CoverOne®

Patient Enrollment Form
PO Box 29293
Phoenix, AZ 85038-9293
Phone: 1-844-8COVER1
(844-826-8371)
Fax: 1-800-214-7295
CoverOne.com

Please enroll online at CoverOne.com or complete and fax signed enrollment form to 1-800-214-7295

CoverOne Services: The patient is requesting assistance with the following services for BAVENCIO® (avelumab) Injection 20 mg/mL (select all that apply):

___ Verification of Insurance Benefits/Drug Coverage/Patient Assistance Program Pre-screening
___ Prior Authorization Assistance/Guidance
___ Apply for Co-Pay Assistance (for privately insured patients only)
___ CoverOne Patient Assistance Program: Please apply if uninsured or you are unsure if you have insurance coverage for BAVENCIO. **Include a prescription for the patient if applying for Patient Assistance Program**
___ Denied/Underpaid Claims Assistance ___ Other _____

PATIENT INFORMATION

First Name:	Last Name:	Date of Birth:	Home Phone #:
Street Address (No PO Box):			Work Phone #:

City:	State:	ZIP :	Email:	Cell Phone #:

Gross Annual Household Income*: $	Number of People in Household:	Is patient a U.S. citizen or U.S. resident? ☐ YES / ☐ NO

INSURANCE INFORMATION - Please provide copies of all medical and pharmacy insurance cards (front and back)

Does the patient have medical benefits and/or pharmacy benefits through any private or government health insurer/payer/program? ☐ YES / ☐ NO
If "YES", please check applicable boxes and complete all that apply below.

Government Health Insurers/Payers/Programs

☐ Medicare Part A ☐ Medicare Part C (Medicare Advantage) ☐ Medicaid ☐ Veterans Affairs
☐ Medicare Part B ☐ Medicare Part D - Drug Plan ☐ TRICARE ☐ Other: _____

List Medicare Beneficiary Identifier: _____

	Name of Insurer/Plan:	*Policy ID #:*	*Group #:*	*Insurer Phone #:*	*Policy Holder Name (if applicable):*
☐ **Private Insurance** - Medical (Primary) *Is this an ACA Qualified Health Plan?* ☐ YES / ☐ NO					
☐ **Private Insurance** - Medical (Secondary) *Is this an ACA Qualified Health Plan?* ☐ YES / ☐ NO					
☐ **Private** - Pharmacy Benefits Manager					

PATIENT SIGNATURE – By signing below, I confirm that I have read and understand the *Authorization for Use and Disclosure of Health and Other Personal Information* and the *Patient Consent for CoverOne Program* and agree to the terms on Page 2.

Patient Name (print) _____ Patient Signature (required) _____ Date _____

Legal Representative/Guardian Signature (If applicable) _____ Relationship to Patient _____ Date _____

PHYSICIAN INFORMATION

Treating Physician Name:		Physician Email:	
State License #:	NPI:	Physician Tax ID #:	PTAN:
Facility Name:	Street Address (No PO Box):		
City:	State:	ZIP:	
Office Contact Name:	Phone:	Office Contact Email:	Fax:

PATIENT MEDICAL INFORMATION: Primary ICD-10-CM code: Secondary ICD-10-CM code:		List Planned BAVENCIO Dates of Service:	
Is patient being treated with BAVENCIO in combination with axitinib? ☐ YES / ☐ NO	List Previous Therapies:	Has patient received prior treatment with platinum-containing chemotherapy? ☐ YES / ☐ NO If yes, has patient disease progressed on platinum-containing chemotherapy? ☐ YES / ☐ NO	
Is the patient's primary cancer metastatic? ☐ YES / ☐ NO	**Site of Care** Physician Office: _____ Outpatient Hospital: _____ Other: _____		

PHYSICIAN SIGNATURE – By signing below, I confirm that I have read and understand the *Treating Physician Certification for CoverOne Program* and agree to the terms on Page 2.

Physician Name (print) _____ Physician Signature (required) _____ Date _____

*For patients applying to the Patient Assistance Program, include before-tax wages, Social Security benefits, and any other source of household income.
NOTE: Please include income documentation if applying for the Patient Assistance Program.

Authorization for Use and Disclosure of Health and Other Personal Information

By signing the CoverOne® Enrollment Form, I agree to the following:

- I authorize my physician(s), pharmacist(s), other health care providers, patient advocacy organizations and insurance companies ("My Health Care Providers and Plans") to disclose my health and other personal information, including, but not limited to, the information on this form ("My Health Information") to EMD Serono, Inc. and Pfizer Inc., which co-promote BAVENCIO® (avelumab) injection 20 mg/mL, and individuals and companies working with EMD Serono and Pfizer and their agents and representatives (collectively, "CoverOne") in order that I may participate in the CoverOne patient support program. My Health Information may also include, but is not limited to, information regarding my diagnosis of and treatment for the one or more conditions for which I may be or have been prescribed BAVENCIO (the "Product"), financial information, insurance status, information included in any Statement of Medical Necessity for me for a Prescription and Enrollment Form, and any other information deemed relevant by My Health Care Providers and Plans regarding my health care condition or medications.
- CoverOne may use and further disclose my Health Information obtained pursuant to this Authorization to: (1) contact me by mail, email, and/or telephone to enroll me in and administer the CoverOne program; (2) provide me with materials relating to the CoverOne program; (3) verify the accuracy of the information I provide and in my application for the CoverOne program; (4) provide me with reimbursement support services; and (5) conducting quality assurance, surveys, and other internal business activities in connection with the CoverOne program.
- I understand that this Authorization will remain in effect for ten (10) years, or such shorter period as may be required by state law, from the date of my signature, unless I revoke this authorization earlier by contacting CoverOne in writing at the address on page one of the form. If I revoke this Authorization, My Health Care Providers and Plans will stop disclosing this information to CoverOne.
- I understand that my refusal to sign this Authorization will not affect my ability to receive BAVENCIO, my treatment, payment for treatment, eligibility for or enrollment in health benefits; however, such refusal will limit my ability to receive support services for BAVENCIO through the CoverOne program.
- I understand that, once my Health Information is disclosed pursuant to this Authorization, it may be subject to redisclosure and no longer protected by federal privacy laws.
- I understand that I have the right to receive a copy of this authorization.

Patient Consent for CoverOne Program

By signing the CoverOne Enrollment Form, I agree and certify the following:

- I confirm that all financial and insurance information is complete and accurate. Additionally, during participation in the CoverOne program, and while I am receiving treatment with BAVENCIO, I agree to immediately notify CoverOne if my health insurance status changes in the future, if I obtain any new health insurance plan, or if I become entitled to, or enroll in a government health insurance program/payer (i.e. Medicare or Medicaid).
- I understand that CoverOne reserves the right to modify, change, or terminate the CoverOne program at any time with or without notice.
- I understand that if I am a California resident I have certain rights with respect to my personal information that are described in the EMD Serono California Consumer Privacy Act Privacy Policy available at https://www.emdserono.com/us-en/privacy-policy.html
- I understand that non-identifiable information from all CoverOne program participants may be summarized for statistical or other purposes.

Treating Physician Certification for CoverOne Program

By signing the CoverOne Enrollment Form, I agree to and certify the following:

- BAVENCIO is medically appropriate for the patient identified above and that I, or a physician in my Practice, will be supervising the patient's treatment.
- The CoverOne program is a patient support program available to assist patients, and that program participation is voluntary, and that patient eligibility for services is not connected to or contingent on any past or future purchase of BAVENCIO.
- If the patient applies for and is eligible for donated product through the CoverOne Patient Assistance Program, I will not seek reimbursement for such donated product administered to the patient from any insurance company or program, including federal healthcare programs, such as Medicare and Medicaid. Additionally, I agree to notify CoverOne immediately if the patient is no longer receiving BAVENCIO through the Patient Assistance Program, and agree to return unused donated Patient Assistance Program product to CoverOne.
- I understand that information concerning program participants may be summarized for statistical or other purposes and provided to EMD Serono and Pfizer but such summaries will not contain information that identifies program participants personally.
- The information provided on the enrollment form is complete and accurate to the best of my knowledge.
- CoverOne reserves the right to modify, change, or terminate the CoverOne program at any time with or without notice.

EMD Serono, Inc. and Pfizer Inc do not guarantee coverage or reimbursement for BAVENCIO.
Coverage and reimbursement decisions are made by insurance companies following the receipt of claims.

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