Helping Your Patients Get Their Bayer Medications Through Access Services by Bayer™

Instructions for completing the Access Services by Bayer Patient Support Request Form (SRF).

SELECT ALL THAT APPLY:

Benefits Investigation* *(complete steps 1-3)*

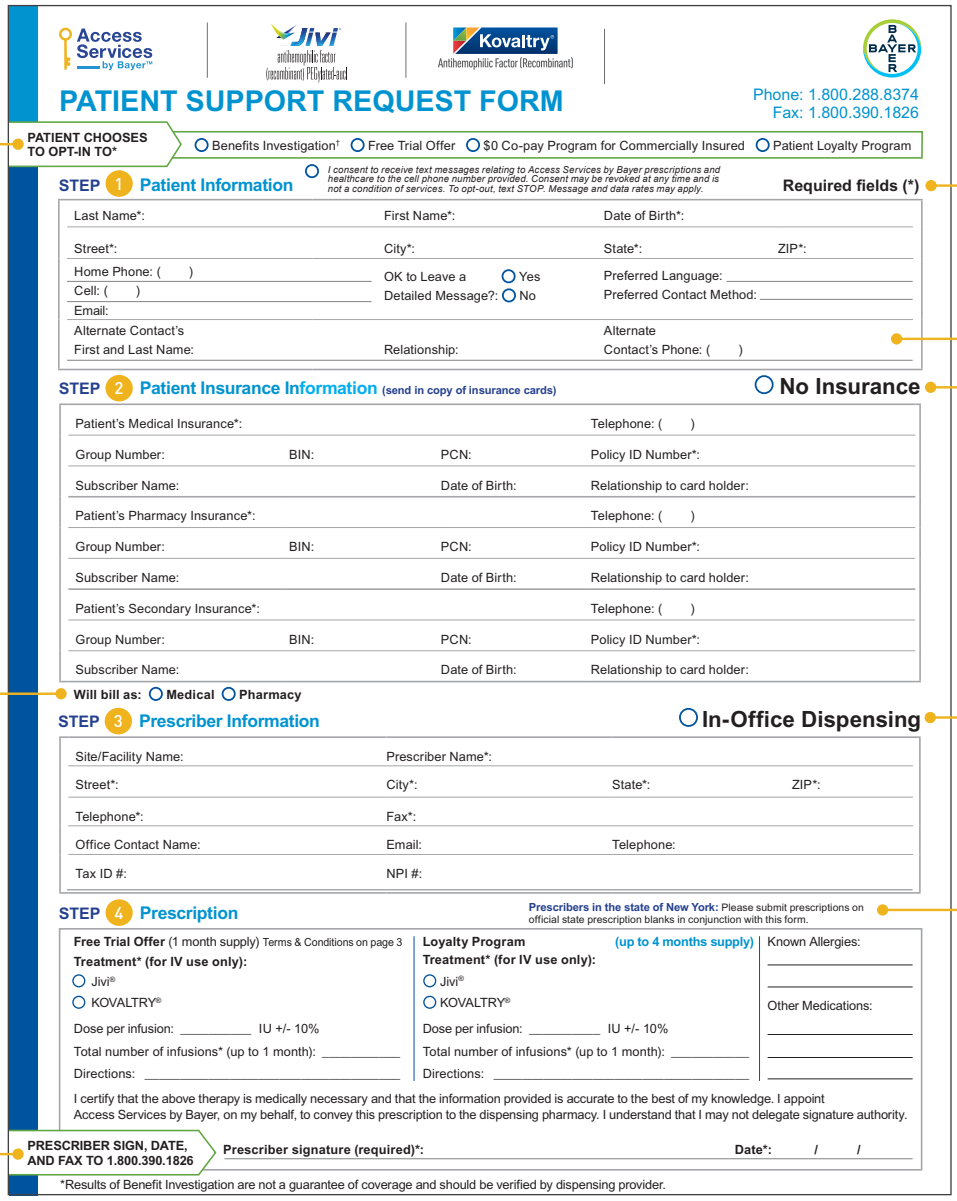
- **Check patient's insurance** to determine coverage
- **Eligible** patients auto-enrolled in the $0 Co-pay Program
- **Eligible** patients auto-enrolled in the Patient Loyalty Program

Free Trial Offer *(complete steps 1,3, and 4)*

- Eligible patients receive a 1 month supply
- Step 2 is optional but can be completed to find out the patient's insurance coverage

To streamline the benefits investigation process, select how your site will bill the patient's insurance.

Missing signatures **WILL** cause a delay in processing. Signature must be from prescriber in Step 3.



Access Services by Bayer™ | Jivi® antihemophilic factor (recombinant) PEGylated-aucl | Kovaltry® Antihemophilic Factor (Recombinant) | BAYER

PATIENT SUPPORT REQUEST FORM

Phone: 1.800.288.8374
Fax: 1.800.390.1826

PATIENT CHOOSES TO OPT-IN TO* ○ Benefits Investigation† ○ Free Trial Offer ○ $0 Co-pay Program for Commercially Insured ○ Patient Loyalty Program

STEP 1 Patient Information ○ *I consent to receive text messages relating to Access Services by Bayer prescriptions and healthcare to the cell phone number provided. Consent may be revoked at any time and is not a condition of services. To opt-out, text STOP. Message and data rates may apply.* Required fields (*)

Last Name*: First Name*: Date of Birth*:
Street*: City*: State*: ZIP*:
Home Phone: ( ) OK to Leave a Detailed Message?: ○ Yes ○ No Preferred Language:
Cell: ( ) Preferred Contact Method:
Email:
Alternate Contact's First and Last Name: Relationship: Alternate Contact's Phone: ( )

STEP 2 Patient Insurance Information (send in copy of insurance cards) ○ No Insurance

Patient's Medical Insurance*: Telephone: ( )
Group Number: BIN: PCN: Policy ID Number*:
Subscriber Name: Date of Birth: Relationship to card holder:
Patient's Pharmacy Insurance*: Telephone: ( )
Group Number: BIN: PCN: Policy ID Number*:
Subscriber Name: Date of Birth: Relationship to card holder:
Patient's Secondary Insurance*: Telephone: ( )
Group Number: BIN: PCN: Policy ID Number*:
Subscriber Name: Date of Birth: Relationship to card holder:

Will bill as: ○ Medical ○ Pharmacy

STEP 3 Prescriber Information ○ In-Office Dispensing

Site/Facility Name: Prescriber Name*:
Street*: City*: State*: ZIP*:
Telephone*: Fax*:
Office Contact Name: Email: Telephone:
Tax ID #: NPI #:

STEP 4 Prescription **Prescribers in the state of New York:** Please submit prescriptions on official state prescription blanks in conjunction with this form.

Free Trial Offer (1 month supply) Terms & Conditions on page 3
Treatment* (for IV use only):
○ Jivi®
○ KOVALTRY®
Dose per infusion: _____ IU +/- 10%
Total number of infusions* (up to 1 month): _____
Directions: _____

Loyalty Program (up to 4 months supply)
Treatment* (for IV use only):
○ Jivi®
○ KOVALTRY®
Dose per infusion: _____ IU +/- 10%
Total number of infusions* (up to 1 month): _____
Directions: _____

Known Allergies: _____ _____
Other Medications: _____ _____ _____

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I appoint Access Services by Bayer, on my behalf, to convey this prescription to the dispensing pharmacy. I understand that I may not delegate signature authority.

PRESCRIBER SIGN, DATE, AND FAX TO 1.800.390.1826 Prescriber signature (required)*: Date*: / /

*Results of Benefit Investigation are not a guarantee of coverage and should be verified by dispensing provider.

COMPLETE ALL REQUIRED FIELDS INCLUDING PATIENT SIGNATURES TO AVOID DELAYS IN TREATMENT

Alternate contacts may include family members to whom the patient has given permission to speak with Access Services by Bayer™ on their behalf

Check this circle if the patient does not have health insurance

Please check this circle for **In-Office Dispensing**. This informs Access Services by Bayer to refer your patient back to your site after completing the Free Trial Offer.

Prescribers in NY must submit prescriptions on official state prescription blanks with this form

To report any adverse events, product technical complaints, or medication errors associated with the use of Jivi or Kovaltry, contact: Bayer at 1-888-842-2937, or send the information to DrugSafety.GPV.US@bayer.com.

Please click to see full Prescribing information for Jivi and Prescribing information for Kovaltry.

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STEP 1 Patient Information

○ *I consent to receive text messages relating to Access Services by Bayer prescriptions and healthcare to the cell phone number provided. Consent may be revoked at any time and is not a condition of services. To opt-out, text STOP. Message and data rates may apply.*

Required fields (*)

Last Name*: First Name*: Date of Birth*:

Street*: City*: State*: ZIP*:

Home Phone: ( ) OK to Leave a Detailed Message?: ○ Yes ○ No Preferred Language:

Cell: ( ) Preferred Contact Method:

Email:

Alternate Contact's First and Last Name: Relationship: Alternate Contact's Phone: ( )

STEP 2 Patient Insurance Information (send in copy of insurance cards)

○ **No Insurance**

Patient's Medical Insurance*: Telephone: ( )

Group Number: BIN: PCN: Policy ID Number*:

Subscriber Name: Date of Birth: Relationship to card holder:

Patient's Pharmacy Insurance*: Telephone: ( )

Group Number: BIN: PCN: Policy ID Number*:

Subscriber Name: Date of Birth: Relationship to card holder:

Patient's Secondary Insurance*: Telephone: ( )

Group Number: BIN: PCN: Policy ID Number*:

Subscriber Name: Date of Birth: Relationship to card holder:

Will bill as: ○ **Medical** ○ **Pharmacy**

STEP 3 Prescriber Information

○ **In-Office Dispensing**

Site/Facility Name: Prescriber Name*:

Street*: City*: State*: ZIP*:

Telephone*: Fax*:

Office Contact Name: Email: Telephone:

Tax ID #: NPI #:

STEP 4 Prescription

Prescribers in the state of New York: Please submit prescriptions on official state prescription blanks in conjunction with this form.

Free Trial Offer (1 month supply) Terms & Conditions on page 3

Treatment* (for IV use only):

○ Jivi®
○ KOVALTRY®

Dose per infusion: _____ IU +/- 10%

Total number of infusions* (up to 1 month): _____

Directions: _____

Loyalty Program **(up to 4 months supply)**

Treatment* (for IV use only):

○ Jivi®
○ KOVALTRY®

Dose per infusion: _____ IU +/- 10%

Total number of infusions* (up to 1 month): _____

Directions: _____

Known Allergies:

_____

_____

Other Medications:

_____

_____

_____

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I appoint Access Services by Bayer, on my behalf, to convey this prescription to the dispensing pharmacy. I understand that I may not delegate signature authority.

PRESCRIBER SIGN, DATE, AND FAX TO 1.800.390.1826

Prescriber signature (required)*: **Date*:** / /

*Results of Benefit Investigation are not a guarantee of coverage and should be verified by dispensing provider.

To report any adverse events, product technical complaints, or medication errors associated with the use of Jivi or Kovaltry, contact: Bayer at 1-888-842-2937, or send the information to DrugSafety.GPV.US@bayer.com.

PATIENT HIPAA AUTHORIZATION

I voluntarily provide this authorization for the use and disclosure of my Protected Health Information ("PHI"), as such term is defined by the Health Insurance Portability and Accountability Act of 1996 (as amended, "HIPAA"). I understand that PHI is health information that identifies me or that could reasonably be used to identify me.

I authorize my healthcare provider, including my physician and pharmacy, and my health plan, to disclose to Bayer and its contracted agents my name, address, telephone number, health insurance status and coverage and such medical information as may be necessary for me to enroll in Access Services by Bayer™. I understand this disclosure(s) will contain PHI, including information about my current medical condition, treatment, coordination of treatment and receipt of medication. I allow the use and disclosure of my PHI to Bayer its contracted agents for the following purposes:

- To verify my insurance information and coverage
- To ensure the accuracy and completeness of the Access Services by Bayer™ Enrollment Form
- To help with my insurance coverage questions for Bayer medications
- To determine if I qualify for other Bayer patient support programs
- To determine my eligibility for other sources of prescription medication financial assistance
- To provide education, training, and ongoing support on the use of my Bayer medication
- To send me information on Bayer products and services related to my treatment
- To send me refill reminders for my Bayer prescription medication and to encourage its appropriate use
- To communicate with me, my healthcare providers and health plan about my medical care and treatment
- To contact me for market research feedback, sales support purposes, and as necessary to comply with applicable laws
- Bayer may contact me for potential adverse event follow-up information

I understand that:

- This Authorization will remain in effect until the end of my participation in Access Services by Bayer™ or 5 years, unless subject to applicable law from the date of my signature on this Authorization, whichever occurs later.
- I may cancel this Authorization at any time by writing to: Access Services by **Bayer, PO BOX 2230, Columbus OH 43216**.
- If I cancel this Authorization my healthcare provider and health plan will stop sharing my PHI with Bayer and its contracted agents. However, the revocation will not affect prior use or disclosure of my PHI in reliance on this Authorization.
- I may opt-out of being contacted for market research feedback, sales support purposes and still enroll in the patient support program.
- That entities that receive my PHI in accordance with this Authorization may not be required by law to keep the information private and that it will no longer be protected by the HIPAA privacy law. It may become available in the public domain.
- I do not need to sign this Authorization to receive (i) medical treatment or medication or (ii) coverage, payment, enrollment in or eligibility for benefits from my health plan. However, if I do not sign this Authorization, I may not participate in Access Services by Bayer™ or be eligible for other Bayer patient support programs.
- I understand that some of my health care providers, such as my pharmacies, may receive payment from Bayer in return for services that require use or disclosure of my PHI to Bayer and its contracted agents.

I have read and understand the terms of this Authorization and have had an opportunity to ask questions about the uses and disclosures of PHI. I understand that I am entitled to receive a signed copy of this Authorization and I can also get a copy by contacting Access Services by Bayer™ at 1-800-288-8374.

PATIENT SIGN AND DATE

Patient name (print)*:

Patient (or legal guardian) signature*: **Date*:** / /

If signed by a legal representative: Print Name:

Relationship to patient:

To report any adverse events, product technical complaints, or medication errors associated with the use of Jivi or Kovaltry, contact: Bayer at 1-888-842-2937, or send the information to DrugSafety.GPV.US@bayer.com.

JIVI®, KOVALTRY®, and $0 CO-PAY PROGRAM TERMS AND CONDITIONS

Patient must meet eligibility requirements of the Jivi®, KOVALTRY®, and $0 Co-pay Program; for example, only commercially insured patients are eligible: (i) Patient must inform Jivi® and KOVALTRY® $0 Co-pay Program of change in insurance status; (ii) it is required that the patient understand, accept, and meet the terms of all the Jivi®, KOVALTRY® $0 Co-pay Program requirements; (iii) use of the Jivi®, KOVALTRY® $0 Co-pay Program must be consistent with and not prohibited by the requirements of the patient's health insurance; (iv) the Jivi®, KOVALTRY® $0 Co-pay Program benefit has a maximum amount of $20,000 per year, per patient; (v) the Jivi®, KOVALTRY® $0 Co-pay Program is for commercially insured patients using Jivi® or KOVALTRY® for an approved FDA indication; (vi) the Jivi®, KOVALTRY® $0 Co-pay Program does not cover costs for changes associated with administering Jivi®, KOVALTRY® or patient visits; (vii) offer valid only for patients treated in the USA, including Puerto Rico, Guam and US Territories; (viii) Bayer reserves the right to determine eligibility, monitor participation, fairly distribute product, and may change or end the Jivi® or KOVALTRY® $0 Co-pay Program at any time with or without notice; (ix) patient agrees to provide necessary health information to the administration of the Jivi® or KOVALTRY® $0 Co-pay Program.

For questions about the Jivi® or KOVALTRY® $0 Co-pay Program, please call us at 1-647-245-5619.

FREE TRIAL OFFER TERMS AND CONDITIONS

The Free Trial Offer (FTO) provides up to one month supply to a maximum of 40,000 IU of Jivi® or KOVALTRY® for patients 12 years of age and older, who meet the FTO eligibility requirements and who agree to the FTO terms and conditions by submitting a Patient Service Request Form with steps 1, 3, and 4 completed and signed. Participation in the FTO is limited to 1 time only per patient, per product. (i) FTO is a free trial offer, intended solely to allow new patients to try Jivi® or KOVALTRY® and to determine with their healthcare provider whether Jivi® or KOVALTRY® is right for them. There is no obligation to continue use of Jivi® or KOVALTRY® after the free trial has been completed; (ii) to be eligible, patient must: (1) reside in the United States or Puerto Rico and (2) be a new patient to either Jivi® or KOVALTRY®; (iii) Jivi® or KOVALTRY® supplied through the FTO will be dispensed only through a pharmacy designated by Bayer up to the limits above; (iv) product may only be delivered to the patient's home address (no P.O. boxes) or the prescribing healthcare provider's office; (v) it is unlawful for any person to sell, purchase, trade, barter or export Jivi® or KOVALTRY® supplied through the FTO or make an offer to do so; (vi) KOVALTRY® or Jivi® supplied through the FTO may not be billed (in whole or part, directly or indirectly) to any patient or third-party payer, including Medicare, Medicaid and commercial insurance plans; (vii) Bayer reserves the right to change or discontinue the FTO at any time without notice; (viii) the FTO is not health insurance; (ix) the FTO is not a discount, rebate, coupon, cost-sharing program, or other form of financial assistance and no portion of the value of the FTO product may count as a patient out-of-pocket expense under any health insurance program; (x) Jivi® or KOVALTRY® supplied free of charge through the FTO is not contingent on continued use of Jivi® or KOVALTRY® or any other prescriptions or use of Bayer products. To continue a patient on therapy, a separate prescription must be written by the healthcare provider and filled at the patient's covered specialty pharmacy; (xi) The FTO is void where prohibited by law and where use is prohibited by the patient's insurance.

PATIENT LOYALTY PROGRAM TERMS AND CONDITIONS

Patient must meet eligibility requirements of the Patient Loyalty Program: (i) The Patient Loyalty Program is for commercially insured patients using Jivi® or KOVALTRY® for an approved FDA indication; (ii) patient must inform Access Services by Bayer of change in insurance status; (iii) offer valid only for patients treated in the USA, including Puerto Rico, Guam and US Territories; (iv) Bayer reserves the right to determine eligibility, monitor participation, fairly distribute product and may change or end the Patient Loyalty Program at any time with or without notice; (v) use of the Patient Loyalty Program must be consistent with and not prohibited by the requirements of the patient's health insurance; (vi) patient agrees to provide necessary health information to the administration of the Patient Loyalty Program. As a member of the Patient Loyalty Program, patients may:

- Eligible patients may enroll in this program to help fill insurance gaps for up to 4 months when:
  - Patients experience changes in insurance coverage
  - Patients are between jobs and experience a gap in insurance coverage
- Open to current and new Jivi® or KOVALTRY® Patients. Benefits are transferrable between Jivi® and KOVALTRY®.

For questions about the Patient Loyalty Program, please call Access Services by Bayer at 1-800-288-8374.

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