Access Services by Bayer™

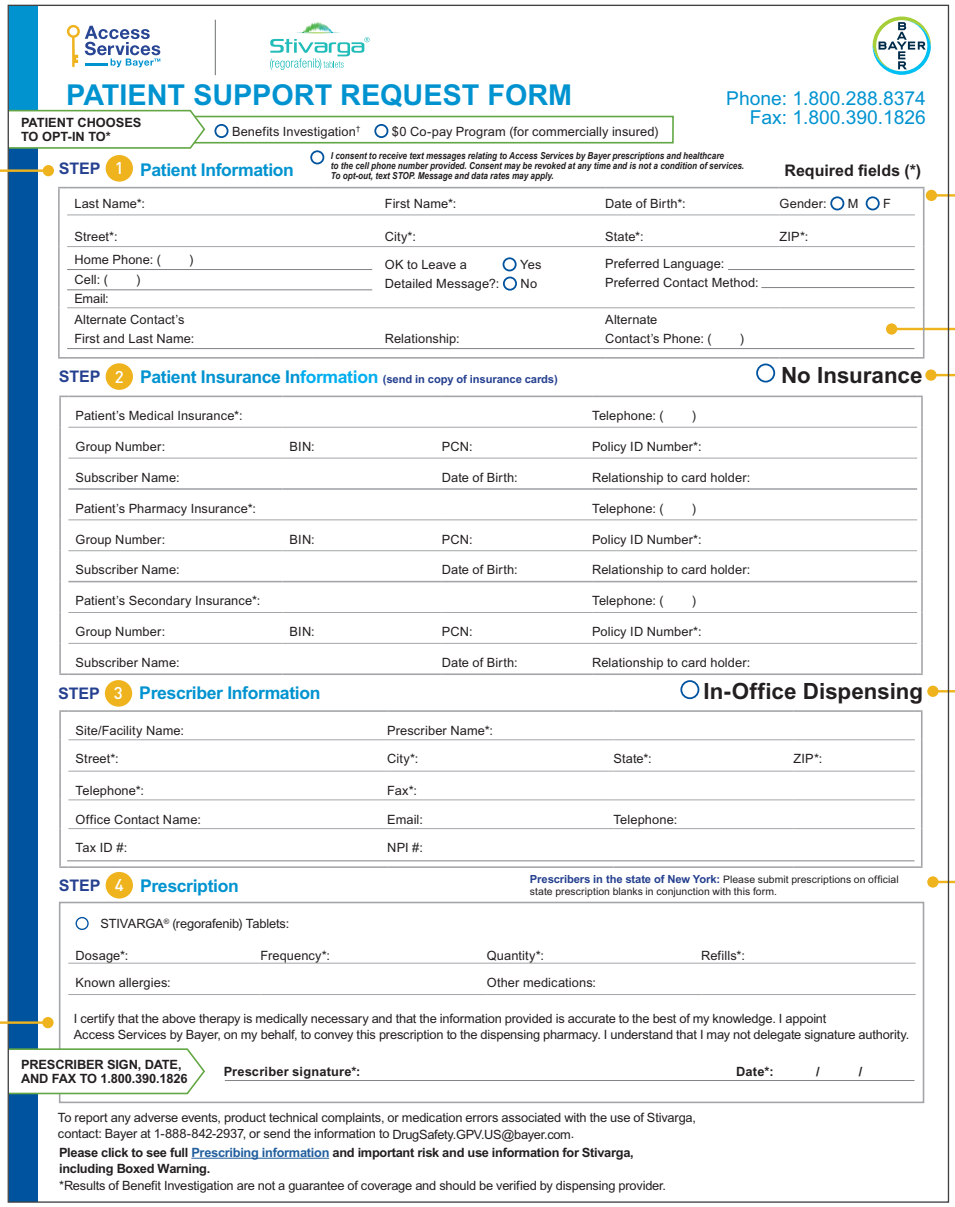
# Helping Your Patients Get Their Bayer Medications Through Access Services by Bayer™

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



Access Services by Bayer™ | Stivarga® (regorafenib) tablets

## PATIENT SUPPORT REQUEST FORM

Phone: 1.800.288.8374
Fax: 1.800.390.1826

PATIENT CHOOSES TO OPT-IN TO* ○ Benefits Investigation† ○ $0 Co-pay Program (for commercially insured)

**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*: | Gender: ○ M ○ F
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:

**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.

○ STIVARGA® (regorafenib) Tablets:
Dosage*: | Frequency*: | Quantity*: | Refills*:
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*:** **Date*:** / /

To report any adverse events, product technical complaints, or medication errors associated with the use of Stivarga, contact: Bayer at 1-888-842-2937, or send the information to DrugSafety.GPV.US@bayer.com.
**Please click to see full Prescribing information and important risk and use information for Stivarga, including Boxed Warning.**
*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**.

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

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

**Please click to see full Prescribing information and important risk and use information for Stivarga, including Boxed Warning.**

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

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

Access Services by Bayer™

Stivarga® (regorafenib) tablets

BAYER

# PATIENT SUPPORT REQUEST FORM

Phone: 1.800.288.8374
Fax: 1.800.390.1826

**PATIENT CHOOSES TO OPT-IN TO***

○ Benefits Investigation† ○ $0 Co-pay Program (for commercially insured)

## 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*: | Gender: ○ M ○ F |
| 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: |

## 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.

○ STIVARGA® (regorafenib) Tablets:

| | | | |
|---|---|---|---|
| Dosage*: | Frequency*: | Quantity*: | Refills*: |
| 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*:** **Date*:** / /

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

**Please click to see full Prescribing information and important risk and use information for Stivarga, including Boxed Warning.**

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

Access Services by Bayer™

Stivarga® (regorafenib) tablets

BAYER

# 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:**

**Please click to see full Prescribing information and important risk and use information for Stivarga, including Boxed Warning.**

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

# STIVARGA $0 CO-PAY PROGRAM TERMS AND CONDITIONS

- Patient must meet the eligibility requirements of the STIVARGA $0 Co-pay Program; for example, only commercially insured patients are eligible
- Patient eligibility will be reassessed annually
- Offer is expressly contingent on the requirement that the patient understand, accept, and comply with all requirements of the Co-pay Program
- Use of the Co-pay Program must be consistent with and not prohibited by the requirements of the patient's health insurance
- Patient agrees not to submit any portion toward the product dispensed pursuant to this Co-pay Program to a federal or state healthcare program for purposes of counting it toward the patient's out-of-pocket expenses (such as Medicaid)
- Co-pay assistance is capped at $25,000 per year, per patient
- Use of $0 co-pay must be for STIVARGA® (regorafenib) use that is consistent with the FDA-approved indications
- The program does not cover costs associated with a patient visit including prescriber, staff, or administrative charges associated with administering the applicable Bayer product
- Offer valid only for patients treated in the USA, including Puerto Rico, Guam and US Territories
- Bayer reserves the right to determine eligibility, monitor participation, equitably distribute product and modify or discontinue the $0 Co-pay Program at any time with or without notice
- Patient agrees to provide necessary health information to the administrators of the STIVARGA $0 Co-pay Program
- For questions about the STIVARGA Co-pay Program, call the $0 Co-pay Program support at 1-647-245-5622

**Please click to see full Prescribing information and important risk and use information for Stivarga, including Boxed Warning.**

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