Please complete and fax this form to **1-844-826-8391**

Enrollment Form

Select Services: Please check the appropriate box(es) and complete the Enrollment Form for Nypozi™ (filgrastim-txid) Injection:

☐ Benefit Verification and/or prior authorization support
Complete Sections: (1-4 and 6)

☐ TANVEX CARES™ Copay Assistance Program
Complete Sections: (1-6)

1. Patient Information (To be completed by Patient) **INDICATES REQUIRED FIELDS*

***Name (First, MI, Last)**		Gender	M ☐ F ☐
***Street Address**	***City**	***State**	***Zip**
***Date of Birth (MM/DD/YY)**	Home Phone #	Cell Phone #	
	Okay to Leave Message	☐ Home	☐ Cell
Alternate Contact Name (First, Last)	Relationship to Patient	Phone #	

My Caregiver has consented to have TANVEX CARES™ communicate directly with them on my behalf. ☐ Yes ☐ No
Permanent U.S. Resident? ☐ Yes ☐ No

2. Insurance & Financial Information (To be completed by Patient)

Income information requested only for Patient Assistance Program (PAP) or Independent Copay Foundation referrals.

Annual Gross Household Income (Before Taxes): $_________________ Total Number Living in Household: _______________

TANVEX CARES™ reserves the right to request proof of income to validate patient's eligibility for the Patient Assistance Program.

No Insurance ☐ (Skip to Section 3)

Patient Primary Insurance Information	Patient Secondary Insurance Information
Insurance Name	Insurance Name
Member / Policy ID #	Member / Policy ID #
Policy Holder Name	Policy Holder Name
Policy Holder Date of Birth (MM/DD/YY)	Policy Holder Date of Birth (MM/DD/YY)
Relationship to Patient	Relationship to Patient
Insurance Phone #	Insurance Phone #
Group #	Group #

3. Treatment Information / Prescription for Nypozi™ (filgrastim-txid)
(To be completed by Healthcare Provider) **INDICATES REQUIRED FIELDS*

***Primary ICD-10 Code**	Secondary ICD-10 Code	
***Dispense ☐ 300mcg/0.5mL 1CT / Quantity:**	**☐ 480mcg/0.8mL 1CT / Quantity:**	**Refills:**
***Administration (SIG)**		

4. Healthcare Provider Information (To be completed by Healthcare Provider) **INDICATES REQUIRED FIELDS*

***Prescriber Name (First, MI, Last)**			
***Facility / Site Name**			
***Street Address**	***City**	***State**	***Zip**
***Office Phone #**	***Office Fax #**	***NPI #**	
Group Tax ID #	***State License #**		
Specialty:	Office Primary Contact	Office Contact Phone #	
Site of Care: ☐ Physician Office	☐ Hospital Outpatient (HOPD)	☐ Home Health	

***Healthcare Provider Signature** ***Healthcare Provider (Print Name)** ***Date**

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For assistance, please call 1-833-TANVEX1 (1-833-826-8391)
Hours of Operation: Monday – Friday, 9AM-8PM ET

tanvex cares™
compassionate prescription savings

Enrollment Form

*PATIENT NAME	*DATE OF BIRTH (MM/DD/YY)

5. Healthcare Provider Attestation *INDICATES REQUIRED FIELDS*

On behalf of my patient, I request assistance for the pharmaceutical product manufactured by Tanvex BioPharma USA, Inc. and its affiliates ("Tanvex") described in this application. I hereby attest and certify that to the best of my knowledge, all of the information contained in this enrollment form is complete and accurate. I also hereby attest and certify that I have prescribed the drug specified in this application based on my good faith professional judgment of medical necessity for the patient. I will notify Tanvex immediately if I determine or discover that the product is no longer medically necessary for this patient's treatment or if my patient's insurance or financial status changes. I have a signed copy on file of my patient's current and completed HIPAA Authorization Form. This HIPAA Authorization Form is correct in form and substance, and it fully authorizes me to share all patient health information with the TANVEX CARES™ Program that I disclose or that is otherwise submitted to the program. I understand that the patient must satisfy certain financial parameters in order to be eligible under the program. I will receive, take possession of, and secure my patient's medication at my office at all times, until it is administered to my patient, when applicable. I certify that I have not received, and will not seek to receive, reimbursement for any drug requested, replaced and/or supplied under the TANVEX CARES™ Program.

I understand that the offer is not valid for prescriptions that are eligible to be reimbursed, in whole or in part, by any of the following: Medicaid, Medicare including, without limitation, Medicare Advantage and Part A, B, and D plans, MediGap, Tricare, CHAMPUS, the Veterans Administration, Department of Defense health coverage, or other federal or state healthcare programs (including any state prescription drug assistance programs) and the Government Health Insurance Plan available in Puerto Rico, or by any private health benefit programs which provide reimbursement for the entire cost of prescription drugs. I hereby certify that to the best of my knowledge; this prescription is not and will not at any time in the future be covered, in whole or in part, by any of the foregoing programs.

I hereby certify the following: no free product provided under the TANVEX CARES™ Program will be distributed for sale to any individual or organization or returned for credit. This applies to each and every organization, whether public or private, in any jurisdiction, including, without limitation, to Medicare, Medicaid, to any of the other programs listed above, or any other benefit provider. If a retroactive insurer policy change allows for reimbursement of product already supplied at no charge, then I understand that, Tanvex will bill me for the covered product. I agree that I am and will be responsible for payment of any such bill. If I submit a claim to any patient's insurance company for any services rendered in conjunction with the administration of any product provided under the program, I hereby agree that I will promptly, fully and accurately disclose in writing to each and every such insurance company each applicable product that was provided free of charge. I hereby agree to abide by this certification during my entire participation in the program. I hereby agree to notify a Patient Access Specialist in writing if aspects of my certification are no longer applicable. I understand that if the patient's income or insurance status changes, the patient may no longer be eligible under this program. I agree to immediately notify a Patient Access Specialist in writing if any such change should occur. I agree to immediately notify a Patient Access Specialist in writing if a retroactive insurer policy change allows for reimbursement of product already supplied at no charge. I understand that Tanvex reserves all rights to modify or terminate this program at any time without prior notice and reserves all rights to recall the product when necessary. I will cooperate with Tanvex in the exercise of any such rights. I understand that I am under no obligation to prescribe any Tanvex drug to participate in this program. I hereby certify that I have not received, nor will I at any time in the future receive any direct or indirect benefit, compensation, or remuneration from the TANVEX CARES™ Program for prescribing a Tanvex drug. I understand that Tanvex and its affiliates and Tanvex Vendors are not responsible for filing any insurance claim. I understand that the information provided on this enrollment form is subject to random audits and verification. I consent to and will cooperate with any such audits and verification.

The TANVEX CARES™ Patient Assistance Program (PAP) is available to assist patients in the delivery of treatment that has been prescribed as medically necessary by their healthcare provider (maximum benefit of $10,000 annually).

By signing below, I hereby certify that I am the healthcare provider that has prescribed the drug to the patient identified on the enrollment form. I certify that this drug therapy is medically necessary, and that I have provided the patient with a copy of the TANVEX CARES™ enrollment form, including signed authorizations.

I understand that in a number of circumstances, as described in the program's supporting material, if the claim is denied, I will be required to file an appeal with the patient's insurance company before receiving any product under this program. I agree to become familiar with these requirements. I hereby certify that in circumstances where an appeal is required, prior to requesting free product under this program: (i) I will submit a claim to the patient's insurance company; and (ii) if the claim is denied I will submit an appeal to the patient's insurance company. If product is provided by Tanvex under this program, I will return to the applicable patient all deductibles or co-insurance amounts paid by such patient for the product.

I acknowledge that I have assisted the patient in enrolling in the TANVEX CARES™ PAP for the sole purpose of patient care and not for expectation of, or actual receipt of remuneration of any sort. I understand that the TANVEX CARES™ Program may be revised, changed, or terminated at any time. I attest and certify that to the best of my knowledge, the patient listed on the form meets the program's eligibility criteria for the PAP.

This offer is valid only in the United States, Puerto Rico and Guam. Certain restrictions may apply. Offer may not be available to patients in all states.

*Healthcare Provider Signature	*Healthcare Provider (Print Name)	*Date

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Confidentiality Notice: This information is intended for the use of the person to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. If the reader of this information is not the intended recipient, or the authorized agent or individual responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you received this document in error, please notify us immediately and destroy the related document.

Tanvex Cares compassionate prescription savings

Enrollment Form

*PATIIENT NAME	*DATE OF BIRTH (MM/DD/YY)

6. Patient Consent **INDICATES REQUIRED FIELDS*

All patients must read the following information carefully and provide a signature to enroll in the TANVEX CARES™ Program:

I authorize my healthcare provider(s), health insurer(s) and pharmacy to disclose my personal health and insurance information. I give them permission to disclose my personal information, including insurance information, prescriptions, my medical condition, my Protected Health Information ("PHI") and treatment to Tanvex BioPharma USA, Inc. ("Tanvex") and its affiliates, Tanvex Vendors or service providers, including its patient support program service provider so that Tanvex and Tanvex Vendors can provide the following program support and services (i) enrollment in TANVEX CARES™ Program, (ii) assistance to verify health benefits, (iii) assistance with prior authorization requirements, (iv) assistance with appeals of denied claims or denied prior authorizations, (v) assessment of patient eligibility for free product and prescription fulfillment via the TANVEX CARES™ Patient Assistance Program, (vi) assessment of eligibility for the TANVEX CARES™ commercial Copay Assistance Program, (vii) referrals to external financial support resources, and (viii) operation and administration of the TANVEX CARES™ Program.

I give permission to Tanvex to disclose my Protected Health Information (PHI) to my healthcare provider(s) health insurer(s), and pharmacy, my caregiver(s) and other third parties for the purposes described above. I also give permission to Tanvex to contact me directly for the purposes described above. I understand that once my PHI is disclosed it may no longer be protected by federal privacy law.

I understand that the offer is not valid for prescriptions that are eligible to be reimbursed, in whole or in part, by any of the following: Medicaid, Medicare including, without limitation, Medicare Advantage and Part A, B, and D plans, MediGap, Tricare, CHAMPUS, the Veterans Administration, Department of Defense health coverage, or other federal or state healthcare programs (including any state prescription drug assistance programs) and the Government Health Insurance Plan available in Puerto Rico, or by any private health benefit programs which provide reimbursement for the entire cost of prescription drugs.

I authorize Tanvex and its affiliates and Tanvex Vendors to contact me via telephone, email, or mail at the telephone number(s) and address provided on the program enrollment form. By providing my signature below, I also agree to receive voicemail messages from Tanvex and Tanvex Vendors at the telephone number(s) provided. I understand that my cell phone carrier's standard rates may apply for telephone calls to my cell phone number. I understand and agree that my Protected Health Information (PHI) transmitted via email or cell phone cannot be secured against unauthorized access or use. I understand that Tanvex does not permit my personal information to be used by its business partners for their own separate marketing purposes.

I understand that I do not have to sign this authorization or enroll in the TANVEX CARES™ Program. A decision by me not to sign this authorization will not affect my ability to obtain medical treatment, insurance coverage, access to health benefits, or to receive Tanvex medication as prescribed by my healthcare provider. I may withdraw from receiving communications and individual support services offered by the program or opt out of the program entirely at any time in the future by calling a Patient Access Specialist at 1-833-TANVEX1 (1-833-826-8391), by mailing a letter to TANVEX CARES™, PO Box 220215, Charlotte, NC 28222, or faxing a written request to 1-844-826-8391. I also understand that the program services may be revised, changed, or terminated at any time. I understand that my consent will remain in effect for 24 months. I also understand that I am entitled to a copy of this signed authorization. If I do not sign this authorization, I understand that I will not be able to participate in the TANVEX CARES™ Program.

In addition to the services I have authorized above, I understand that the TANVEX CARES™ Program also offers free patient services and product programs, TANVEX CARES™ Patient Assistance Program, related to my therapy (maximum benefit of $10,000 annually). If necessary, I would like to take part in these programs and understand that these services are optional and my decision to participate or not will not impact the services outlined above. I give permission to Tanvex to use my Protected Health Information (PHI) for these additional programs. These services may include communicating with me via telephone, email or mail and I authorize Tanvex and its affiliates and Tanvex Vendors to contact me. I also understand that Tanvex may share information from my participation in these programs with my healthcare provider. I may withdraw from receiving communications and individual support services offered by the program or opt out of the program entirely at any time in the future by calling a Patient Access Specialist at 1-833-TANVEX1 (1-833-826-8391), by mailing a letter to TANVEX CARES™, PO Box 220215, Charlotte, NC 28222, or faxing a written request to 1-844-826-8391.

I certify that the information I have provided on my enrollment form is truthful and accurate to the best of my knowledge. I understand that any program assistance provided to me is contingent upon my ability to meet the program's eligibility criteria and that this application does not guarantee acceptance into the program. I agree that I will notify the program within thirty (30) calendar days if my insurance or financial situation changes as this may impact my eligibility to participate in the program. I have read, understand, and agree with all of the above information.

This offer is valid only in the United States, Puerto Rico, and Guam. Certain restrictions may apply. Offer may not be available to patients in all states.

*Patient Signature	*Patient (Print Name)	*Date
Representative Signature	Representative (Print Name)	Date
Relationship to Patient:		

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