MonoFerric Patient Solutions®

1-800-992-9022 1-833-888-8837 monoferric-patient-solutions.com
For assistance completing this form, program representatives are available Monday-Friday, 8 AM to 8 PM ET

CHECKLIST FOR COMPLETING THIS FORM

Print the form or save and fill in PDF. Complete all required fields.

☐ All steps except step 4 and 5 are required for Benefits Verification, Prior Authorization, Claims Support, and Copay Assistance

☐ Steps 1-6 are required for the Patient Assistance Program (PAP)

NOTES:

- **The face/patient demographics sheet can be used in place of completing step 1**
- **A copy of the insurance card can also be submitted in place of step 2**
- **Healthcare Professional signature is required on page 3 for all services; Prescriber signature is required for PAP**
- **Please review program terms and conditions on page 3**

With which programs does your patient need assistance?

Select all that apply.

☐ Benefits Verification ☐ Prior Authorization Support ☐ Claims Support ☐ Patient Assistance Program ☐ Copay Assistance Program

STEP 1 Patient Information ☐ *Check box if face sheet is attached*

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

Primary Diagnosis Code: _____ Secondary Diagnosis Code: _____

STEP 2 Patient Insurance Information ☐ *Check box if a copy of the insurance card(s) is attached*

Insurance Type: ☐ Commercial/Private ☐ Medicare ☐ Medicaid ☐ Uninsured ☐ Other

Primary Plan Information:

Insurance Name: _____ Insurance Phone: (_____) _____ - _____

Policy ID #: _____ Group #: _____ Policyholder Name: _____

Policyholder Relationship to Patient: _____ Policyholder Date of Birth (MM/DD/YYYY): _____ / _____ / _____

Secondary Plan Information (optional):

Insurance Name: _____ Insurance Phone: (_____) _____ - _____

Policy ID #: _____ Group #: _____ Policyholder Name: _____

Policyholder Relationship to Patient: _____ Policyholder Date of Birth (MM/DD/YYYY): _____ / _____ / _____

Continue on Page 2

STEP 3 Healthcare Provider Information

Provider 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 (optional):

Administering Facility Name: _____ Street Address: _____

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

Email: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

If Specialty Pharmacy is completing this form, please complete the following:

Specialty Pharmacy Name: _____ Street Address: _____

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

Email: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

STEP 4 Patient Assistance Program *Required only if applying for the PAP*

Uninsured or underinsured patients who are prescribed Monoferric® (ferric derisomaltose) injection may be eligible for free product. Patients with claims covered, paid or reimbursed, in whole or in part, by Medicaid, Medicare, or other federal or state healthcare programs are not eligible for this program. 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 U.S. states, the District of Columbia, Puerto Rico, and U.S. Virgin Islands). Citizenship or legal status is not a requirement.

Income Verification:

Please enter Annual 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.

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)	1 Vial	☐ Infuse 1,000 mg IV over at least 20 minutes as single dose ☐ Infuse 20 mg/kg IV over at least 20 minutes as single dose

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

_____

Patient's Concurrent Medications: _____

STEP 5 Prescriber Signature† *Required for Patient Assistance Program*

By signing this document, I certify that I have prescribed Monoferric for an on-label diagnosis based on my professional judgment of medical necessity and that I will supervise the patient's medical treatment. I have also read and agree to the terms, conditions and authorizations listed on page 3 and that all information provided in this Enrollment Form is complete and accurate to the best of my knowledge.

Prescriber Name (please print): _____ **Collaborative Physician 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.
‡ Applicable for AL, GA, HI, IL, KS, LA, MA, MO, NC, NJ, OK, SC, TN, TX.

Note: Office Contact signature needed for Hub and/or copay assistance enrollment

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STEP 6 Healthcare Professional (Office Contact) Signature¶ *Required for all services*

By completing and transmitting this form, I am certifying that I have received from our patient and have on file the patient's HIPAA consent and all other necessary permissions from my patient authorizing the release of the patient's identification and insurance information to Pharmacosmos Therapeutics Inc. its affiliates, its program administrator, and their respective agents and service providers for them to use in providing the patient with benefit verification and support services as described herein. I certify that I have read and agree to the terms, conditions, and authorizations listed on page 3 and that all information provided in this Enrollment Form is complete and accurate to the best of my knowledge.

Office Contact Name (please print): _____

SIGN & DATE **Office Contact Signature:** _____ **Date:** _____ / _____ / _____

¶Examples include Prescriber, Nurse, Pharmacist, Physician Assistant, Reimbursement Counselor, Account Manager, and Authorized Office Personnel.

Program Terms and Conditions

Monoferric Patient Solutions® (MPS) Copay Assistance Program Terms and Conditions:

- Prescribed Monoferric for an on-label diagnosis
- This offer is valid for commercially insured patients only
- All information applicable to the MPS 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 MPS Copay Assistance Program
- Depending on insurance coverage, eligible patients receive savings on out-of-pocket (OOP) expenses (i.e., deductible, copay, or coinsurance obligations) for Monoferric of up to $2,000 per dose. If iron deficiency anemia (IDA) returns within the coverage period a patient would receive an annual maximum savings on OOP expenses of up to $4,000. Patients must have OOP costs of over $0 to participate. Patient OOP expenses for Monoferric may vary
- This offer is not valid for patients enrolled in Medicare, Medicare Advantage, Medicaid, TRICARE, Veteran Affairs healthcare, 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 MPS 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 MPS Copay Assistance Program is valid for the patient's OOP cost for Monoferric only. It is not valid for any other OOP 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 MPS 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 OOP cost for Monoferric and submission of the claim by the patient's physician for the cost of the medication
- Patient enrollment is for the calendar year and each patient may reenroll in the MPS 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 MPS Copay Assistance Program
- Offer good only in the U.S., including Puerto Rico, at participating pharmacies or healthcare providers
- This patient savings under the MPS 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 MPS 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

Monoferric Patient Solutions® Patient Assistance Program Terms and Conditions: 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.

Prescriber Authorizations: 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 on page 2 of this 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 MPS copay benefit for the above-named patient in accordance with the applicable Terms and Conditions of the MPS 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 MPS 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 MPS immediately at 1-800-992-9022.

PHARMACOSMOS THERAPEUTICS

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US-FDI-2200016

MonoFerric® (ferric derisomaltose) injection