AVYXASSIST™

Visit us at www.avyxassist.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 on avyxassist.com).

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

Date _____ Date of Service _____

If applicable:

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

Product to be Replaced

- ◯ AVGEMSI™ (gemcitabine) injection — Strength _____ NDC_____
- ◯ AXTLE™ (pemetrexed) for injection — Strength _____ NDC_____
- ◯ DOCIVYX® (docetaxel) injection* — Strength _____ NDC_____
- ◯ FRINDOVYX™ (cyclophosphamide) injection — Strength _____ NDC_____
- ◯ KYXATA™ (carboplatin) injection** — Strength _____ NDC_____
- ◯ LUTRATE® DEPOT (leuprolide acetate) for depot suspension — Strength _____ NDC_____
- ◯ POSFREA™ (palonosetron) injection — Strength _____ NDC_____

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 _____

*Please see the full Prescribing Information for DOCIVYX® including BOXED WARNING.

**Please see the full Prescribing Information for KYXATA™ including BOXED WARNING.

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Replacement Prescription Information

Medication: _____ Strength: _____ Route of Administration _____

Instructions: Administer as: _____

Dosing: ◯ mg/kg ◯ mg/m² Dose _____ Days: _____ Total Vials per Schedule _____ Refills _____

I authorize AVYXA™ Pharma, LLC (AVYXA™) and the designated non-commercial pharmacy to dispense AVYXA™ product directly to the Facility Setting address as part of the Product Replacement Program.

Prescriber Name (Print): _____ Signature (No Stamps) _____

Date _____

Product-Specific Benefit Verification

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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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 herin are true and accurate.

Prescriber (Name) _____ Date _____

Prescriber Signature _____

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