Xofigo® radium Ra 223 dichloride INJECTION

Xofigo® Access Services

Instructions for completing the Patient Support Request Form

Benefits Investigation* (complete steps 1-3)

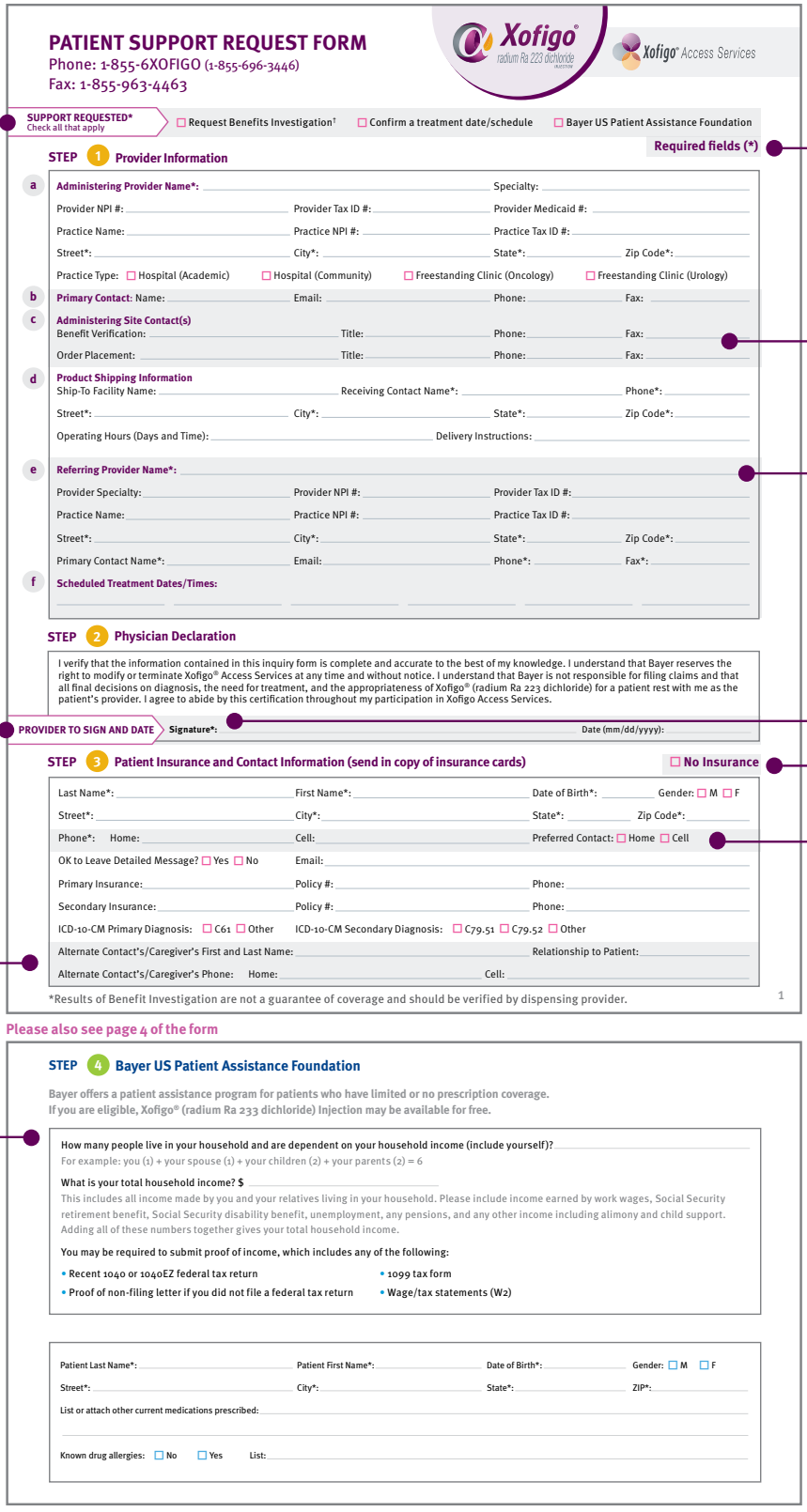
- Check patient's insurance to determine coverage

Confirm a Treatment Date/Schedule

- Verification of when Xofigo® will be administered to the patient

Bayer US Patient Assistance Foundation (complete steps 1, 3, and 4)

- For eligible patients who need additional financial assistance



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

SUPPORT REQUESTED* Check all that apply ☐ Request Benefits Investigation† ☐ Confirm a treatment date/schedule ☐ Bayer US Patient Assistance Foundation

Required fields (*)

STEP 1 Provider Information

a Administering Provider Name*: Specialty:
Provider NPI #: Provider Tax ID #: Provider Medicaid #:
Practice Name: Practice NPI #: Practice Tax ID #:
Street*: City*: State*: Zip Code*:
Practice Type: ☐ Hospital (Academic) ☐ Hospital (Community) ☐ Freestanding Clinic (Oncology) ☐ Freestanding Clinic (Urology)

b Primary Contact: Name: Email: Phone: Fax:

c Administering Site Contact(s)
Benefit Verification: Title: Phone: Fax:
Order Placement: Title: Phone: Fax:

d Product Shipping Information
Ship-To Facility Name: Receiving Contact Name*: Phone*:
Street*: City*: State*: Zip Code*:
Operating Hours (Days and Time): Delivery Instructions:

e Referring Provider Name*:
Provider Specialty: Provider NPI #: Provider Tax ID #:
Practice Name: Practice NPI #: Practice Tax ID #:
Street*: City*: State*: Zip Code*:
Primary Contact Name*: Email: Phone*: Fax*:

f 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® (radium Ra 223 dichloride) 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 Patient Insurance and Contact Information (send in copy of insurance cards) ☐ No Insurance

Last Name*: First Name*: Date of Birth*: Gender: ☐ M ☐ F
Street*: City*: State*: Zip Code*:
Phone*: Home: Cell: Preferred Contact: ☐ Home ☐ Cell
OK to Leave Detailed Message? ☐ Yes ☐ No Email:
Primary Insurance: Policy #: Phone:
Secondary Insurance: Policy #: Phone:
ICD-10-CM Primary Diagnosis: ☐ C61 ☐ Other ICD-10-CM Secondary Diagnosis: ☐ C79.51 ☐ C79.52 ☐ Other
Alternate Contact's/Caregiver's First and Last Name: Relationship to Patient:
Alternate Contact's/Caregiver's Phone: Home: Cell:

*Results of Benefit Investigation are not a guarantee of coverage and should be verified by dispensing provider. 1

Please also see page 4 of the form

STEP 4 Bayer US Patient Assistance Foundation

Bayer offers a patient assistance program for patients who have limited or no prescription coverage.
If you are eligible, Xofigo® (radium Ra 233 dichloride) Injection may be available for free.

How many people live in your household and are dependent on your household income (include yourself)?
For example: you (1) + your spouse (1) + your children (2) + your parents (2) = 6

What is your total household income? $
This includes all income made by you and your relatives living in your household. Please include income earned by work wages, Social Security retirement benefit, Social Security disability benefit, unemployment, any pensions, and any other income including alimony and child support. Adding all of these numbers together gives your total household income.

You may be required to submit proof of income, which includes any of the following:

- Recent 1040 or 1040EZ federal tax return
- 1099 tax form
- Proof of non-filing letter if you did not file a federal tax return
- Wage/tax statements (W2)

Patient Last Name*: Patient First Name*: Date of Birth*: Gender: ☐ M ☐ F
Street*: City*: State*: ZIP*:
List or attach other current medications prescribed:
Known drug allergies: ☐ No ☐ Yes List:

COMPLETE ALL REQUIRED FIELDS, INCLUDING PATIENT SIGNATURE, TO AVOID DELAYS IN TREATMENT

Program communications will be sent to the administrating site contact(s).

If requesting a benefits investigation* only:

Referring providers complete

- Step 1: e-f
- Step 2
- Step 3

Administering providers complete

- Step 1: a-f
- Step 2
- Step 3

The provider completing this form (administering or referring) **must** sign here.

Missing signatures **WILL** cause a delay in processing.

Alternate contacts may include caregivers to whom patients have given permission to speak with Xofigo® Access Services on their behalf.

Check this box if the patient does not have health insurance. **Complete Step 4 on page 4.**

At least 1 phone number is required.

Financial information will help determine if your patient is eligible for additional financial assistance.

Patient **must** sign the patient authorization on page 5.

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Xofigo® radium Ra 223 dichloride INJECTION

Xofigo® Access Services

SUPPORT REQUESTED*
Check all that apply

☐ Request Benefits Investigation† ☐ Confirm a treatment date/schedule ☐ Bayer US Patient Assistance Foundation

Required fields (*)

STEP 1 Provider Information

a

Administering Provider Name*: _____ Specialty: _____

Provider NPI #: _____ Provider Tax ID #: _____ Provider Medicaid #: _____

Practice Name: _____ Practice NPI #: _____ Practice Tax ID #: _____

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

Practice Type: ☐ Hospital (Academic) ☐ Hospital (Community) ☐ Freestanding Clinic (Oncology) ☐ Freestanding Clinic (Urology)

b

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

c

Administering Site Contact(s)

Benefit Verification: _____ Title: _____ Phone: _____ Fax: _____

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

d

Product Shipping Information

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

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

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

e

Referring Provider Name*: _____

Provider Specialty: _____ Provider NPI #: _____ Provider Tax ID #: _____

Practice Name: _____ Practice NPI #: _____ Practice Tax ID #: _____

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

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

f

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® (radium Ra 223 dichloride) 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 Patient Insurance and Contact Information (send in copy of insurance cards)

☐ **No Insurance**

Last Name*: _____ First Name*: _____ Date of Birth*: _____ Gender: ☐ M ☐ F

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

Phone*: Home: _____ Cell: _____ Preferred Contact: ☐ Home ☐ Cell

OK to Leave Detailed Message? ☐ Yes ☐ No Email: _____

Primary Insurance: _____ Policy #: _____ Phone: _____

Secondary Insurance: _____ Policy #: _____ Phone: _____

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

Alternate Contact's/Caregiver's First and Last Name: _____ Relationship to Patient: _____

Alternate Contact's/Caregiver's Phone: Home: _____ Cell: _____

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

PATIENT SUPPORT REQUEST FORM

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Xofigo® radium Ra 223 dichloride INJECTION

Xofigo® Access Services

PATIENT AUTHORIZATION AND CONSENT

WRITTEN PERMISSION TO SHARE PROTECTED HEALTH INFORMATION

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, my eligibility for assistance, 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 verify my insurance information; (2) to ensure the accuracy and completeness of the Xofigo Access Services Patient Support Request Form; (3) to help with my reimbursement questions; (4) to determine if I qualify for patient assistance; (5) to determine my eligibility for other sources of funding; (6) to provide education, training, and ongoing support on the use of my medication; (7) to send me information on related products and services related to my treatment; (8) to send me refill reminders for my prescription and to encourage appropriate use; (9) to communicate with me, my healthcare providers and health plan insurers about my medical care and treatment; (10) to contact me for market research feedback; (11) for sales support purposes and (12) 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.

If you would like more information about how Bayer handles your personal data, please review our Privacy Statement at https://labeling.bayerhealthcare.com/html/privacy.htm.

☐ I have read and agree to the XOFIGO $0 Co-Pay Program Terms and Conditions on page 3.

PATIENT TO SIGN AND DATE

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

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

PATIENT SUPPORT REQUEST FORM

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Xofigo® Access Services

XOFIGO $0 CO-PAY PROGRAM TERMS AND CONDITIONS

Patient must meet eligibility requirements of the XOFIGO $0 Co-pay Program; for example, only commercially insured patients are eligible: (i) Patient must inform XOFIGO $0 Co-pay Program of change in insurance status; (ii) it is required that the patient understand, accept, and meet the terms of all the XOFIGO $0 Co-pay Program requirements; (iii) use of the XOFIGO $0 Co-pay Program must be consistent with and not prohibited by the requirements of the patient's health insurance; (iv) the XOFIGO $0 Co-pay Program benefit has a maximum amount of $25,000 per year, per patient; (v) the XOFIGO $0 Co-pay Program is for commercially insured patients using XOFIGO for an approved FDA indication; (vi) the XOFIGO $0 Co-pay Program does not cover costs for charges associated with administering XOFIGO or patient visits; (vii) offer valid only for patients treated in the USA, including Puerto Rico, Guam and US Territories; (viii) Bayer reserves the right to determine eligibility, monitor participation, fairly distributed product and may change or end the XOFIGO $0 Co-pay Program at any time with or without notice; (ix) patient agrees to provide necessary health information for the administration of the XOFIGO $0 Co-pay Program.

For questions about the XOFIGO $0 Co-pay Program, please call us at 1-855-6XOFIGO (1-855-696-3446).

FOR PRACTICES

FORM BACKGROUND

Fax a completed Xofigo Access Services Patient Support Request Form, including the signed Patient Authorization, (page 2 of this form) or call us to request an insurance benefit investigation*, confirm a treatment date/schedule, or both. Xofigo Access Services will call the payer(s) to verify coverage for your patient, including any prior authorization requirements. An Access Counselor will call your facility to discuss the results within 24-48 hours and fax you a summary of insurance benefits. 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 or log onto the Provider Portal at XofigoAccessOnline.com up to 7 business days prior to each scheduled treatment to place the order. If you have not placed the order a minimum of 3 business days prior to the scheduled treatment date, Xofigo Access Services will call you to confirm.

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PATIENT SUPPORT REQUEST FORM

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Bayer US Patient Assistance Foundation

Complete Step 4 for additional financial assistance

STEP 4 Bayer US Patient Assistance Foundation

Bayer offers a patient assistance program for patients who have limited or no prescription coverage. If you are eligible, Xofigo® (radium Ra 233 dichloride) Injection may be available for free.

How many people live in your household and are dependent on your household income (include yourself)? _____

For example: you (1) + your spouse (1) + your children (2) + your parents (2) = 6

What is your total household income? $ _____

This includes all income made by you and your relatives living in your household. Please include income earned by work wages, Social Security retirement benefit, Social Security disability benefit, unemployment, any pensions, and any other income including alimony and child support. Adding all of these numbers together gives your total household income.

You may be required to submit proof of income, which includes any of the following:

- Recent 1040 or 1040EZ federal tax return
- Proof of non-filing letter if you did not file a federal tax return
- 1099 tax form
- Wage/tax statements (W2)

Patient Last Name*: _____ Patient First Name*: _____ Date of Birth*: _____ Gender: ☐ M ☐ F

Street*: _____ City*: _____ State*: _____ ZIP*: _____

List or attach other current medications prescribed: _____

Known drug allergies: ☐ No ☐ Yes List: _____

Healthcare Professional Authorization

I certify that I am the healthcare professional who prescribed the medication requested in this application for the sole benefit of the named patient, and that my decision to prescribe was based on my independent professional judgment. I authorize the Bayer US Patient Assistance Foundation free drug program (the "Program"), and agents acting on its behalf to use my provider information, including National Provider ID, in the eligibility assessment process, and to forward this prescription, as necessary, to a dispensing pharmacy. In addition to the above, my signature below certifies the following: (i) I will not charge patients any fee for, or related to, their application, enrollment in the Program, any co-payment, or other cost-sharing amount related to free drug provided under the Program; (ii) no claim for payment for any product provided through the Program may be submitted to any third-party payer, including private insurers, Medicaid or Medicare; (iii) this medication provided by the Program will only be utilized by the patient named on this form, and will not be offered for sale, trade, barter, or returned for credit; (iv) the patient applying for assistance through the Program is being treated in an outpatient setting; (v) to the best of my knowledge, the information provided on this form is current, complete and accurate.

I understand and acknowledge that (i) submission of the application does not guarantee the patient's eligibility in the Program; (ii) the Program has the right to discontinue the Program at any time; and (iii) medication provided through the Program for enrolled patients is not contingent on any past, present or future prescriptions for this or any other Bayer product.

PRESCRIBER TO SIGN AND DATE

Dispense as written: _____ **Date (mm/dd/yyyy):** _____

PATIENT SUPPORT REQUEST FORM

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Fax: 1-855-963-4463

Bayer US Patient Assistance Foundation

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

I agree to allow my healthcare providers and health insurers to give the Bayer US Patient Assistance Foundation free drug program, Bayer and its agents, my personal and medical information, including healthcare condition, diagnosis and medicines, for the following purposes: (1) (i) Determine if I am eligible for the program, (ii) provide me with free medicine through the Bayer US Patient Assistance Foundation free drug program if I am eligible to participate, and (iii) comply with any laws that may require the use or disclosure of my information. (2) Contact me or my healthcare provider for additional information to evaluate any adverse event or product complaint that I report or that my provider reports on my behalf. (3) Contact me to ask for feedback on the quality or customer service of the program. (4) Proper management and administration of the program and as permitted or required by applicable law.

I UNDERSTAND:

(1) Application to Bayer US Patient Assistance Foundation is entirely voluntary and I may choose to not complete or sign this form. My decision will not change the way my healthcare providers or health insurers treat me. However, if I do not complete and sign this application, I will not be able to participate in the Bayer US Patient Assistance Foundation free drug program. (2) Privacy laws may not prevent further disclosure of my information after it has been provided to the program, Bayer, their agents, or third-party providers authorized to administer the program. (3) This consent to provide my personal and medical information will continue until I am no longer enrolled in the program or until I choose to cancel my consent, which I may do at any time. (4) I can cancel my authorization at any time by writing to the Bayer US Patient Assistance Foundation, PO Box 5670, Louisville, KY 40255. Cancelling my consent will not have any effect on information given to or used by the program or its agents before the program received my written notice to cancel the consent. (5) I should keep a copy of this form. I also can get a copy by contacting the program at 1-866-2BUSPAF (1-866-228-7723).

INCOME VERIFICATION CONSENT

By applying for the Bayer US Patient Assistance Foundation free drug program, I understand and agree that: (i) there is no charge to participate and my participation in the program is not contingent on any requirement to purchase or use any Bayer product; (ii) completing and signing the program application does not guarantee my eligibility; (iii) the program may change or end at any time; (iv) I will not sell or trade any medicine that I get through this program; (v) I will notify the program within thirty (30) days if there is any change in my income, health insurance, eligibility to enroll in Medicare Part D, or any other reason that may affect my eligibility; (vi) I will not seek to be reimbursed or receive credit from my insurance provider, including Medicare Part D plans, for medicine I receive through the program; (vii) I will not seek credit for medicine from the program toward my true out-of-pocket expenses under Medicare Part D; (viii) the information I provided in this application is correct and complete.

I am providing 'written instructions' under the Fair Credit Reporting Act to the program, including its agents, administrators, and service providers, authorizing the program to obtain information from my credit profile and/or other information from Experian Health. I authorize the Bayer US Patient Assistance Foundation, including its agents, administrators, and service providers, to obtain such information solely to determine my eligibility to participate in the program.

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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