Bayer US **Patient Assistance Foundation**
P.O. Box 5670, Louisville, KY 40255 / 1-866-2BUSPAF (228-7723)

Application

Bayer understands that sometimes people face financial challenges, and we are here to help. The Bayer US **Patient Assistance Foundation** is a charitable organization that helps eligible patients get their Bayer prescription medicine at no cost.

How do I know if I may be eligible?

You may be eligible for the Bayer US **Patient Assistance Foundation** free drug program if you:

- Live in the United States or Puerto Rico
- Meet certain income limits
- Don't have insurance, or your Bayer prescription medicine is not covered

How do I apply?

- Complete and sign the **Patient Information Section** (pages 2-5). A caregiver can also complete this portion of the form.
- Ask your doctor or healthcare professional (HCP) to complete and sign the **Healthcare Professional Section** (page 6).
- Make a copy of the completed and signed application for your records.
- Fax or mail the complete application for review by the program.

Where do I send my completed application?

The completed and signed application can be submitted by fax or mail:

Fax: 1-866-575-6568

Mail: Bayer US Patient Assistance Foundation
P.O. Box 5670, Louisville, KY 40255

Your application can only be reviewed if it is **completely filled out; signed by both you and your doctor.** Use the checklist on page 7 of this application to make sure all information is included.

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Patient Information Section

The Patient Information Section can be completed by you or a caregiver. Your application cannot be considered without a fully completed and signed form.

Your Medication(s)

The following Bayer prescription medicines are included in this program; please check all items you are applying for:

- ☐ Adempas® (riociguat)
- ☐ Aliqopa™ (copanlisib)
- ☐ Angeliq® (drospirenone and estradiol)
- ☐ Betaseron® (interferon beta-1b)
- ☐ Biltricide® (praziquantel)
- ☐ Climara PRO™ (estradiol, levonorgestrel transdermal)
- ☐ Jivi® antihemophilic factor (recombinant) PEGylated-aucl
- ☐ Kogenate® Antihemophilic Factor (recombinant)
- ☐ Kovaltry® Antihemophilic Factor (recombinant)
- ☐ Kyleena® (levonorgestrel-releasing intrauterine system)
- ☐ Menostar® (estradiol transdermal system)
- ☐ Mirena® (levonorgestrel-releasing intrauterine system)
- ☐ Natazia® (estradiol valerate and estradiol valerate/dienogest)
- ☐ Nexavar® (sorafenib)
- ☐ Nubeqa® (darolutamide)
- ☐ Safyral® (drospirenone/ethinyl estradiol/levomefolate)
- ☐ Skyla® (levonorgestrel-releasing intrauterine system)
- ☐ Stivarga® (regorafenib)
- ☐ Vitrakvi® (larotrectinib)

Your Name and Contact Information

Name _____ (First) _____ (Last) Date of birth ____/____/____ (Month / Date / Year) Gender ☐ Male ☐ Female

Mailing address _____ City _____ State _____ Zip code _____

Preferred contact ☐ Home _____ ☐ Cell _____ ☐ Work _____

Your email address _____

Your Household Income

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.

Upon request, you may be asked to submit proof of income, which includes any of the following:

☐ Recent 1040 or 1040EZ federal tax return ☐ 1099 tax form ☐ Wage/tax statements (W2)

☐ Proof of non-filing letter if you did not file a federal tax return

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Your Healthcare Insurance Information

Do you have healthcare insurance? ☐ Yes ☐ No If yes, please complete all sections below that apply.

☐ Your Primary Healthcare or State/Government Insurance

Insurer name _____ Group # _____

Plan name _____ Type: ☐ Commercial/Private ☐ Medicare

Plan phone number (_____) _____ ☐ Medicaid

Name of plan subscriber _____ ☐ Veterans Affairs/Dept. of Defense

Subscriber relationship to patient _____ ☐ State Elderly Drug Assistance

Membership ID/policy # _____ ☐ State Children's Health Insurance

☐ Other

☐ Your Secondary Healthcare Insurance (supplemental)

If you do not have any other insurance, you do not need to fill out this section

Insurer name _____ Group # _____

Plan name _____ Type: ☐ Commercial/Private ☐ Medicare

Plan phone number (_____) _____ ☐ Medicaid

Name of plan subscriber _____ ☐ Veterans Affairs/Dept. of Defense

Subscriber relationship to patient _____ ☐ State Elderly Drug Assistance

Membership ID/policy # _____ ☐ State Children's Health Insurance

☐ Other

☐ Your Pharmacy Insurance (commercial or Medicare Part D prescription coverage)

Insurer name _____ Membership ID/policy # _____

Plan name _____ Group # _____

Plan phone number (_____) _____ Type: ☐ Commercial/Private ☐ Medicare Part D

Name of plan subscriber _____

Subscriber relationship to patient _____

By applying for the **Bayer US Patient Assistance Foundation** free drug program, I understand and agree:

- 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.
- Completing and signing the program application does not guarantee my eligibility.
- The program may change or end at any time.
- I will not sell or trade any medicine that I get through this program.
- 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.
- 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.
- I will not seek credit for medicine from the program toward my true out-of-pocket expenses under Medicare Part D.
- 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/Representative Signature _____ ____/____/____
Month Day Year
Date (required)

Check point!
You are almost done. Please review the information, **sign, and date on the following page**.

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 purposes listed below:

- (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.
- 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.
- Contact me to ask for feedback on the quality or customer service of the program.
- Proper management and administration of the program and as permitted or required by applicable law.

I understand:

- Application to the program 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.
- 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.
- 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.
- 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.
- I should keep a copy of this form. I also can get a copy by contacting the program at 1-866-2BUSPAF (228-7723).

Patient/Representative Signature _____ ____/____/____

Month Day Year

Date (required)

Check point!
Make sure you completed every part of the **Patient Information Section**.
A fully completed application is needed to see if you are eligible for the program.

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Healthcare Professional Section (To be completed by your healthcare professional)

Healthcare Professional (HCP) Name and Contact Information

HCP name _____ (First) _____ (Last) Specialty _____

Address _____ City _____ State _____ Zip code _____

Phone number _____ Fax _____

DEA # _____ State license # _____ NPI # _____

Office contact _____ Phone _____ Fax _____

Office email address _____

Information on Patient's Bayer Prescription

Patient name _____ (First) _____ (Last) Date of birth ____/____/____ (Month / Day / Year)

Bayer prescription #1 _____

Strength _____ Quantity _____ Number of refills _____ Rx directions _____

Bayer prescription #2 _____

Strength _____ Quantity _____ Number of refills _____ Rx directions _____

For Betaseron, it is recommended to follow the listed titration schedule:
Weeks 1-2: 0.0625 mg (0.25 cc) QOD SC; Weeks 3-4: 0.125 mg (0.5 cc) QOD SC; Weeks 5-6: 0.1875 mg (0.75 cc) QOD SC; Weeks 7+: 0.25 mg (1 cc) QOD S

List or attach other current medications prescribed _____

Known drug allergies ☐ Yes ☐ No List _____

Please check here for a replacement unit for: ☐ Kyleena®, ☐ Mirena®, or ☐ Skyla®. Date of Service _____

HCP 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 judgement. 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 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.
- 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.
- 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.
- The patient applying for assistance through the Program is being treated in an outpatient setting.
- 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.

Required Prescriber's Signature (Dispense as Written):

_____

Date (required):____/____/_____

Please make sure every part of the Healthcare Professional Information section is completed.

Checklist

If you are the patient (or caregiver), did you:

- ☐ Complete the **Patient Information Section** on pages 2-5?
- ☐ Sign and date both of the Patient Authorization Information sections on pages 4 & 5?
- ☐ Ask your doctor to complete the Healthcare Professional section of this form?
- ☐ Make a copy of your completed application for your records?

If you are the healthcare professional, did you:

Complete the **HCP Information Section** on page 6?

- ☐ Submit the original prescription, if required by your state?
- ☐ Sign and date the HCP Authorization?

If all the boxes are checked, you are ready to submit the application.

The completed and signed application can be submitted by fax or mail:

Fax: 1-866-575-6568
If sending the application by fax, please be sure to include a fax cover sheet.

Mail: Bayer US Patient Assistance Foundation
P.O. Box 5670, Louisville, KY 40255

What is the next step after you send in your application?

We will review and process your application once we receive the completed form. We will contact you once the review is finished.

Questions?

If you have any questions, please call a Bayer US Patient Assistance Foundation representative at

1-866-2BUSPAF (228-7723)
Monday through Friday, 9:00 AM to 6:00 PM EST.