PATIENT SUPPORT REQUEST FORM

Phone: 1-855-6XOFIGO (1-855-696-3446)
Fax: 1-855-963-4463

Xofigo® radium Ra 223 dichloride INJECTION

Xofigo® Access Services

FOR USE BY VA/DoD ONLY

STEP 1 Provider Information

Required fields (*)

Administering Provider Name*: _____ Specialty: _____

NPI #: _____

Facility Name: _____

Street*: _____ City*: _____ State*: _____ Zip Code*: _____

Primary Contact: Name*: _____ Email: _____ Phone*: _____ Fax*: _____

Administering Site Contact(s):

Name: _____ Title: _____ Phone*: _____ Fax*: _____

Order Placement*: _____ Title: _____ Phone*: _____ Fax*: _____

Product Shipping Information:

Ship-To Facility Name: _____ Receiving Contact Name*: _____ Phone*: _____

Street*: _____ City*: _____ State*: _____ Zip Code*: _____

Operating Hours (Days and Time): _____ Delivery Instructions: _____

Referring Provider Name*: _____

Specialty: _____ NPI #: _____

State License #: _____

Facility Name: _____

Street*: _____ City*: _____ State*: _____ Zip Code*: _____

Primary Contact Name*: _____ Email: _____

Phone*: _____ Fax*: _____

Scheduled Treatment Dates/Times:

_____ _____ _____ _____ _____ _____

STEP 2 Physician Declaration

I verify that the information contained in this inquiry form is complete and accurate to the best of my knowledge. I understand that Bayer reserves the right to modify or terminate Xofigo® Access Services at any time and without notice. I understand that Bayer is not responsible for filing claims and that all final decisions on diagnosis, the need for treatment, and the appropriateness of Xofigo for a patient rest with me as the patient's provider. I agree to abide by this certification throughout my participation in Xofigo Access Services.

PROVIDER TO SIGN AND DATE

Signature*: _____ Date (mm/dd/yyyy): _____

STEP 3 Contact Information

Last Name*: _____ First Name*: _____ Date of Birth*: _____

Email: _____

ICD-10-CM Primary Diagnosis: ☐ C61 ☐ Other ICD-10-CM Secondary Diagnosis: ☐ C79.51 ☐ C79.52 ☐ Other

FOR PRACTICES – FORM BACKGROUND

Fax a **completed and signed** Xofigo Access Services Patient Support Request Form, **including the signed Patient Authorization,** (page 2 of this form) to **1-855-963-4463,** or call us at **1-855-6XOFIOGO (1-855-696-3446)** to confirm a treatment date/schedule, or both. Access Counselors are available from 9:00 AM – 7:00 PM ET (M-F). You can also log onto the Xofigo Access Services Provider Portal 24 hours a day, 7 days a week at **XofigoAccessOnline.com**.

FOR ADMINISTERING PROVIDERS:

Call Xofigo Access Services up to 7 business days prior to each scheduled treatment to verbally place the order with Cardinal Health Nuclear Pharmacy Services. **Please be sure to identify yourself as a VA/DoD provider.** Orders can also be placed online via the secure Provider Portal at **XofigoAccessServicesOnline.com**. If you have not placed the order **a minimum of business 3 days** prior to the scheduled treatment date, Xofigo Access Services will call you to process the order.

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PATIENT AUTHORIZATION FOR XOFIGO® ACCESS SERVICES

I authorize the use and disclosure of my Protected Health Information ("PHI") as defined by the Health Insurance Portability and Accountability Act of 1996, which was amended by the Health Information Technology for Economic and Clinical Health Act (as amended, "HIPAA"). I understand that Protected Health Information is health information that identifies me or that could reasonably be used to identify me and that this authorization to release my information is voluntary.

I authorize my healthcare provider, including my physician, pharmacies and my health plan, to disclose my name, address, and telephone number along with certain medical information including my treatment, the coordination of my treatment, the receipt of my medication and my participation in the Patient Support Program, Xofigo® Access Services, to Bayer and its agents.

I allow the use and disclosure of my PHI for the following purposes: (1) to ensure the accuracy and completeness of the Xofigo Access Services Patient Support Request Form; (2) to provide education, training, and ongoing support on the use of my medication; (3) to send me information on related products and services related to my treatment; (4) to send me refill reminders for my prescription and to encourage appropriate use; (5) to communicate with me and my healthcare providers about my medical care and treatment; (6) to contact me for market research feedback; (7) for sales support purposes and (8) to comply with applicable law.

This authorization shall be in effect for 5 years from the date of my signature, or the date of last enrollment, whichever comes first, unless a shorter period is required by law. If I (or my representative) revoke this authorization, healthcare providers will stop using my PHI for the purposes outlined in this authorization, but the revocation will not affect prior use or disclosure of my PHI in reliance on this authorization. I (or my representative) may revoke this authorization at any time by calling 1-855-696-3446, faxing a request to 1-855-963-4463, or by mailing a written request to Xofigo Access Services, PO Box 220009, Charlotte, NC 28222-0009.

I also understand that persons or entities that receive my PHI under this authorization may not be required by privacy laws (such as the HIPAA Privacy Rule) to protect the information and may share it with others without my permission, if they are allowed to by law.

My healthcare providers and health plan insurer will not base my medical treatment or its payment, insurance enrollment, or eligibility for insurance benefits on my signing this form. However, the Program needs access to PHI to provide assistance to me. I understand that if I do not agree to the sharing of my PHI as described in this form, Bayer will not be able to provide assistance under the Program to me.

I have read this authorization and/or had its contents read to me. I have been able to ask questions about the use and sharing of my PHI and any questions I had have been fully answered. By submitting this form, I agree to receive communications from Bayer by mail, email, phone, and/or other electronic means. I authorize the use and sharing of my information as described in this form. I understand that I am entitled to receive a signed copy of this authorization.

PATIENT TO SIGN AND DATE

Patient signature: _____ **Date (mm/dd/yyyy):** _____

If signed by a legal representative: **Print Name:** _____ **Relationship to patient:** _____

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