COMPLETE THIS FORM OR CALL 844-ONIVYDE (664-8933) FOR SUPPORT FOR:

☐ Benefit verification ☐ Referral to a nonprofit organization for cost-share (for federally insured patients)

☐ Referral to a nonprofit organization for travel assistance

Certain services might require us to contact your patient to offer assistance. Do we have your permission to do so? ☐ Yes ☐ No

1. PROVIDER INFORMATION

Prescriber Name: ______________________________ Tax ID #: ______________

Payer Specific Provider #: ______________ NPI #: ______________ Provider Medicaid #: ______________

Facility Name: ______________________________

Facility Type: ☐ Physician Office (Place of Service, 11) ☐ Hospital Outpatient (Place of Service, 22)

Group NPI#: ______________ Tax ID#: ______________

Address: ______________________________

City: ______________ State: ______________ ZIP: ______________

Primary Office Contact: ______________________________ Title: ______________

Telephone: ______________ Fax: ______________

Secondary Office Contact: ______________________________ Title: ______________

Telephone: ______________ Fax: ______________

2. PATIENT INFORMATION

First Name: ______________ Last Name: ______________ DOB: ______________

Address: ______________________________

City: ______________ State: ______________ ZIP: ______________ Sex: ______________

Telephone: ______________ ☐ Home ☐ Mobile ☐ Work SSN: ______________

Primary Diagnosis Code (ICD-10-CM): ☐ C25.0 ☐ C25.1 ☐ C25.2 ☐ C25.3 ☐ C25.7 ☐ C25.8 ☐ C25.9

Secondary Diagnosis Code (ICD-10-CM): ☐ C79.89 ☐ ☐ Other ______________

Anticipated Treatment Start Date: ______________

Is the cancer metastatic? ☐ Yes ☐ No

Previously treated with gemcitabine-based therapy? ☐ Yes ☐ No

3. INSURANCE INFORMATION *(please also attach a two-sided copy of the patient's insurance cards)* ☐ None

Primary Insurance: ______________________________ Phone Number: ______________

Policy Number: ______________ Group Number: ______________

Policy Holder (if different than patient)

First Name: ______________ Last Name: ______________ DOB: ______________ SSN: ______________

Secondary Insurance: ______________________________ Phone Number: ______________

Policy Number: ______________ Group Number: ______________

Policy Holder (if different than patient)

First Name: ______________ Last Name: ______________ DOB: ______________ SSN: ______________

4. PROVIDER DECLARATION

By signing below, I am certifying that the information contained in this form is complete and accurate to the best of my knowledge. I understand that Merrimack reserves the right to modify or terminate PROVYDE™ (ONIVYDE® Access Services) at any time and without notice. I understand that Merrimack is not responsible for filing claims and that the information provided by PROVYDE Access Services are advisory in nature. All final decisions on diagnosis, the need for treatment, and the appropriateness of ONIVYDE® (irinotecan liposome injection) for a particular patient rest with me as the patient's provider. I understand that I am under no obligation to prescribe any Merrimack drug and I have not received and will not receive any benefit from Merrimack for prescribing a Merrimack drug. I further verify that I have the required authorizations from my patient to release the referenced medical and/or other patient information relating to my patient's treatment to PROVYDE. If my patient participates in the Patient Assistance Program, I certify that I will not charge the patient or submit a claim to any third party for services related to my patient's ONIVYDE therapy. I understand that any product provided under the Patient Assistance Program must only be used for the approved patient and may not be sold, traded, or returned for credit.

Prescriber Signature: ______________________________ Date: ______________

Printed Name: ______________________________

Please see Indication and Important Safety Information, including Boxed WARNING, for ONIVYDE on pages 4–5. Click here for full Prescribing Information.

THIS FORM IS REQUIRED TO EVALUATE PATIENT ELIGIBILITY FOR:

☐ $0 Copay Program (commercial insurance only; exceptions apply) ☐ Patient Assistance Program (uninsured/underinsured patients)

5. PATIENT FINANCIAL INFORMATION – COMMERCIAL COPAY AND PATIENT ASSISTANCE PROGRAM ONLY

Total Household Monthly Income ____________________ Household Size ____________________

Attach proof of income. Appropriate Proof of Income may include:

- Copy of the most recent US Income Tax Return (IRS form 1040)
- Copy of the most recent Social Security Income Statement (SSA 1099)
- Copy of the most recent pay stub
- Notarized letter stating patient has no annual income

6. PATIENT CERTIFICATION

I attest that the information in this application is true, correct, and complete. I agree to update PROVYDE™ (ONIVYDE® Access Services) ("the Program") should any of this information change, including if I become eligible for any benefit through a federal, state, or private program, which may reimburse for ONIVYDE® (irinotecan liposome injection). I understand that changes in my health insurance coverage may impact my eligibility for the Program.

By signing this form, I authorize my treating doctor, my employer, and my health insurer to give people who work for and with Merrimack, including its business partners and agents ("Merrimack"), information about my insurance and all information about my health, including my medications and medical conditions. Merrimack may use my information to help verify or coordinate insurance coverage or to obtain payment or other support for my treatment. In carrying out these activities, Merrimack may share information about me with my doctor, my employer, my health insurer, and independent third-party patient assistance foundations. I understand that once my health information is disclosed it may no longer be protected by federal or state law regarding patient privacy. I understand that my consent lasts for 1 year from the date that I am approved into the Program.

I understand that Merrimack has the right to change or end the Program at any time without prior notification to me. I understand that I may refuse to sign this form and that doing so will not affect my doctor's treatment of me or my eligibility for insurance benefits. I may revoke this Authorization at any time by contacting the Program. I understand if I do not sign, refuse to sign, or cancel my authorization, I will not be eligible for the Program.

Patient/Caregiver Signature: ____________________ Date: ____________________

Printed Name: ____________________

MAIL OR FAX COMPLETED FORM AND FINANCIAL DOCUMENTATION TO:

PROVYDE™ (ONIVYDE® Access Services)
PO Box 4133
Gaithersburg, MD 20885-4133
Fax: 844-269-3039

CONTACT:

Hours: 8AM–8PM ET, Monday–Friday
Phone: 844-ONIVYDE (664-8933)

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Click here for full Prescribing Information.