R-PHARM US

ACCESS + SUPPORT™

Committed to patients. Committed to care.

2730 S. Edmonds Lane
Suite 300
Lewisville, TX 75067

Selection of services (to be completed by provider)

Please choose all services you would like to use.

☐ Benefit investigation/prior authorization/appeals assistance

☐ R-Pharm US co-pay assistance program
Please read and sign the provider certification on the next page. Applying for co-pay assistance does not guarantee acceptance into the program.

☐ R-Pharm US patient assistance program
Please read and sign the provider certification on the next page. Applying for patient assistance does not guarantee acceptance into the program.

Treatment and product information (to be completed by provider)

☐ IXEMPRA® (ixabepilone) for injection, 15 mg ☐ IXEMPRA® (ixabepilone) for injection, 45 mg

Patient diagnosis: ICD-10 code _____ Description _____

Will this be? ☐ Monotherapy ☐ In combination with _____

IXEMPRA provided in: ☐ Doctor's office ☐ Hospital ☐ Outpatient facility

Patient information

First name _____ Middle initial _____ Last name _____ Date of birth ___/___/_____

Social Security number* _____ Gender: ☐ Female ☐ Male
* Providing Social Security number is optional.

Address _____ City _____ State _____ Zip _____

Home phone (____) _____ Cell phone (____) _____ Patient e-mail address _____

Insurance information (please check all that apply)

☐ Private insurance ☐ Medicare Part A/B ☐ Part D ☐ Medicare Advantage ☐ Medicaid ☐ VA or Military ☐ None

Primary insurance: please list below
Insurance name:
Phone:
ID/Policy #:
Group #:
Policy holder name:
Policy holder DOB:

Secondary insurance: please list below
Insurance name:
Phone:
ID/Policy #:
Group #:
Policy holder name:
Policy holder DOB:

Financial information (complete if choosing patient assistance program)

Number of people in your household _____ (includes your spouse and dependents)

Total household income: $_____ per month OR $_____ per year

For reimbursement assistance, call the Support Center at **1-855-991-7277**,
8 AM to 8 PM ET, Monday-Friday, fax **1-877-541-7813**, or visit **rpharm-us.enrollsource.com**.

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Patient authorization and agreement

Please read and sign the patient authorization and agreement.

By signing this authorization, I authorize my health plans, physicians, and pharmacy providers to disclose my personal health information, including, but not limited to, information relating to my medical condition, treatment, care management and health insurance, as well as all information provided on this form and any prescription ("Protected Health Information"), to Sonexus Health—and its representatives, agents, and contractors for the following purposes: (1) to establish my eligibility for benefits; (2) to communicate with my healthcare providers and me about my medical care; (3) to facilitate the provision of products, supplies, or services by a third party including, but not limited to specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; and (5) to contact me with educational or treatment support materials and requests for participation in patient programs related to treatment.

I understand that I may refuse to sign this authorization and that my treatment, payment, enrollment, or eligibility for benefits is not conditioned on my signing this authorization. I understand that I am entitled to a copy of this authorization. I understand that I may cancel this authorization at any time by mailing a letter requesting such cancellation to R-Pharm US Access and Support c/o Sonexus Health, 2730 South Edmonds Lane, Ste 300, Lewisville, TX 75067, but that this cancellation will not apply to any information already used or disclosed through this authorization.

SIGNATURE I have read this authorization and agree to its terms:

_____ _____

Print name of patient or personal representative | Description of personal representative's authority

_____

Signature of patient or personal representative | Date

Physician information

Physician name _____

State license # _____ Physician NPI # _____ Physician tax ID # _____

Facility name _____ Phone (____) _____ Fax (____) _____

Facility address _____ City _____ State _____ Zip _____

Primary contact name _____ Phone (____) _____ Fax (____) _____

Primary contact e-mail address _____ Title _____

Provider certification

I certify to the following:

(1) To the best of my knowledge, the patient and physician information in this form is complete, and accurate. **(2)** I have the authority to disclose this patient's information and have obtained, if required by HIPAA or other applicable privacy laws or regulations this patient's authorization for the disclosure. **(3)** To the best of my knowledge, this patient satisfies the eligibility criteria and I will immediately notify the program if I become aware that this patient's insurance or income status has changed. **(4)** I have read and agree to all of the terms and conditions of the program. **(5)** To the best of my knowledge, participation in this program is not inconsistent with any contract or arrangement with any third-party payer to which this office/site will submit a bill or claim for reimbursement for a covered R-Pharm US product administered to the patient. **(6)** This office/site will comply with applicable obligations, if any, to disclose participation in this program to the applicable payers. **(7)** The bill or claim that this office/site will submit to the insurer or patient for payment for a covered R-Pharm US product will have a covered R-Pharm US product listed separately from any bill or claim for drug administration or any other items or services provided to the patient. **(8)** I will not submit an insurance claim or other claim for payment to any third-party payer (private or government) for the amount of assistance that my patient receives from the program. **(9)** If this office/site receives payment directly from the program for this patient, the office/site will not accept payment from the patient for the amount received from the program. I will ensure payment is made back to the patient if funds have already been received from the patient for their share of the cost of a covered R-Pharm US product (minus $25 per treatment) for any dates of service paid through the program.

I understand that:

(1) R-Pharm US reserves the right to verify all information provided by providers, suspend participation where inadequate information is provided, and limit enrollment based on available resources. **(2)** R-Pharm US reserves the right to modify or terminate this program, or recall or discontinue medications, at any time without notice. **(3)** R-Pharm US is relying on the certifications in this form. **(4)** The program reserves the right to not provide assistance until an accurate and complete application with a signed certification is received, along with any other required documentation.

Please sign and date below and fax back to R-Pharm US Access and Support at 1-877-541-7813. An original physician signature is required. Stamped signatures or signatures by persons other than the prescribing healthcare physician are not acceptable. We will be unable to process the patient's request for assistance until we receive a complete application with your certification and the patient's signature and proof of income. If you have any questions please call R-Pharm US Access and Support at 1-855-991-7277. We are available to answer your call Monday through Friday, from 8:00 AM to 8:00 PM Eastern Time (excluding holidays).

_____ _____ _____

Original signature of prescribing physician | Prescribing physician's name (please print) | Date