Please complete and fax signed enrollment form to 1-800-214-7295

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

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:	SSN:	Home Phone #:
Street Address (No PO Box):				Work Phone #:
City:		State:	ZIP:	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 B ☐ Medicare Part C (Medicare Advantage) ☐ Medicare Part D - Drug Plan ☐ Medicaid ☐ TRICARE ☐ Veterans Affairs ☐ Other: _____

	Name of Insurer/Plan:	*Policy ID #:*	*Group # (if applicable):*	*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've read and understand the *Patient Authorization for Use and Disclosure of Health and 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:

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

PATIENT MEDICAL INFORMATION: Primary ICD-10-CM code: Secondary ICD-10-CM code:

Site of Care
Physician Office: ☐ Outpatient Hospital: ☐ Other: _____

PHYSICIAN SIGNATURE – By signing below, I confirm that I've 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.

Patient Authorization for Use and Disclosure of Health and Personal Information

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

- I authorize the disclosure and use, as described below, of my financial information, insurance information, medical information, including personally identifiable protected health information, to the CoverOne program, 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 (collectively, "CoverOne"), for the purpose of allowing CoverOne to provide me with reimbursement support services, patient assistance program services, and/or co-pay assistance, and/or to evaluate me for eligibility in the CoverOne program.

- I also authorize my physician(s), pharmacist(s), other healthcare providers, patient advocacy organizations, and insurance companies to disclose to CoverOne, and the companies that help administer the CoverOne program, information about my medical condition, treatments, financial information, insurance status, and protected health information for the purpose of providing CoverOne program services and assistance.

- Once my information has been disclosed pursuant to this authorization, I understand that federal privacy laws may no longer protect that information. I understand I may revoke this authorization by giving written notice of my revocation to CoverOne at the address on page 1 of the form. After revocation of this authorization, CoverOne will stop using and disclosing my information, but the revocation will not affect prior use or disclosure of my information.

- I understand that this authorization will remain in effect for ten years, or such shorter period as may be required by state law, from the date of my signature, unless I revoke this authorization earlier.

- 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 I have the right to receive a copy of this authorization.

Patient Certification 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'm 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. such as 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 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 access 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.
- 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.

March 2017 US/AVE/1016/0118a