800-992-9022 833-888-8837 monoferric-patient-solutions.com

HOW TO USE THIS FORM

- Complete all required fields
- Print the form
- Obtain prescriber and patient signatures on pages 2-3

With which programs does your patient need assistance?

Select all that apply.

Benefits Verification   Copay Assistance Program   Prior Authorization Support   Claims Support   Patient Assistance Program (see page 2)

*All Patients will be auto-enrolled into the Supplemental Nursing Support Program

STEP 1 Patient Information

First Name: ________________________ Last Name: ________________________ Date of Birth (MM/DD/YYYY): ______ / ______ / ______

Gender (optional): Female Male Email (optional): ____

Street Address: ____ City: ________________________ State: ________ Zip Code: __________

Primary Phone: (______) ______ - ________ Cell Home Alternate Phone (optional): (______) ______ - ________ Cell Home

STEP 2 Patient Diagnostic Information

Primary Diagnosis Code: ____________________________________ Secondary Diagnosis Code: ____________________________________

Optional Fields:

Has patient been treated with and/or failed oral iron therapy? Yes No If yes, how long was treatment? ______________________________

Is patient intolerant to oral iron therapy? Yes No

If available, please provide recent lab values: TSAT (%): ___________________________ Hemoglobin (g/dL): ___________________________

Has patient tried/failed other IV Iron therapies? Yes No If yes, how long was treatment? ____

Does the patient have any contradictions to Monoferric? Yes No

STEP 3 Patient Insurance Information

Insurance Type: Commercial/Private Medicare Medicaid Uninsured Other

Primary Plan Information:

Insurance Name: __________________________________ Insurance Phone: (______) ______ - ________

Policy ID #: ___________________ Group #: ___________________ Policyholder Name: ____

Policy Holder Relationship to Patient: __________________________________ Policyholder Date of Birth (MM/DD/YYYY): ______ / ______ / ______

Secondary Plan Information (optional):

Insurance Name: __________________________________ Insurance Phone: (______) ______ - ________

Policy ID #: ___________________ Group #: ___________________ Policyholder Name: ____

Policy Holder Relationship to Patient: __________________________________ Policyholder Date of Birth (MM/DD/YYYY): ______ / ______ / ______

STEP 4 Healthcare Provider Information

Physician Name: __________________________________ NPI #: ___________________ Tax ID #: ___________________

Facility Name: ___________________ Street Address: ____

Contact Name and Title: __________________________________ City/State/Zip: __________________________________

Email: ____ Phone: (______) ______ - ________ Fax: (______) ______ - ________

If administration site is different than site of prescribing physician, please complete the following:

Administering Facility Name: __________________________________ Street Address: ____

Contact Name and Title: __________________________________ City/State/Zip: __________________________________

Email: ____ Phone: (______) ______ - ________ Fax: (______) ______ - ________

STEP 5 Patient Assistance Program

Uninsured patients who are prescribed Monoferric® may be eligible for free product. Please note this does not constitute health insurance and excludes office visit and/or administration costs associated with treatment. Patient must be a resident of the United States (residency includes anyone who lives in one of the US states, the District of Columbia, Puerto Rico, and U.S. Virgin Islands). Citizenship or legal status is not a requirement.

Income Verification:

Please enter Gross Household Income (including salary/wages, Social Security income, disability income, any other income)*

Annual Gross Income: ___________________________ Household size: ___________________________

* Additional supporting documentation may be required

Pharmacosmos Therapeutics Inc. and its authorized third-party agents will use the patient's date of birth or social security number and/or additional demographic information as needed to access credit information and information derived from public and other sources to estimate income in conjunction with the eligibility determination process. *As a soft credit inquiry, this option will not impact credit scores*. Pharmacosmos Therapeutics Inc. and its authorized third-party agents reserve the right to ask for additional documents and information at any time.

Enroll in Patient Assistance Program Yes No *By checking the box "yes" the patient certifies he/she understands and agrees to the terms of the Patient Assistance Program*

Prescription/Order Information:

Patient Last Name: ___________________________ Patient First Name: ___________________________

Date of Birth (MM/DD/YYYY): ______ / ______ / ______ Patient Weight (kg): ___________________________

MEDICATION	STRENGTH/FORM	QUANTITY	DIRECTIONS FOR ADMINISTRATION
Monoferric® (ferric derisomaltose)	1,000 mg iron /10 mL (100 mg/mL) single-dose vial (individually boxed)		

Drug Allergies: No Yes (if yes, please list medication(s) and reaction(s)):

____

Patient's Concurrent Medications: ____

STEP 6 Prescriber Signature

I certify that the information provided in this Patient Support Enrollment Form is complete and accurate to the best of my knowledge. By signing this Patient Support Enrollment Form I certify that I have prescribed Monoferric® based on my professional judgment of medical necessity and that I will supervise the patient's medical treatment. I authorize Pharmacosmos Therapeutics Inc. and The Lash Group, LLC to provide any information on this form or any other medical information provided by me to Pharmacosmos Therapeutics Inc. and The Lash Group, LLC to the insurer of the named patient and to forward the above prescription, by fax or by other mode of delivery to the pharmacy chosen by the named patient.

Payment is for the Monoferric Patient Solutions Copay Benefit for the above-named patient in accordance with the applicable Terms and Conditions of the Monoferric Patient Solutions Copay Assistance Program. By accepting this payment on behalf of your patient, you and your office agree that you will apply the payment to the satisfaction of the above-named patient's obligation for the cost of Monoferric only. If you/your office already received payment from the patient for the patient's share of the cost of Monoferric, you agree you will refund the amount received back to the patient. You/your office will not seek reimbursement for all or any part of the benefit received by the patient through the Monoferric Patient Solutions Copay Assistance Program. If you believe this payment was made to you/your office on behalf of the above-named patient in error, or if you do not agree to these terms, please contact Monoferric Patient Solutions immediately at 800-992-9022.

Prescriber Name (please print): ____

SIGN & DATE **Prescriber Signature:** ____ **Date:** ______ / ______ / ______

*In addition to completing this section, NY Prescribers must submit an eRx and/or submit an Official New York State prescription

STEP 7 Copay Program

Terms and Conditions:

- This offer is valid for commercially insured patients only; cash paying patients may also qualify
- All information applicable to the Copay Assistance Program requested on the enrollment form must be provided and all certifications must be signed. Forms that are modified or do not contain all the necessary information will not be eligible for benefits under the Copay Assistance Program
- Depending on insurance coverage, eligible patients receive savings of up to $1000 for Monoferric for the first dose and up to a maximum savings limit of $2000 annually (on a total of 2 doses). Patients must have out-of-pocket costs of over $0 to participate. Patient out-of-pocket expenses for Monoferric may vary
- This offer is not valid for patients enrolled in Medicare, Medicare Advantage, Medicaid, TRICARE, Veteran Affairs health care, a state prescription drug assistance program, the Government Health Insurance Plan available in Puerto Rico (formerly known as "La Reforma de Salud") or any other federal or state healthcare programs
- Patients may not use the Copay Assistance Program if the entire cost of the patient's Monoferric prescription is reimbursable by their commercial insurance plan or other commercial health or pharmacy benefit programs
- The Copay Assistance Program is valid for the patient's out-of-pocket cost for Monoferric only. It is not valid for any other out-of-pocket costs (for example, office visit charges or medication administration charges) even if such costs are associated with the administration of Monoferric. Claim for Monoferric must be submitted by provider to patient's private health insurance separately from other services and products
- The patient's healthcare professional must submit an explanation of benefits (EOB) statement from the patient's commercial insurance provider within 120 days of the date of service for the patient to receive assistance under the Copay Assistance Program. No EOB may be submitted more than 90 days after the expiration or [termination date of the program], and the EOB must be for administration of Monoferric prior to the program expiration or termination date. The EOB must reflect the patient's out-of-pocket cost for Monoferric and submission of the claim by the patient's physician for the cost of the medication

Terms and Conditions (continued):

- Patient enrollment is for the calendar year and each patient may reenroll in the Copay Assistance Program in subsequent years, as needed
- The patient should not participate in the program if his/her insurer or health plan prohibits use of manufacturer coupons/copay assistance
- Patients must be 18 years of age or older to participate in the Copay Assistance Program
- Offer good only in the USA, including Puerto Rico, at participating pharmacies or healthcare providers
- This patient savings under the Copay Assistance Program may not be combined with any other coupon, discount, prescription savings card, free trial, or other offer
- Void if prohibited by law, taxed, or restricted
- The funds provided for a specific patient case are not transferable. The selling, purchasing, trading, or counterfeiting of a patient's unique account number is strictly prohibited
- **This program is not health insurance**
- This offer is not conditioned on any past or future purchases
- Data related to your receipt of financial assistance under the Copay Assistance Program may be collected, analyzed, and shared with Pharmacosmos, for market research and other purposes related to assessing Pharmacosmos's programs. Data shared with Pharmacosmos will be aggregated and de-identified; it will be combined with data related to other program use and will not identify you
- Pharmacosmos Therapeutics Inc. reserves the right to rescind, revoke, or amend this offer without notice
- By redeeming this assistance, you acknowledge that you are an eligible patient and that you understand and agree to comply with the terms and conditions of this offer
- Qualified patients receiving Monoferric will be allowed a 120-day retroactive enrollment period to receive benefits under the program rules

STEP 8 Patient Authorization and Release

By providing my signature on page 3 of this form, I authorize my physician(s), healthcare provider(s), health insurance company, and my pharmacy to disclose information about me (for example, my name, address, and insurance policy number) and my medical condition (for example, my diagnosis or medications) to Pharmacosmos Therapeutics Inc. and its third-party vendors, suppliers, and other service providers supporting Monoferric Patient Solutions. I authorize service providers supporting Monoferric Patient Solutions to share information about me with each other. I recognize that this type of personally identifiable information could include spoken or written facts about my health or healthcare or copies of records about my health and insurance benefits provided by my healthcare provider(s) or health plan. My decision to sign this form (or not to sign this form) will not affect the treatment I receive from any healthcare professional or entity involved in my care or coverage.

This authorization will remain in effect unless I revoke it in writing by mailing a letter to Monoferric Patient Solutions, PO Box 220573, Charlotte, NC 28222. I am entitled to receive a copy of this authorization. The personal and health insurance information I have provided on this form is complete and accurate to the best of my knowledge. I will update my information promptly if any of the information reflected on this form changes by contacting Monoferric Patient Solutions at 800-992-9022.

ATTESTATION FOR PATIENTS WITH PRIVATE INSURANCE:

I confirm I currently have commercial or private health insurance that I will use for my Monoferric medication, including commercial insurance provided through an employer or former employer, provided to me as a federal or state employee, and insurance I pay for myself, as well as plans available through state and federal healthcare exchanges.

I confirm that I will NOT seek reimbursement from any state or federal government-subsidized healthcare program to cover any portion of the Monoferric medication costs such as Medicare Parts A, B, C (also known as Medicare Advantage Plan), D, and Medicare Supplement, Medicaid, TRICARE, Department of Defense, or Veterans Administration.

I confirm that I will not submit out-of-pocket costs paid by this program as a claim for payment to any third-party payer, pharmaceutical patient assistance foundation, or account such as a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Account (HRA).

Patient Name (please print): ____

SIGN & DATE **Patient Signature:** ____ **Date:** ______ / ______ / ______

PHARMACOSMOS THERAPEUTICS

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MonoFerric® (ferric derisomaltose) injection