SANDOZ ONE SOURCE® ENROLLMENT FORM

Dear HealthCare Professional,

Thank you for choosing the Sandoz One Source Program. Please take a moment to read brief instructions on how to complete our One Step form. Please note: An incomplete form may lead to delays in processing your request.

Product Selection *(Please enter product name in Section 3)*

☐ Zarxio® (filgrastim-sndz)

Follow the steps below to complete the Enrollment Form

Benefit Verification (BV), Prior Authorization, Denials/Appeals Information, Commercial Co-Pay Program and/or Information on External Resources (Complete Sections 1-7)

Section 1: Patient Information - Please complete this section with all relevant information. Please note that Social Security number is only required for PAP requests.

Section 2: Insurance Information - Please include policy information for both your patient's primary and secondary insurance (as applicable). It helps to include a copy of the front and back of the patient's insurance card(s).

Section 3: Treatment & Prescription Information – Please provide patient's treatment and prescription information. PLEASE NOTE: An on label diagnosis code for the Sandoz product is required. Both a primary and a secondary ICD/Dx *may* be required. Remember to enter Drug name in the first row of this section.

Section 4: Prescriber Information - Complete with all relevant information, including office/primary contact person.

Section 5: Patient Authorization & Signature – Be sure to have the patient sign the Patient Authorization.

Section 6: Prescriber Authorization - Remember to sign the Prescriber Authorization.

Section 7: Commercial Co-Pay Program - Be sure to have the patient sign this Section if requesting enrollment into the commercial co-pay program.

BV and Patient Assistance Program (PAP) Request (Complete Sections 1-6, plus Section 8)

Section 1: Patient Information - Please complete this section with all relevant information. Please note that Social Security number is only required for PAP requests.

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

Section 3: Treatment & Prescription Information – Please provide patient's treatment/prescription information, and attach prescription. PLEASE NOTE: An on label diagnosis code for the Sandoz product is required. Both a primary and a secondary ICD/Dx *may* be required.

Section 4: Prescriber Information - Complete with all relevant information and office/primary contact person

Section 5: Patient Authorization & Signature – Be sure to have the patient sign the Patient Authorization.

Section 6: Prescriber Authorization - Remember to sign the Prescriber Authorization.

Section 7: Commercial Co-Pay Program – Skip this section if applying for the Patient Assistance Program (PAP)

Section 8: Patient PAP Consent/Signature & Financial Info: This section only needs to be completed if you believe the patient could be eligible for Patient Assistance Program (PAP). For patient assistance consideration, your patient may sign consent for real-time income projector or may opt to include proof of income documentation.

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10/2016

SANDOZ ONE SOURCE®ENROLLMENT FORM

Sandoz One Source ● PO Box 220188 ● Charlotte, NC 28222-0188 ● Phone: 844-726-3691 ● Fax: 844-726-3695
Hours of Operation: Monday–Friday, 9 am-8 pm ET

1. Patient Information

Patient's First Name:_____ MI:_____ Last Name:_____ Gender: ☐ M ☐ F

Street Address:_____ City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Social Security # (*required for PAP only*):_____

Email:_____ Home Phone #:_____ Cell Phone #: _____

Contact patient by: ☐ Cell Phone ☐ Home Best time to call: ☐ Morning ☐ Afternoon ☐ Evening

US Resident? ☐ Yes ☐ No Veteran? ☐ Yes ☐ No Disabled? ☐ Yes ☐ No

2. Patient Insurance *(A front and back copy of the patient's insurance cards may be submitted in lieu of filling out this section)*

☐ No Insurance *(Skip to Section 3)*

Primary Insurance:	Secondary Insurance:
Policy #:	Policy #:
Policy Holder Name:	Policy Holder Name:
Date of Birth:	Date of Birth:
Insurance Phone #:	Insurance Phone #:
Group #:	Group #:

3. Treatment and Prescription Information *(Please attach prescription if requesting PAP.) Primary & Secondary ICD/Dx may be required.)*

Drug: _____ ***An on label diagnosis code for the Sandoz product is required.***

Primary ICD/Dx: _____ Secondary ICD/Dx: _____

Dosage: _____ Frequency: _____

CPT Code(s): _____

4. Prescriber Information

Prescriber First Name:_____ Prescriber Last Name:_____

Prescriber Type/Specialty:_____ State where Licensed:_____ State License #:_____

NPI #:_____ Tax ID #:_____ DEA #:_____

Physician Name (if different from Prescriber):_____ State where Licensed:_____ State License #:_____

Practice/Facility Name:_____ Facility Type: ☐ Physician Office ☐ Hospital Outpatient ☐ Hospital Inpatient

Other Facility Address:_____ City:_____ State:_____ Zip Code:_____

Office/Primary Contact Name:_____ Title/Role:_____

Office Contact Primary Phone #:_____ Primary Fax #:_____

Email Address (Prescriber or Office Contact):_____

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5. Patient Authorization

I authorize my healthcare providers (including my doctors and their staff), my pharmacies, my employer and health insurer(s) to disclose my personal information, including information about my insurance. I give permission for my health care providers, my pharmacies, and my health insurer(s) to disclose my personal information, including information about my insurance, prescriptions, medical condition and health ("Protected Health Information") to Sandoz, a Novartis Division, its affiliates, business partners, agents (together, "Sandoz") , and independent contractors, vendors, or service providers ("Sandoz Vendors") so that Sandoz and Sandoz Vendors can (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with the prescribed drug, (ii) coordinate my receipt of, and payment for the prescribed drug, (iii) facilitate my access to the prescribed drug, (iv) manage the Sandoz One Source Program, (v) provide me with information about the prescribed drug, and (vi) provide me with information on external resources that might be available to me.

I give permission to Sandoz and Sandoz Vendors to disclose my Protected Health Information to any pharmacies, my health insurer(s), health care providers, my caregivers, and other third parties for the purposes described above. I give permission to Sandoz and Sandoz Vendors to contact me directly for the purposes described above.

I agree to receive telephone calls, emails, text messages and mailing materials from Sandoz and Sandoz Vendors at the telephone number and addresses provided on the enrollment form. By providing my signature below, I also agree to receive autodialed and pre-recorded calls and text messages from Sandoz and Sandoz Vendors at the telephone numbers provided. I understand that my cell phone carrier's standard rates may apply for calls and texts to my cell phone. I understand and agree that Protected Health Information transmitted by email and cell phone cannot be secured against unauthorized access.

I understand that once my Protected Health Information is disclosed it may no longer be protected by federal privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization at any time in the future by calling 1-844- 726-3691 (1- 844-SANDOZ1) or by writing to the Sandoz One Source, P.O. Box 220188, Charlotte, NC 28222-0188. My refusal or future revocation will not affect the commencement or continuation of my treatment by my doctor(s); however, if I revoke this authorization, I may no longer be eligible to participate in the prescribed drug patient support program. If I revoke this authorization, Sandoz will stop using or sharing my information (except as necessary to end my participation in the program) but my revocation will not affect uses and disclosures of my Personal Information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for five (5) years after the date of my signature, unless I revoke it earlier. I also understand that any programs provided may change or end at any time without prior notification. I understand that I may receive a copy of this authorization.

I confirm that I am the subscriber for the telephone number(s) provided and the authorized user for the e-mail address(es) provided, and I agree to notify Sandoz promptly if any of my number(s) or address(es) change in the future.

I understand that Sandoz, a Novartis Division does not permit my Personal Information to be used by its business partners for their own separate marketing purposes. I understand and agree that Protected Health Information transmitted electronically and by cell phone cannot be secured against unauthorized access.

Point of contact: ☐Patient ☐Patient Advocate (Please provide information below.)

Advocate Name:_____ Advocate Phone:_____

Advocate Street Address: _____ Advocate City:_____ Advocate State:_____ Advocate Zip Code:_____

SIGN HERE _____ _____ _____

Patient Signature (required) | Printed Name | Date

6. Prescriber Authorization

Authorization: By signing below, I certify that I am the prescriber who has prescribed the prescribed drug to the patient identified above. I certify this therapy is medically necessary, and that I have provided the patient with a copy of this Sandoz One Source enrollment form, including signed authorizations.

Patient Assistance Program Authorization: The intent of the Patient Assistance Program is to help facilitate the delivery of treatment that has been prescribed as medically necessary. For the purposes of transmitting this prescription, I authorize the Novartis Patient Assistance Foundation and its affiliates, business partners, and agents, to forward as my agent for these limited purposes, this prescription electronically, by facsimile, or by mail to a dispensing pharmacy chosen by the above-named patient. I certify that any medications received from the Novartis Patient Assistance Foundation (as defined above) in connection with this application will be used only for the patient named on this form. These medications will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning these medications to Medicare, Medicaid, or any third party, nor will any medications be returned for credit. I acknowledge that I have assisted the patient in enrolling in the Novartis PAP exclusively for purposes of patient care and not in consideration for, expectation of, or actual receipt of remuneration of any sort. I also agree that the Novartis Patient Assistance Foundation has the right to contact the patient directly to confirm receipt of medications, and I understand that the Novartis Patient Assistance Foundation may revise, change, or terminate this program at any time. Finally, to the best of my knowledge, the patient listed above meets the Novartis Patient Assistance Foundation's eligibility criteria for the PAP.

Finally, for the purposes of transmitting this prescription to the Patient Assistance Program (if applicable), I authorize Sandoz, a Novartis company, and its affiliates, business partners, and agents, to forward as my agent for these limited purposes, this form and corresponding prescription electronically, by facsimile, or by mail to the Novartis Patient Assistance Foundation.

If patient is approved, please ship PAP product to: ☐ Prescriber Address for Prescriber Administration ☐Patient Address

SIGN HERE _____ _____ _____

Prescriber Signature (required) | Printed Name | Date

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7. Commercial Co-pay Program Consent for Patient

Eligibility Requirement

The Co-Pay Program provides up to $10,000 in annual Co-Pay support for ZARXIO® (filgrastim-sndz) prescriptions. Patient pays $0 out-of-pocket for first dose or cycle, and $10 out-of-pocket for subsequent doses or cycles for up to a 12-month period. Prescription must be for an approved indication. This program is not health insurance. This program is for insured patients only; uninsured cash-paying patients are not eligible. Patients are not eligible if prescriptions are 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 indemnity health insurance plans that do not cover prescription drugs, or HMO insurance plans that reimburse you for the entire cost of your prescription drugs, or where prohibited by law. Program may not be combined with any other rebate, coupon, or offer. Sandoz reserves the right to rescind, revoke, or amend this offer without further notice.

CO-PAY ENROLLMENT

I give permission for my doctor(s) and their staff to disclose my personal information, including information about my insurance, prescription, medical condition, and health ("Health Information") to Sandoz One Source so it can be determined if I am eligible for the Commercial Co-Pay Program. If my health coverage changes, I will call Sandoz One Source at 1-844-726-3691. I know that Sandoz may change or end the Commercial Co-Pay Program at any time. I know that if I do not sign this form, I will not be able to participate in the Commercial Co-pay Program, but this will not affect my ability to get medical care, seek payment for this care, or affect my enrollment or eligibility for insurance. I know that I can cancel this permission at any time by calling Sandoz One Source at 1-844-726-3691. If I do, then I will no longer be enrolled in the program. I understand that I have the right to receive a copy of this form.

SIGN HERE _____ _____ _____
Patient Signature (required for co-pay enrollment) Printed Name Date

AUTHORIZATION TO PROVIDE CO-PAY CARD NUMBER TO HCP

If eligible for the Commercial Co-Pay Program, I authorize Sandoz Inc. Sandoz Vendors, and/or Sandoz One Source to coordinate, provide, and communicate my Commercial Co-Pay Program account information, including but not limited to Co-Pay card number, directly to my healthcare provider and/or healthcare provider's office to assist in the administration of the Commercial Co-Pay Program and payment of the Commercial Co-Pay Program benefit to my healthcare provider on my behalf.

SIGN HERE _____ _____ _____
Patient Signature (required for authorization) Printed Name Date

8. Patient Assistance Program (PAP) Consent for Patient *(Mandatory for Patients Enrolling in the Patient Assistance Program)*

I give permission for my doctor(s) and their staff to disclose my personal information, including information about my insurance, prescription, medical condition, and health ("Health Information") to the Novartis Patient Assistance Foundation, Inc. (the "Foundation") so that the Foundation can decide if I am eligible for the Novartis Patient Assistance Program ("PAP"); operate the PAP and the Foundation; send me information about PAP and other programs that might help me pay for my medicines; send my information to other programs that might help me pay for my medicines; ask me for financial, insurance, and/or medical information and share my information as requested or permitted by law. I give permission to the Foundation to use information on this Application and any other information I give to the Foundation for these same reasons. I also give the Foundation permission to share my Health Information and other information with people and companies that work with the Foundation; government agencies, including the Centers for Medicare and Medicaid Services; insurance companies, including Medicare Part D plans; my doctor(s) and other people or institutions who are involved in my health care, such as pharmacies and hospitals; other organizations that might help me pay for my medication. I promise that any information, including financial and insurance information that I provide to the Foundation, are complete and true and unless I have said something different in this application, I have no drug insurance coverage, which includes Medicaid, Medicare, or any public or private assistance programs or any other form of insurance. If my income or health coverage changes, I will call the PAP at 1-800-277-2254. I know that the Foundation may change or end the PAP at any time. I know that if I do not sign this form, I will not be able to participate in the PAP, but this will not affect my ability to get medical care, seek payment for this care, or affect my enrollment or eligibility for insurance. I know that I can cancel this permission at any time by calling the PAP at 1-800-277-2254. If I do, then I will not be able to stay in the PAP. I understand that I have the right to receive a copy of this form.

Total # of people in the household: ☐1 ☐2 ☐3 ☐4 ☐5 ☐Other:_____ Annual Household Income: $_____

Income Verification: Sandoz One Source Program and its authorized third party agents will use my date of birth or social security number and/or additional demographic information as needed to access my credit information derived from public and other sources to estimate my income in conjunction with the eligibility determination process. The free product financial approval tool (via soft credit inquiry) will not impact my credit score.

☐ Opt-Out Box for the Free Product Financial Approval Tool (soft credit inquiry): Please do not access my credit information to estimate my income via soft credit inquiry.

By checking this box, I will provide one of the following income documents along with this Sandoz One Source Enrollment Form:

- Copy of W-2 or most recently filed U.S. Income Tax Return, (IRS Form 1040, 1040A, 1040EZ, 1040NR or 1040PR), or
- Copy of most recent pay stub plus most recently filed US Income Tax Return, or
- Copy of transcript received through submission of IRS 4506-T (request for transcript form is not accepted) or
- Copy of most recent Social Security/Disability monthly check, award Letter, Benefit Statement or 1099 or
- Copy of Unemployment Determination letter

Point of contact: ☐Patient ☐ Patient Advocate (Please provide information below.)

Advocate Name:_____ Advocate Phone:_____

Advocate Street Address: _____ Advocate City:_____ Advocate State:_____ Advocate Zip Code:_____

SIGN HERE _____ _____ _____
Patient Signature (required) Printed Name Date

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