

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

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

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

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

PATIENT SUPPORT REQUEST FORM
Phone: 1-855-6XOFIGO (1-855-696-3446)
Fax: 1-855-963-4463

SUPPORT REQUESTED* Check all that apply

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

STEP 1 Provider Information Required fields (*)

a Administering Provider Name*:

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*:

Referring Provider Name*: _____ 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

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 223 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

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

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

At least 1 phone number is required.

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

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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: _____

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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 Xofigo Access Services. 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 Xofigo Access Services 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

I understand that:

- This Authorization will remain in effect until the end of my participation in Xofigo Access Services or 5 years from the date of my signature on this Authorization, whichever occurs later.
- I may cancel this Authorization at any time by writing to:
Xofigo Access Services, PO Box 220009, Charlotte, NC 28222-0009.
- 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.
- 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 Xofigo Access Services 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 Xofigo Access Services at 1-855-696-3446.

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

**PATIENT TO
SIGN AND DATE**

Patient name (print)*: _____

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

If signed by a legal representative:

Print Name: _____

Relationship to patient: _____

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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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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
- 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: _____

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): _____

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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:** _____

