# ENROLLMENT FORM

Bioverativ

Print and fax completed enrollment forms to 1-855-398-7634

# INSTRUCTIONS FOR PATIENTS

## PATIENT INFORMATION (Required)

Patient name: ______________________________ DOB: ___/___/___ SSN (last 4 digits only): ___ ___ ___ ___ Sex: M F

Street address: ______________________________ City: ______________ State: _____ ZIP: __________

Phone: ____________________ ☐ OK to leave message Email: ______________________________

Current Therapy: ______________________________ Have you ever been on ELOCTATE or ALPROLIX? ☐ Yes ☐ No

Adjusted gross income (this is your gross income from taxable sources minus allowable deductions, such as unreimbursed business expenses, medical expenses, alimony, and deductible retirement plan contributions)†: ______________

The information you provide is subject to verification for which documentation may be requested.

## PATIENT INSURANCE INFORMATION (Required)

☐ Check if patient does not have insurance

Primary insurance name: ______________________________

Insurance phone: __________ Policy #: ______________

Policy holder name: __________ Policy holder DOB: ___/___/___

Secondary insurance name: ______________________________

Insurance phone: __________ Policy #: ______________

Policy holder name: __________ Policy holder DOB: ___/___/___

Pharmacy plan name: ______________ Group #: ________ Policy #: ________ Rx BIN #: ________ Rx PCN #: ________

## READ AND SIGN AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION (Required)

By signing this Authorization, I authorize my healthcare provider, my health insurance company, and my pharmacy or other institutional healthcare providers to disclose to Bioverativ, and companies working with Bioverativ (collectively, "Bioverativ"), health information relating to my medical condition, treatment, and insurance coverage that is needed to provide me with product support including but not limited to online support, and financial and reimbursement services. I also authorize the disclosure of my health information to specific individuals I have designated below. Once my health information has been disclosed to Bioverativ and/or such other individuals, I understand that federal privacy laws may no longer protect the information. However, Bioverativ agrees to undertake reasonable efforts to maintain my Personal Health Information in a secure manner and not to disclose it to third parties without a legitimate reason for doing so or as required by law or regulations. I understand that my pharmacy provider may receive remuneration from Bioverativ in exchange for the health information and/or for any therapy support services provided to me.

I may cancel this Authorization at any time by mailing a letter to: Bioverativ, Attn: Patient Services, 225 2nd Avenue, Waltham, MA 02451 or visiting Bioverativ.com/privacy. Canceling this Authorization will end my consent to further disclosure of my health information to Bioverativ, and my receipt from Bioverativ of therapy support services, after the date Bioverativ receives my letter, but will not affect my healthcare providers' or Bioverativ's ability to use and disclose health information that it has already disclosed or received before receipt of my letter. Canceling this authorization will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance.

This Authorization expires twenty (20) years from the day it is given as indicated by the date to the right, unless canceled as set forth above. I understand I may receive a copy of the signed authorization if requested. I understand that I may refuse to sign this authorization and that it is strictly voluntary. I further understand that my treatment (including with a Bioverativ product), payment for treatment, insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization.

PATIENT SIGNATURE: ______________________________ Date: ______________

PARENT / GUARDIAN SIGNATURE (for patients under 18 years old): ______________________ Date: ______________

(Optional) In addition, I authorize the disclosure of my health information to the following designated individual:

Designated Individual (print name) ______________________________ Relationship: ______________

## PATIENT SERVICES AUTHORIZATION

I further authorize Bioverativ to provide me with various therapy support services for which I am eligible, including but not limited to: online support, financial assistance services, reimbursement services, and compliance and persistency services, as well as any information or materials related to such services. I also authorize Bioverativ to contact me to ask me about my experience with or thoughts about products, services, and programs that Bioverativ offers or sponsors. I understand and agree that any information I provide may be used by Bioverativ to help develop new products, services, and programs. I understand and agree that Bioverativ may contact me about such services and information by mail, e-mail, telephone call, fax, or text message (including autodialed or prerecorded calls), or other means at the telephone numbers, e-mail, and mailing addresses I provide. I also authorize Bioverativ to use my health information in connection with the services, including, without limitation, sharing such information with my healthcare provider, insurance provider, or pharmacy.

PATIENT SIGNATURE: ______________________________ Date: ______________

PARENT / GUARDIAN SIGNATURE (for patients under 18 years old): ______________________ Date: ______________

## AGREE TO RECEIVE RELEVANT BIOVERATIV MARKETING COMMUNICATIONS

Bioverativ would like to send you additional information about our products and financial assistance programs.

You must be thirteen (13) years or older to enroll. If you are aged 13 to 18, you should get your parent's or guardian's permission before providing your personal health information. We will not sell or transfer your Personal Data to any unrelated third party for marketing purposes without your express permission. We may also share such Personal Data with regulatory authorities, if required, or contact you to conduct market research. (Continued on next page)

ELOCTATE® [Antihemophilic Factor (Recombinant), Fc Fusion Protein]

ALPROLIX® [Coagulation Factor IX (Recombinant), Fc Fusion Protein]

†Required for Factor Access Program Only

## AGREE TO RECEIVE RELEVANT BIOVERATIV MARKETING COMMUNICATIONS CONT.

I authorize Bioverativ, and companies working with Bioverativ, to contact me by mail, e-mail, fax, and/or telephone, including calls and text messages made using an automatic telephone dialing system or a prerecorded voice at the telephone number(s) provided to provide me with the information I requested and other related information and services or programs that Bioverativ offers or sponsors, or other topics of interest.

I understand that I am not required to provide this consent as a condition of purchasing any property, goods, or services from Bioverativ. To learn more about how your personal information is used or if you decide that you no longer want to receive information about Bioverativ's products and services, please visit Bioverativ.com/privacy.

PATIENT SIGNATURE: ______________________ Date: ______________

PARENT / GUARDIAN SIGNATURE (for patients under 18 years old): ______________________ Date: ______________

## BIOVERATIV SUPPORT PROGRAMS

### FREE TRIAL PLUS*

Receive your first 30-day supply of therapy immediately with a valid prescription from your healthcare provider. You may also be able to receive free factor for up to 1 year, if needed.

### COPAY ASSISTANCE*

Bioverativ offers a copay program to eligible patients that can cover up to $12,000 of out-of-pocket, co-payment or co-insurance costs associated with your prescription.

### FACTOR ACCESS*

Bioverativ can help you access therapy, even if your insurance coverage is interrupted. You may also be able to receive free factor for up to 1 year, if needed.

*Those with federal and state government insurance, such as Medicare, Medicaid, or TRICARE® are not eligible. Other eligibility requirements may apply. Bioverativ reserves the right to modify or discontinue the programs at any time. Please visit ELOCTATE.com for more information.

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# INSTRUCTIONS FOR HEALTHCARE PROVIDERS

Prescription for: ☐ ELOCTATE OR ☐ ALPROLIX

**SELECT BIOVERATIV SUPPORT PROGRAM:** ☐ Free Trial Plus ☐ Copay ☐ Factor Access

## PRESCRIBER INFORMATION

Prescriber name: ______________ State License #______________ NPI #: ______________

Tax ID #______________ DEA: ______________ PTAN: ______________

Facility name/address: ______________ City: ______________ State: ____ ZIP: ________

Office contact: ______________ Phone: ______________ Fax: ______________ Email: ______________

Ship to: ☐ Patient home ☐ Prescriber's Office

## PRESCRIPTION INFORMATION (Complete if Applying for Free 30-Day Trial or Factor Access)

To be dispensed by RxCrossroads only.

Directions: ______________

Patient Weight:_______ kg _________ lb # of Refills: _________

Dose: ______________

## PRESCRIBER AUTHORIZATION FOR FREE 30-DAY TRIAL OR FACTOR ACCESS (Required)

I acknowledge that I have obtained authorization to release the patient's personal health information and the information on this form and any prescription to Bioverativ, its affiliates, and their representatives, agents and contractors, for the purpose of providing product support services. I further certify that any service provided by Bioverativ on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe or use any Bioverativ product or service for anyone, and my decision to prescribe a Bioverativ product was based solely on my determination of medical necessity, and that I will not seek reimbursement for any medication or service provided by or through Bioverativ from any government program or third-party insurer. I will notify Bioverativ immediately if the Bioverativ product is no longer medically necessary for this patient's treatment or if my patient's insurance status changes.

I authorize Bioverativ as my designated agent and on behalf of my patient to (1) forward the above service request form and furnish any information on this form to the insurer of the above-named patient and (2) forward the above prescription, by fax or other mode of delivery, to the pharmacy chosen by the above-named patient.
I certify the rationale for prescribing ALPROLIX [ICD-10 D67] or ELOCTATE [ICD-10 D66] and I will be supervising the patient's treatment accordingly.

PRESCRIBER SIGNATURE (dispense as written) ______________________ DATE: ______________

PRESCRIBER SIGNATURE (substitution permitted) ______________________ DATE: ______________

ELOCTATE® [Antihemophilic Factor (Recombinant), Fc Fusion Protein]

ALPROLIX® [Coagulation Factor IX (Recombinant), Fc Fusion Protein]