribed at: tevacares.org/DownloadApplication.aspx. Completed applications should be faxed to 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

Teva offers Comprehensive Oncology Reimbursement Expertise (CORE) to patients, caregivers, and healthcare professionals to help patients better understand reimbursement eligibility. Teva CORE representatives are available at 1.888.587.3263, Monday through Friday, 9:00 am to 6:00 pm ET, for assistance with the following:

- Benefit verification and coverage determination
- Pre-certification and prior authorization support
- Coverage guidelines and claims investigation assistance
- 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/enrollment. Fax the completed form to 866.676.4073. Providers can also create an account and enroll their patients online.

Adaptive Biotechnologies

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

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

PATIENT ASSISTANCE

Adaptive Assist™

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

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

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

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

In most cases, Adaptive Biotechnologies will send a notification letter indicating your final program eligibility determination within 10 working days following receipt of your fully completed and signed application. An incomplete form may result in delays to processing and/or enrollment.

Foundation Medicine

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

Patient and Reimbursement Assistance Website
access.foundationmedicine.com/

PATIENT ASSISTANCE

FoundationAccess™

Financial assistance may be available for based on the patient's financial situation. If the patient is uninsured or cannot afford the applicable out-of-pocket cost, contact the Client Services team, 888.988.3639, Monday through Friday, 8:00 am to 8:00 pm ET, with regard to eligibility. To apply for financial assistance or download a paper application, visit access.foundationmedicine.com.

Patients with Medicare

For many patients with advanced solid tumor cancer, FoundationOne CDx is covered by Medicare. If the patient is on Medicare and meets the following criteria, they may not have out-of-pocket expenses for their FoundationOneCDx solid tumor testing:

- The patient has either recurrent, relapsed, refractory, metastatic, or advanced stages III or IV cancer.
- This is their first time having a FoundationOne CDx test for this cancer diagnosis or have had a FoundationOne CDx test before, but this is a different type of cancer—a "new primary" cancer diagnosis
- They have decided to seek further cancer treatment such as therapeutic chemotherapy; and
- Their testing is ordered by a treating physician.

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

Patients with Private Insurance

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

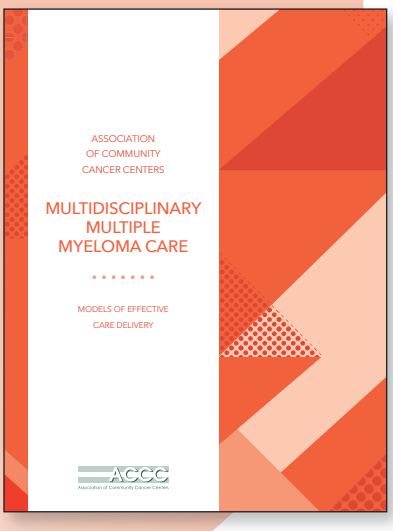
If the insurance company denies coverage, with patient consent, we will work on behalf of the patient to attempt to obtain coverage and will work with the patient and doctor in pursuing appeals to minimize the financial burden. If the patient is eligible for financial assistance, this is applied to their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

Note: If the patient has private/commercial insurance, a prior authorization form may be required in some cases.

ASSOCIATION OF COMMUNITY
CANCER CENTERS

DELIVERING EFFECTIVE MULTIPLE MYELOMA CARE

The **Multidisciplinary Multiple Myeloma Care** project delivers effective practices and vetted resources to support the cancer care team in the diagnosis, treatment, and management of multiple myeloma patients.



Models of Effective Care Delivery

This new publication offers a convenient summary of recent updates in the management of this heterogeneous disease, including:

- Diagnostic Criteria by the International Myeloma Working Group
- Revised International Staging System
- ASCO Clinical Practice Guideline Update: Role of Bone-Modifying Agents in Multiple Myeloma

Plus, read how three cancer programs—a community-based comprehensive program, an academic medical center, and an NCI-designated program—are delivering multidisciplinary care to this patient population.

Online Resource Center

Access a robust resource compendium comprised of multifaceted information to support your role in caring for patients with multiple myeloma.

Regional Lecture Series

View on-demand webinars that outline how to effectively manage patients with high-risk profiles and the need for a team-based approach to care.

Access at accc-cancer.org/multiple-myeloma-care

In partnership with:

MM RF MULTIPLE MYELOMA Research Foundation

Funding and support is provided by:

AMGEN Oncology

ACCC
Association of Community Cancer Centers

The **Association of Community Cancer Centers (ACCC)** is the leading education and advocacy organization for the multidisciplinary cancer team. ACCC is a powerful network of 25,000 cancer care professionals from 2,100 hospitals and practices nationwide. ACCC is recognized as the premier provider of resources for the entire oncology care team. For more information visit accc-cancer.org or call 301.984.9496. Follow us on Facebook, Twitter, and LinkedIn, and read our blog, ACCCBuzz.

Want to hear fresh perspectives in oncology care delivery ON THE GO?

Stream or subscribe to the ACCC podcast, **CANCER BUZZ** —smart conversations that unpack the issues and spark insight! Where stakeholders from the front lines of cancer care to the C-suite, research through registry, and chairside to benchside, explore emerging topics and their real-world impact.

ACCC
Association of Community Cancer Centers

Access episodes at accc-cancer.org/podcast or on your favorite podcast app to hear the latest buzz—anytime, anywhere.

Other Patient Assistance Programs & Resources

Aging care.com®
agingcare.com

A web-based resource for caregivers, including the Prescription Drug Assistance Program Locator: agingcare.com/Articles/prescription-drugassistance-program-locator-171753.htm. This tool allows older adults and their families to search for financial aid programs for prescription medications. Search for prescription drug assistance plans by state 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. Patients can apply for many of the programs online or print an application form. Here are the types of expenses patients may get help with:

- Medications
- Food
- Utilities
- Legal
- Healthcare
- Housing
- In-home services
- Taxes
- Transportation
- Employment training.

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

- Their income is below $18,210 if single or $24,690 if married
- Their combined savings, investments, and real estate are not worth more than $14,100 if single or $28,150 if married (see online for exclusions).

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 Program. Patients will also find out if there are other benefits programs that can save them money. Apply online at: benefitscheckup.org/medicare-rx-extra-help-application-welcome.

CancerCare®
cancercare.org

CancerCare provides limited finan-cial 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. In order to be eligible for financial assistance patients must:

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

Here's how to apply:

1. Call 800.813.HOPE (4673) and speak with a CancerCare social worker to complete a brief interview, Monday through Thursday, 10:00 am to 6:00 pm ET, and Friday, 10:00 am to 5:00 pm ET.
2. If patients are eligible to apply, we will:
    - Mail the patient an individualized barcoded application
    - Request documentation to verify the patient's income.
3. Patients must submit a com-pleted 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 applications 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 or five 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). Patients must sign and attest that their primary diagnosis matches our fund, and additional documentation may be requested by the prescribing physician on a case-by-case basis. Patients must currently be undergoing chemotherapy or prescribed and/or using a targeted treatment drug when they apply to CCAF.
- ***Insurance.*** Patients must have insurance that covers a portion of their medications. Some funds are restricted to assist only those covered by a federal health insurance program such as Medicare, Medicaid, or TRICARE, while others accept both private and federal insurance.
- ***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), Monday through Friday, 9:00 am to 7:00 pm EST, and Friday, 9:00 am to 5:00 pm EST, 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: portal.cancercare copay.org.

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 (copays.org/patients) available 24 hours a day.
2. Medical providers may apply on behalf of their patients via the Provider Online Application Portal (copays.org/providers) available 24 hours a day.
3. Pharmacies may apply on behalf of their patients via the Pharmacy Online Application Portal (copays.org/pharmacy) 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.

FamilyWize®
familywize.org

Since 2005, FamilyWize has offered a free prescription discount program for patients nationwide, saving money on prescription drugs that are excluded by insurances plan or that are not covered because patients have exceeded their insurance plan's maximum limits. Through partnerships with major and regional chain pharmacies, FamilyWize negotiates discounted prices on all FDA-approved prescription medications.

The free FamilyWize Prescription Discount Card (familywize.org/free-prescription-discount-card) never expires and is available both as a physical card and as a convenient mobile app. Patients, healthcare providers, and pharmacists can use FamilyWize to ensure the lowest possible price for a prescription medication is paid at the counter.

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

Prescription drug discount card must be presented with prescription to a participating pharmacy to obtain the discount price. Pricing is always the lesser of the discounted price or pharmacy's retail price. If the pharmacy's price is less, there is no discount. Cannot be used with other prescription cards. All benefits are subject to change without notice. Some restrictions apply.

Learn more at familywize.org, or call 800.222.2818.

Good Days®
mygooddays.org

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

Good Days covers what insurance won't—the costly co-pays for drugs and treatments that can extend life and alleviate suffering. Good

Days also has a premium assistance program for patients with a qualified diagnosis who need help paying their monthly medical insurance premiums. Their Travel Concierge Program helps those eligible with everything from air travel to overnight stays to parking, when medically necessary as determined by prescribing physicians.

Good Days has streamlined the enrollment process so patients can receive immediate determination of eligibility for financial assistance. Eligibility criteria:

- Patient must be diagnosed with a covered disease and program must be accepting enrollments
- Patient must have a valid Social Security number to apply for assistance and receive treatment in the United States
- Patient must be seeking assistance for a prescribed medication that is FDA approved to treat the covered diagnosis
- Patient is required to have valid insurance coverage
- Patient income level must be at or below 500% of the Federal Poverty Level (FPL).

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

HealthWell Foundation®
healthwellfoundation.org

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.

To be eligible, patients must meet certain criteria:

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

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, Monday through Friday, 9:00 am to 5:00 pm ET.

NOTE: Providers, pharmacists, 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, be sure to contact the company that makes the medication the patient needs. Manufacturers have generous assistance programs that exceed what most non-profit foundations can offer, particularly for commercially insured patients.

Here's what is needed to complete the application:

- Patient contact, household income, and insurance information
- Specific disease, treatment, and physician information, including the office fax number
- Type of assistance requested (co-pay or premium)

If approved, HealthWell allocates each patient a grant for a rolling 12 months, after which patient or provider may reapply as long as funding is available. Grant amounts vary by disease state. Patients will receive a HealthWell Pharmacy Card and a Reimbursement Request Form. Patients can use reimbursement forms in cases where they cannot use their pharmacy card. Patients must use their grant at least once every 120 days to keep their grant active. There are no restrictions on the provider or pharmacy a patient selects. Patients are free to change medications, providers, or pharmacies at any time, as long as the eligibility criteria continues to be met. Patients can change assistance type—co-pay to premium or premium to co-pay—one time during their enrollment period.

All patients who have been approved for a grant are subject to an income documents review. During the review process, the patient's grant will be temporarily inactive until their income has been verified.

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

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

The Leukemia & Lymphoma Society
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: lls.org/support/financial-support/co-pay-assistance-program).

Apply online at: cprportal.lls.org/

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

Patient Aid Program

The Patient Aid Program provides financial assistance to blood cancer patients in active treatment. Eligible patients will receive a one-time $100 stipend to help offset cancer related expenses. Program continuation is dependent on the availability of funds and the program could be modified or discontinued at any time if funding is limited or no longer available. To be eligible, patients must:

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

Apply online at unpportal.lls.org or by phone at 866.446.7377, Monday through Friday, 8:30 am to 5:00 pm ET.

NeedyMeds
needymeds.org

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 Applications 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: 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 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, 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. The card cannot be used in combination with any insurance. Download a card and learn more about its benefits at www.needymeds.org/drug-discount-card. Information on other drug discount cards are also available on the NeedyMeds website.
- ***Diagnosis-Based Assistance:*** There are many government and privately-funded programs that help with costs associated with a specific diagnosis. 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 also has a list of Medicaid sites where you can learn more about Medicaid in your state, as well as general information on Medicaid.

For all questions, call 1.800.503.6897, Monday through Friday, 9:00 am to 5:00 pm ET or email info@needymeds.org.

Partnership for Prescription Assistance

pparx.org

The Partnership for Prescription Assistance (PPA) helps qualifying uninsured and underinsured patients connect to the right assi-stance 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: 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 yourpatient to be considered. If you need assistance, please visit pparx.org/wizard-help or call 1.888.4PPA.NOW (1.888.477.2669).

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/NATDISLTR.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 federally or commercially insured patients with chronic, rare, or life-threatening illnesses. Providers and their patients can apply for assistance by calling 1.866.316.7263 or online through the Pan Foundation Provider Portal: 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 United States or U.S. territories. (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 the following information:

- Diagnosis and medication name
- Demographics: Name, address, phone number, email address, and Social Security Number
- Income: Adjusted gross income applicable to the patient and all members of the patient's household
- Insurance: Health insurance and pharmacy card(s)
- Physician demographics: Prescribing physician's name, phone number, and facility address.

Step 4. 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.

Patient Advocate Foundation
patientadvocate.org

The Patient Advocate Foundation (PAF) is a national non-profit charity that provides direct services to patients with chronic, life-threatening, and debilitating diseases to help access care and treatment recommended by their doctor. It offers the following services:

Case management services: Professional case managers at PAF work with the mission to identify and reduce the challenges that individuals have when seeking care for their disease. Case management services are available on behalf of patients meeting all of the following criteria:

- Have a confirmed diagnosis of a chronic disease, a life-threatening disease, or debilitating disease, or be seeking screening services related to symptoms or suspicion of a chronic, life-threatening, or debilitating disease
- Be in active treatment, had treatment within the past 6 months, or going into treatment in the next 60 days
- Be a U.S. Citizen or Permanent Resident of the U.S.
- Be receiving treatment at a facility in the United States or one of its US territories.

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

MedCareLine: A division of PAF, the MedCareLine's team of professional case managers assist with disability, health insurance navigation including prior authorization, appeals for denied services, second opinion options and screening for clinical trials. The case managers also assist patients who are experiencing financial challenges that are impacting their ability to pay for care and basic cost of living expenses like housing, utilities, food, and transportation, researching and linking them to available financial support programs that may meet some of these needs. Uninsured patients are also supported by

the program with direct support in accessing public programs, health insurance enrollment, and charity care that will allow access to necessary care. For more information, visit patientadvocate.org/connect-with-services/case-management-services-and-medcarelines.

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

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

Questions? Call 1.800.532.5274, Monday through Thursday, 8:30 am to 5:00 pm ET, and Friday, 8:30 am to 4:00 pm ET.

RxAssist
rxassist.org

RxAssist offers a comprehensive database of these patient assistance programs, as well as practical tools, news, and articles so that health care professionals and patients can find the information they need in one place. Go to rxassist.org/search and search by either drug name or company name.

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

RxAssist Prescription Savings Card

With the RxAssist Prescription Savings Card, patients can save up to 85 percent where they already fill their prescription. Savings are possible with insurance, and there is no additional cost to use the card. The card is active for immediate use by patients, family, and friends. Visit rxassist.org/coupon/generic?type=patients, call 877.537.5537, or email info@rxassist.org for more information.

RxHope™
rxhope.com

Healthcare providers and their staff can set up accounts online to order free medications for their patients through the RxHope automated patient assistance online system. If you would like to create a free account for one healthcare provider, visit: rxhope.com/Prescriber/SetupAccount.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: 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 can be found online at rxoutreach.org/find-out-if-you-are-eligible.

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
    - Information on patient allergies and current medications
    - Patient income and household size
    - For faster service, you can include credit card information for payment at this time.
5. The patient should receive a prescription for a 180-day supply with one refill or a 90-day supply with three refills. The patient can provide payment by credit or debit card online or by phone, or check or money order sent in the mail.
6. Fax the prescription and application to 1.800.875.6591 or mail it to Rx Outreach, PO Box 66536, St. Louis, MO, 63166-6536.

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

Tips for Assisting Patients in Applying to Patient Assistance Programs

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

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

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

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

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

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

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FINANCIAL ADVOCACY NETWORK

875+ cancer programs and practices enrolled

2,075+ participants in 50 states

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

Who Should Enroll?

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

Cost

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

***ENROLL at* accc-cancer.org/FANBootCamp**

The ACCC Financial Advocacy Network is supported by:

Pfizer Oncology

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

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

ACCC
Association of Community Cancer Centers

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1801 Research Boulevard, Suite 400
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