EAGLE CAN PATIENT ENROLLMENT FORM

Benefit Investigation and Copay Assistance

EAGLE CAN®
Care & Access Network

Call 1-833-324-5322
Monday through Friday
9:00 am – 5:00 pm EST
eaglecanus.com

Fax completed form to 1-833-324-5346.

If you have any questions, please contact EAGLE CAN®
at 1-833-324-5322, Monday through Friday, 9:00 am – 5:00 pm EST

Benefits with EAGLE CAN Care & Access Network Enrollment form:

- Benefit Verification for BELRAPZO® or PEMFEXY®
- Referral to the Patient Assistance Program (PAP) when applicable*
  and/or
- Commercial Copay Assistance Program for BELRAPZO or PEMFEXY

Patient and/or Advocate Checklist for Benefit Verification, or Copay Assistance:

Page 2

- ☐ Read section 1 – Patient Authorization and Agreement

Page 3

- › If requesting Copay Assistance for BELRAPZO or PEMFEXY, read section 2 – EAGLE CAN Copay Terms and Conditions

Page 4

- ☐ Complete section 3 – Patient Information
- ☐ Complete section 4 – Insurance Information, or provide copy of all insurance cards (front & back) to include pharmacy insurance card (if separate)
- ☐ **Sign and date section 5 – Patient Attestation and Signature**

Provider Checklist for Benefit Verification, or Copay Assistance:

Page 5

- ☐ Check mark the box for support services requested at the top of the page
- ☐ Complete section 6 – Provider Information
- ☐ Complete section 7 – Clinical Information
- ☐ Confirm treatment is FDA approved in section 7
- ☐ **Sign and date section 8 – Provider Attestation and Signature**

***NOTE:** A separate application is required AFTER the referral to the EAGLE CAN PAP Program.

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1 – PATIENT AUTHORIZATION AND AGREEMENT

The EAGLE CAN program is a support program by Eagle Pharmaceuticals ("Eagle") that helps patients understand their insurance coverage and financial support options for Eagle medications, such as copay and free medication assistance. To participate in the EAGLE CAN program, this program will need to receive, use, and disclose your personal information. Please read this authorization carefully.

1. **What information is used and disclosed?**
   - Information on the EAGLE CAN enrollment form
   - My contact information and date of birth
   - Professional and employment information
   - Financial and income information
   - Insurance information
   - Health records and information, including medications
2. **Your Protected Health Information (PHI) may be shared with these entities (together "Health Care Entities")**
   - Your doctors and other healthcare providers
   - Your healthcare plan or health insurance company
   - Clearinghouses or other agents
   - Others who might have your PHI on behalf of your healthcare providers, pharmacies and healthcare plans
3. **What is the purpose for the use and disclosure?**
   My personal information will be used by and shared with the persons and organizations described in this authorization in order to:
   - Process my application for the EAGLE CAN support program
   - Provide the EAGLE CAN program services to me, including verifying my insurance benefits, researching insurance coverage options, and referring me and my caretakers to other plans, support, or assistance programs that may be able to help me
   - Provide co-pay assistance to me, if I am eligible
   - Contact my caretakers and me about the programs and the services that are available
   - Contact other healthcare providers and charitable organizations to determine if I am eligible for, or enrolled in, another plan or program
   - Provide me with free medication through the EAGLE CAN program, if I qualify
   - Improve or develop the programs' services
4. **Other things you should know about sharing and using your PHI:**
   - We only ask for and share the PHI that we need to provide the benefits you want. We do not ask for any PHI that we do not need, but we may receive some in the health records sent to us. Your PHI will be released to Eagle and its affiliates, agents, representatives, and service providers (together "Eagle")
   - You don't have to give permission to share your PHI with Eagle to receive treatment from your healthcare providers, your prescription from your pharmacy, or benefits from your healthcare plan, but the EAGLE CAN program may not be able to help you without it
   - After your PHI has been shared, it may no longer be covered by federal and state privacy laws (such as HIPAA), and it may be shared again with others by Eagle
   - Your signed permission to share and use your PHI lasts for 5 years from the date of your signature. You may revoke your permission before then by writing to EAGLE CAN PO Box 220126 Charlotte, NC 28222, which will preclude reliance on the authorization after the date your written revocation is received
   - You can stop sharing your PHI with us or change what you share by calling us at 1-833-324-5322, or by writing us at EAGLE CAN PO Box 220126 Charlotte, NC 28222
   - Your cancellation or revocation of this Authorization will be effective when your Health Care Entities receive notice of your cancellation or revocation, and will not apply to any information shared with Eagle by your Health Care Entities prior to the time those Health Care Entities receive notice

2 – COPAY TERMS AND CONDITIONS FOR BELRAPZO® or PEMFEXY®

By requesting copay assistance for BELRAPZO or PEMFEXY, you attest that you meet the eligibility criteria, agree to and will comply with the terms and conditions described below:

Patient Eligibility:

1. You must have commercial insurance that covers BELRAPZO or PEMFEXY but it does not cover the full cost and you are responsible for a portion of the cost.
2. You are not able to receive copay assistance for BELRAPZO or PEMFEXY if you participate in any state or federal healthcare program, including Medicaid, Medicare, Medigap, CHAMPUS, DoD, VA, TRICARE, or any other state patient or pharmaceutical assistance program.
3. You must immediately notify the EAGLE CAN Program if your insurance situation changes and that you may no longer be eligible to receive copay assistance for BELRAPZO or PEMFEXY if you begin to participate in one of the programs noted above.
4. You must be 18 years of age or older and receiving BELRAPZO or PEMFEXY for an FDA approved use. Please ask your doctor for information about FDA approved uses.
5. You must reside in the United States or Puerto Rico.

Program Benefits:

1. You will be eligible to receive up to $25,000 in assistance for your documented out-of-pocket costs for BELRAPZO or PEMFEXY.
2. You will be responsible for as little as $0 in out-of-pocket costs for each date of service submitted for copay assistance.
3. You must submit documentation of your out-of-pocket costs for BELRAPZO or PEMFEXY within 180 days of the treatment date.
4. Your healthcare provider can submit documentation for your out-of-pocket costs for BELRAPZO or PEMFEXY on your behalf.
5. For enrolled patients, the Program may provide support for claims with a date of service that falls within 120 days prior to the date the application is received by the Program.

Program Timing:

1. You will be eligible for 12 months from the approval date and will need to apply again if copay assistance continues to be needed when your eligibility ends.

Additional Terms and Conditions of Program:

1. Copay assistance will only be provided for out-of-pocket costs for BELRAPZO or PEMFEXY. Copay assistance will not be provided for your out-of-pocket costs related to the administration procedure, office visits, or other expenses.
2. You will not seek reimbursement from any third-party payers, including flexible spending accounts or healthcare savings accounts, for the value of any payment received from the EAGLE CAN Program.
3. Patients are not re-enrolled automatically prior to the end of the current eligibility period. Re-enrollment of the Program is initiated by the provider and patient.
4. This Program is not insurance.
5. Eagle Pharmaceuticals reserves the right to terminate, rescind, revoke, or amend this offer at any time without notice.

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REQUIRED FIELD*

3 – PATIENT INFORMATION

First Name*	Middle Initial	Last Name*

Date of Birth (MM/DD/YYYY)*	Gender	Email

Address*	City*	State*	ZIP*

Primary Phone Number*	Secondary Phone Number

Okay to Contact Patient for Additional Information?	US Citizen ☐ Yes ☐ No

Alternate Contact Name

Relationship	Phone Number

4 – INSURANCE INFORMATION

☐ Check if patient does not have insurance ☐ Check if patient has secondary insurance ☐ HSA commercial plan ☐ Flexible Spending Account participant

Primary Insurance Name*	Insurance Phone Number*

Policy Number*	Group Number*

Policyholder Name*	Relationship to Patient

Secondary Insurance Name*	Secondary Insurance Phone Number*

Policy Number*	Group Number*

Policyholder Name*	Relationship to Patient

Check any that apply

☐ Insurance & pharmacy card attached
☐ Medicare part A participant EFF. Date _____
☐ Medicare part B participant EFF. Date _____
☐ Medicare application pending
☐ Medicaid participant EFF. Date _____
☐ Medicaid application pending
☐ Champus EFF. Date _____
☐ VA insurance benefits participant EFF. Date _____
☐ VA insurance benefit application pending

5 – PATIENT ATTESTATION AND SIGNATURE

I confirm that the information provided above is true and correct to the best of my knowledge and I request the support provided by the EAGLE CAN Program. I understand I may revoke this request at any time by phoning the EAGLE CAN Program at 1-833-324-5322. I have read and agreed to the Patient HIPAA Authorization, on page 2. I understand I am entitled to a copy of this signed Authorization. If requesting copay assistance for BELRAPZO or PEMFEXY, I confirm that I have read and agreed to the Program terms and conditions on page 3, and understand that copay assistance is only available for commercially insured patients.

Patient Signature*	Date*

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Please see additional information required on the next page.

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By submitting this form, I am requesting support services on behalf of the patient.

- ☐ Benefit Verification and Prior Authorization Support for **BELRAPZO®** (bendamustine hydrochloride injection)
- ☐ Copay Assistance for **BELRAPZO** (bendamustine hydrochloride injection)
- ☐ Benefit Verification and Prior Authorization Support for **PEMFEXY®** (pemetrexed injection)
- ☐ Copay Assistance for **PEMFEXY** (pemetrexed injection)

REQUIRED FIELD*

6 – PROVIDER INFORMATION

First Name*	Middle Initial	Last Name*
Tax ID Number*	Group NPI Number*	Provider NPI Number*
Practice Name*	Practice Contact Name*	
Florida Blue ID Number (if applicable)	Medicare Provider Transaction Access Number (PTAN) (if applicable)	
Address*	City*	State* ZIP*
Practice Phone Number*	Practice Fax Number*	Contact Email

7 – CLINICAL INFORMATION

Primary Diagnosis Code*	Secondary Diagnosis Code	Tertiary Diagnosis Code

Eagle Product Prescribed* ☐ BELRAPZO (bendamustine hydrochloride injection) ☐ PEMFEXY (pemetrexed injection)

Product NDC*	Treatment is FDA Approved* ☐ Yes ☐ No
Previous Therapies, if any	Concurrent Therapies, if any

Site of Care* ☐ Physicians Office ☐ Hospital Outpatient ☐ Other

8 – PROVIDER ATTESTATION AND SIGNATURE

I confirm that I have prescribed the Eagle product identified above as an appropriate treatment for this Patient.
I have not been offered or promised anything of value by Eagle in exchange for writing this prescription.
I confirm that the above provided information is true and correct to the best of my knowledge.
If my patient is approved to receive copay assistance for BELRAPZO or PEMFEXY, I understand that I must not seek reimbursement from health insurance or any third-party for any part of the benefit paid by the EAGLE CAN Program.

Provider Signature*	Date*