



Visit us at www.avyxa.com

PRODUCT REPLACEMENT PROGRAM

ENROLLMENT FORM

Call us at **866-939-8927 Monday - Friday 8:00 AM - 8:00 PM (EST)**

Fax: 833-852-3420

The AVYXASSIST™ Product Replacement program allows physician offices or hospital outpatient departments to receive AVYXA™ Pharma "AVYXA™" replacement product if all eligibility criteria are met. (See AVYXASSIST™ Product Replacement Program Terms and Conditions).

Please complete this form and submit all required documentation to AVYXASSIST™ via **fax at 833-852-3420**

Reason for Product Replacement

- Payer Denial (after eligibility criteria is met)
- Mishandling of the drug (i.e. dropped vial, incorrect mixing)
- Patient unavailable to receive as a result of illness/death
- Patient unavailable to receive because patient refused treatment
- Patient unavailable to receive due to adverse event
- Patient ineligible for treatment

Date _____ Date of Service _____

If applicable:

Date of Denial: _____ Date of 1st appeal: _____

Product to be Replaced

- DOCIVYX™ (docetaxel) injection, 10 mg/mL
- CYCLOPHOSPHAMIDE injection, 500 mg/mL
- POSFREA™ (palonosetron) injection, 0.05 mg/mL

Vial Quantity _____ Lot # _____ Serial # _____ Exp. Date _____

If available, attach invoice to submission

Patient First Name _____ Patient Last Name _____ Patient Date of Birth _____

Provider First Name _____ Provider Last Name _____ Provider Title _____

Treatment Facility _____

Contact Name _____ Contact Phone # _____

Delivery Location _____

Address _____

Product-Specific Benefit Verification

(Complete if asking for Product Replacement for Payer Denial)

For a patient to qualify for the Product Replacement Program, a product-specific benefit verification demonstrating active coverage must have been completed and documented prior to treatment with an AVYXA™ Product. Please complete the following:

The product-specific benefit verification was completed by:

AVYXASSIST™ Provider Office Date benefit verification completed _____

If a Benefit Verification was not completed by the AVYXASSIST™ Patient Support Program, a legible copy of the Summary of Benefits obtained by the office, prior to treatment, must be submitted.

Was a prior authorization (PA) required or a Predetermination recommended?

Yes No Date PA submitted _____

If a PA was required or predetermination was recommended, please submit the PA or predetermination approval documentation with this request form.

All appeals must be completed within the timely filing limit. If appeals were conducted by the provider office, please provide the following documentation with this request form:

- Initial denied claim (EOB)
- Documentation of at least one level of appeal and denial
- A copy of the charge sheet or claim form (CMS 1500 or UBO4) must be submitted to confirm that therapy was used for an FDA approved indication.



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ENROLLMENT FORM (contd)

To be completed by the office

By signing below, I attest that, where required by applicable law, regulation, or other applicable authority, I have obtained patient consent, permission and/or a HIPAA authorization ("Legal Permission") permitting me to use and disclose my patients' health, demographic, and other individually identifiable information, including insurance information, to AVYXA™, its affiliates, its program administrator, and their respective agents, service providers and field reimbursement professionals for the purpose of providing patient support programs, co-pay assistance, and/or patient assistance, reimbursement support as part of the patient's treatment with an AVYXA™ product. I maintain records of such Legal Permission consistent with applicable law. I further certify that (a) any reimbursement investigation support provided to patients through AVYXASSIST™ is not made in exchange, directly or indirectly, for my recommendation, prescription, or use of the above therapy or any other product or service for or from anyone, and (b) my decision to prescribe the above therapy was based solely on my determination of medical necessity. In addition, I attest that a benefits-verification was completed, all payer coverage requirements were followed prior to administration, and that the product was prescribed for a medically appropriate use as determined by the specific payer's policies and coverage guidelines. I also attest that I did not or will not receive payment for the product in which I am requesting a replacement nor do I belong to a physician practice that receives an all-inclusive payment for patients covered under the insurance plan. I understand the program only provides a replacement product and does not cover any costs related to the office visit or administration of the product. I understand and agree, AVYXA™ may modify or discontinue its Product Replacement Program without notice at any time for any reason.

I attest that I will not receive payment for the AVYXA™ product I am requesting to replace and that I do not belong to a physician practice that receives an all-inclusive payment for patients covered under this insurance plan. I acknowledge that this product replacement will be returned if payment is recognized at any time in the future.

I hereby attest that my signature denotes that all facts and circumstances provided herein are true and accurate.

Office Contact (Name) _____ Date _____

Office Contact Signature _____

If you do not have patient consent, please utilize patient consent form at www.avyxa.com