

Fensolvi TotalSolutions[®] Copay Assistance* Form

Follow these instructions

- 1 Fill out this form in its entirety (including caregiver signature on second page).
- 2 Obtain an **Explanation of Benefits (EOB)** from the insurance company. A detailed EOB includes insurance carrier name and logo, name of the plan, patient's responsibility, date of service and drug code broken out by name, J-code or National Drug Code (NDC). If EOB does not contain this detail, you could submit a provider's bill or claim form that contains this information instead.
- 3 Fax or email Copay Assistance Form and the EOB.

Patient Information

PATIENT NAME (LAST, FIRST)			GENDER <input type="checkbox"/> M <input type="checkbox"/> F		DOB
ADDRESS					APT NO.
CITY	STATE	ZIP	Date of Injection (Required) ▶ Date Fensolvi [®] administered on:		
CAREGIVER NAME (LAST, FIRST)			RELATIONSHIP TO PATIENT		
CAREGIVER PHONE			CAREGIVER EMAIL		

Prescriber Information

PRACTITIONER NAME (LAST, FIRST)			NPI NO.	PARTNER PHYSICIAN ID
ADDRESS				BLDG. / SUITE NO.
CITY	STATE	ZIP	PHONE	FAX

Insurance Information

Primary Medical Insurance

INSURANCE PROVIDER	INSURANCE PROVIDER PHONE #	Rx BIN	PCN
MEMBER ID	GROUP	PHONE	Rx MEMBER ID
SUBSCRIBER NAME	SUBSCRIBER RELATIONSHIP	Rx GROUP	

Primary Prescription Insurance

Secondary Medical Insurance

INSURANCE PROVIDER	INSURANCE PROVIDER PHONE #	Rx BIN	PCN
MEMBER ID	GROUP	PHONE	Rx MEMBER ID
SUBSCRIBER NAME	SUBSCRIBER RELATIONSHIP	Rx GROUP	

Secondary Prescription Insurance

* For eligible patients only. Not valid for patients covered under Medicare, Medicaid, Tricare and other federal health care programs. Please review Terms and Conditions on reverse side.

While every effort is made to provide helpful information, Fensolvi TotalSolutions make no representations about the eligibility or guarantee of coverage or reimbursement for any particular claim. Fensolvi TotalSolutions cannot guarantee success in obtaining third-party insurance reimbursement. Third-party coverage and payment for medical products and services is complex and affected by numerous factors. It is always a provider's responsibility to determine and submit the appropriate codes, charges and modifiers for services that are rendered. Providers should contact third-party payors for specific information on their coding, coverage and payment policies. All coding and claims used by a provider in seeking reimbursement must be accurate, complete, and adequately documented in the applicable patient record. All services must be medically appropriate. You are also responsible for ensuring the security of the transmission of information to Fensolvi TotalSolutions, as well as the security of the information that Fensolvi TotalSolutions have transmitted to you. Fensolvi TotalSolutions shall not be liable for any theft, loss or unauthorized access to or interception of such data.

Patient Check Request

Reimbursement Payable To: Patient Provider Other

Payee Name: _____ Phone: _____

Patient ID/Medical Record Number (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Amount Requested: _____

▶ **Patient/Caregiver Signature:** _____ Date: _____

I verify that the information I have provided is true and complete to the best of my knowledge. I provide consent for Tolmar, Inc. and its agents ("Tolmar"), through Fensolvi TotalSolutions, to share my co-pay assistance information with my healthcare provider or specialty pharmacy. I agree that applicable pharmacies, and other healthcare providers, as well as [and] my health insurers, may share my health information with Tolmar. I understand that I may be contacted by Tolmar, my healthcare provider or specialty pharmacy for verification/clarification of benefits.

Fensolvi TotalSolutions[®] Copay Program Terms And Conditions

The Fensolvi[®] Co-pay Assistance Program ("Program") is valid ONLY for patients who are prescribed Fensolvi[®] and are reimbursed exclusively by commercial insurance. This Program is valid only in the United States but void where prohibited by law or by the patient's health insurance provider. This Program is non-transferable, limited to one per person, and cannot be combined with any other coupon, free trial, discount, prescription savings card, or other offer. Restrictions or limits may apply.

Medicare, Medicaid, Tricare, and other federal health care program beneficiaries may not participate in this Program. This Program also is neither available for cash-paying patients or where your commercial plan reimburses you for the entire cost of your prescription drug. Patients cannot seek reimbursement from health insurance or any third party for any part of the assistance received through this Program. The patient or his/her guardian is responsible for reporting the receipt of all benefits or reimbursement received under the Program to any insurer, health plan, or other third party, as may be required. This Program is not insurance and is not intended as a substitute for insurance.

With the Program, you pay as little as \$5 of your co-pay or co-insurance for Fensolvi[®], per prescription. The remainder of your co-pay or co-insurance is covered, up to two prescriptions per calendar year. The Program assists with the cost of Fensolvi only. It does not assist with the cost of other administrations, medicines, procedures or office visit fees.

Tolmar, Inc. ("Tolmar") reserves the right to terminate, rescind, revoke, or modify this Program at any time without notice. This Program expires at the end of the current calendar year, at which time you must re-enroll. For complete information about the terms and conditions of this Program, including the limitations on use and the amount of assistance, please email FensolviTotalSolutions@apollocare.com.

Program managed by Apollo Care on behalf of Tolmar.