

## BIOVERATIV SUPPORT PROGRAMS

My ELOCTATE: 1-855-693-5628 My ALPROLIX: 1-855-692-5776



### 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 copayment or co-insurance costs associated with your prescription.



### FACTOR ACCESS\*

If you do not have insurance coverage or your coverage is interrupted, Bioverativ may be able to help you access therapy. 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 or ALPROLIX.com for more information. TRICARE is a registered trademark of the Department of Defense (DoD), Defense Health Agency (DHA). All rights reserved.

## INSTRUCTIONS FOR HEALTHCARE PROVIDERS

**Bioverativ support program:**  Free Trial Plus  Copay  Factor Access  
 Benefits Investigation

**Prescription:**  ELOCTATE or  ALPROLIX

### PRESCRIBER INFORMATION (required)

Prescriber name: \_\_\_\_\_ State license #: \_\_\_\_\_ NPI #: \_\_\_\_\_

Facility name: \_\_\_\_\_ Facility address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Tax ID #: \_\_\_\_\_

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)

Patient Name: \_\_\_\_\_ DOB: \_\_\_ / \_\_\_ / \_\_\_ Dose: \_\_\_\_\_

Directions: \_\_\_\_\_

Patient Weight: \_\_\_\_\_ kg \_\_\_\_\_ lbs # of Refills: \_\_\_\_\_

### 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: \_\_\_\_\_



**INSTRUCTIONS FOR PATIENTS**

**PATIENT INFORMATION (required)**

Patient name: \_\_\_\_\_ DOB: \_\_\_ / \_\_\_ / \_\_\_ SSN (last 4 digits only): \_\_\_ \_\_\_ \_\_\_ Sex: M F

Parent/guardian name: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_  OK to leave message Email: \_\_\_\_\_

Language preference:  English  Spanish  Other

Current therapy: \_\_\_\_\_ Current weight: \_\_\_\_\_

Have you ever been on ELOCTATE or ALPROLIX?  Yes  No

Adjusted gross income (gross income from taxable sources minus allowable deductions, such as unreimbursed business expenses, medical expenses, alimony, and deductible retirement plan contributions)<sup>†</sup>: \_\_\_\_\_

**†Required for Factor Access program only**

Verification of income is required for participation in the Factor Access Program. Acceptable documentation includes W-2, IRS-1040, or a recent paystub.

**PATIENT INSURANCE INFORMATION (required)**

Check if patient does not have insurance

Primary insurance name: \_\_\_\_\_

Insurance phone: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy holder name: \_\_\_\_\_ Policy holder DOB: \_\_\_ / \_\_\_ / \_\_\_

Subscriber's relationship \_\_\_\_\_

Secondary insurance name: \_\_\_\_\_

Insurance phone: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy holder name: \_\_\_\_\_ Policy holder DOB: \_\_\_ / \_\_\_ / \_\_\_

Pharmacy Benefit Manager (PBM): \_\_\_\_\_ Group #: \_\_\_\_\_

Policy #: \_\_\_\_\_ Rx BIN #: \_\_\_\_\_ Rx PCN #: \_\_\_\_\_

Current specialty pharmacy: \_\_\_\_\_ Phone number: \_\_\_\_\_

Specialty pharmacy address: \_\_\_\_\_



**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 the 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 ten (10) years from the day it is given as indicated by the date below, 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.

PRINT NAME: \_\_\_\_\_

PATIENT SIGNATURE (required): \_\_\_\_\_ Date: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE (required 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 (required): \_\_\_\_\_ Date: \_\_\_\_\_

PARENT / GUARDIAN SIGNATURE (required 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.

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.

PRINT NAME: \_\_\_\_\_

PATIENT SIGNATURE (required): \_\_\_\_\_ Date: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE (required for patients under 18 years old): \_\_\_\_\_ Date: \_\_\_\_\_

