CIMERLI® (ranibizumab-eqrn) Enrollment and Prescription Form

Phone 1-844-472-6369 **Fax** 1-833-966-3043
Hours Monday through Friday 8 AM–8 PM ET
To submit electronically, please visit **Sandoz-OneSource.com/CIMERLI**

CIMERLI® (ranibizumab-eqrn) injection | SANDOZ one source®

To enroll your patient in Sandoz One Source for CIMERLI, please complete all required fields and fax to: 1-833-966-3043

Please print clearly.
*Required field.

1 Select Services (select at least one)

By completing and faxing/submitting this form, I am requesting services on behalf of the patient. I would like the following services completed:
○ Benefits Investigation ○ Prior Authorization/Appeal Support ○ Co-pay Program ○ Sandoz Patient Assistance (SPA) Program

2 Patient Information

*First Name _____ Middle Initial ____ *Last Name _____ *DOB _____ *Sex ○ M ○ F
*Address _____ *City _____ *State _____ *Zip _____
*Phone home and/or mobile _____ Email _____
Preferred Language _____ Caregiver/Guardian Name _____ Caregiver/Guardian Relationship to Patient _____

3 Insurance Information

*Attach a copy of the front and back of the patient's insurance card(s) **OR** complete the section below only if insurance card copies are NOT attached.
○ Copies of insurance cards(s) attached ○ Commercial/Private‡ ○ Medicare ○ Medigap ○ Medicaid, Government-Funded Plan, or VA§ ○ Not Insured
‡Insurance that you or a family member have through an employer or purchased privately. §An example would be a Department of Defense program or TRICARE.

*Primary Medical Insurance _____ *Secondary Medical Insurance _____
Insurance Phone Number _____ Insurance Phone Number _____
*Member Name _____ *Member Name _____
*Member ID # _____ *Member ID # _____
*Policy/Group # _____ *Policy/Group # _____
Pharmacy Rx Insurance (if applicable) _____

4 Diagnosis

Please provide the primary ICD-10 diagnosis code:
*Primary Diagnosis/ICD-10 code _____ Secondary Diagnosis/ICD-10 code, if applicable _____
***Please check one of the following to indicate eye designation:**
○ Left Eye ○ Right Eye ○ Bilateral (Same Diagnosis) ○ Bilateral (Different Diagnosis)†
†If bilateral different diagnosis is selected, expect a call from Sandoz One Source for clarification.
***Please check one:** ○ New to therapy ○ Switching from other therapy(ies)

5 Prescriber Information

*Prescriber's Name (First, Last) _____ Office Name _____
Tax ID # _____ *Individual NPI # _____ *PTAN # (required for Medicare) _____
Site Type ○ HCP Office ○ Hospital Outpatient
*Address _____ *City _____ *State _____ *Zip _____
*Office Contact Name _____ *Office Contact Phone Number _____ *Office Contact Fax Number _____

6 Prescription (Refills and Frequency of Treatments are required for SPA enrollment)

CIMERLI 0.5 mg/0.05 mL (10 mg/mL) single-dose vial NDC:70114-0441-01
*Quantity ○ 1 vial ○ 2 vials ○ Other _____
Refills _____ Frequency of Treatments _____

CIMERLI 0.3 mg/0.05 mL (6 mg/mL) single-dose vial NDC:70114-0440-01
*Quantity ○ 1 vial ○ 2 vials ○ Other _____
Refills _____ Frequency of Treatments _____

Date of last injection (if applicable) _____ Patient's scheduled injection date _____

I certify that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. By completing and faxing/submitting this form, I certify that my patient is aware of the disclosure of their personal health information to Sandoz and its business partners for Sandoz's patient support services, including reimbursement and verification services and the services provided by field reimbursement professionals in your office, as part of the patient's treatment with this product, and for Sandoz Patient Safety requirements. I certify that I have obtained any required patient authorization. I further certify that (a) any service provided through Sandoz One Source on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use CIMERLI or any other Sandoz product or service for anyone, and that (b) my decision to prescribe CIMERLI was based solely on my determination of medical necessity as set forth herein, and that (c) I will not seek reimbursement for any medication or service provided by or through Sandoz One Source for any government program or third-party insurer. For the purposes of transmitting prescriptions, I authorize Sandoz Patient Assistance (SPA), Sandoz, and its affiliates, business partners, and agents to forward these prescriptions electronically, by facsimile, or by mail to the appropriate dispensing pharmacies or alternative sites of care on my behalf.

*Prescriber Signature _____

*Prescriber Full Name (including abbreviated professional title) _____ *Date _____

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Sandoz Patient Assistance (SPA) Program: ELIGIBILITY CRITERIA

Under this program, Sandoz agrees to ship product to the provider for patients who qualify for the SPA. The terms and conditions below must be met in order for a patient to be enrolled in the program:

- Reside in the United States or a U.S. Territory
- Have limited or no prescription insurance coverage
- Have an adjusted annual household income of ≥500 of Federal Poverty Limit (FPL)
- Have a valid prescription for the Sandoz medication
- Be treated by a licensed U.S. health care provider
- Complete and sign consent form and, when applicable, provide income documentation

7 Patient Financial Information

Total Gross Income
Entire Household Income $_____

Household Size
Including yourself, the number of people who live in your home and are dependent on your household income _____

8 Patient Authorization

I give permission for my health care providers (HCPs), pharmacies, health insurer(s), third party contractors, and service providers to disclose my personal information, including information about my insurance, prescriptions, medical condition, and health ("Personal Information") to Sandoz, its affiliates, business partners, and agents (together "Sandoz") so that Sandoz can (i) help verify or coordinate insurance coverage or otherwise obtain payment for my treatment with CIMERLI, (ii) coordinate my receipt of and payment for CIMERLI, (iii) provide or facilitate my access to CIMERLI, (iv) provide me with information about CIMERLI, disease awareness, management programs, and educational materials, (v) manage the Sandoz One Source for CIMERLI, (vi) provide me with adherence reminders and support, (vii) conduct quality assurance, surveys, and other internal business activities in connection with One Source for CIMERLI Program, and (viii) to send me information about programs that might help me pay for my medicines, and to coordinate and share my Personal Information with my health care providers, other programs that might help me pay for medicines, government agencies, and insurance companies for purposes of providing or facilitating this assistance.

I give permission to Sandoz to disclose my Personal Information to my health care providers, pharmacies, health insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above.

I understand that my pharmacy, health insurer(s), and health care providers may receive remuneration (payment) from Sandoz in exchange for disclosing my personal information to Sandoz and/or for providing me with therapy support services.

I understand that once my Personal Information is disclosed it may no longer be protected by federal and state privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization with respect to the Sandoz One Source for CIMERLI Program at any time in the future by calling 1-844-472-6369.

My refusal or future revocation will not affect the commencement or continuation of my treatment by my doctors; however, if I revoke this authorization, I may no longer be able to participate in the Sandoz One Source for CIMERLI Program and/or programs administered by Sandoz. If I revoke this authorization, Sandoz will stop using or sharing my information (except as necessary to end my participation in the program) but my revocation will not affect uses and disclosures of Personal Information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for five (5) years after the date of my signature unless I revoke it earlier. I also understand that the Sandoz One Source for CIMERLI Program and/or programs administered by Sandoz may change or end at any time without prior notification. I understand that I may receive a copy of this authorization.

I agree to be contacted by Sandoz by mail, e-mail, telephone calls, and text messages at the number(s) and address(es) provided on the Sandoz One Source for CIMERLI Program patient enrollment form for all purposes described in this Patient Authorization. I also agree to be contacted by Sandoz, and others on its behalf by telephone calls and text messages made by or using an automatic telephone dialing system or prerecorded voice, at the number(s) provided on this form, for all non-marketing purposes, including but not limited to sending me materials and asking for my participation in surveys. I confirm that I am the subscriber for the telephone number(s) provided and the authorized user for the e-mail address(es) provided, and I agree to notify Sandoz promptly if any of my numbers or addresses change in the future. I understand that my wireless service provider's message and data rates may apply.

I understand that Sandoz does not permit my Personal Information to be used by its business partners for their own separate marketing purposes. I understand and agree that Personal Information transmitted by e-mail and cell phone cannot be secured against unauthorized access.

Telephone Consumer Protection Act (TCPA) Consent: I consent to receive marketing and non-marketing calls and texts from and on behalf of Sandoz, made with an auto dialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase. Number of messages will vary based on your program selections; average of 1-2 messages per week. Message and data rates may apply. Privacy Policy at us.sandoz.com/privacy-policy. Text STOP to opt out and HELP for help.

Fair Credit Reporting Act (FCRA) Authorization: I understand that I am providing "written instructions" authorizing the Sandoz One Source for CIMERLI Program and its vendor, under the FCRA, to obtain information from my credit profile or other information from Experian Health, solely for the purpose of determining financial qualifications for programs administered by Sandoz. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I promise that any information, including financial and insurance information that I provide are complete and true and, unless I have indicated otherwise, I have no drug insurance coverage, which includes Medicaid, Medicare, or any public or private assistance programs or any other form of insurance. If my income or health coverage changes, I will call the Sandoz One Source for CIMERLI Program at 1-844-472-6369. If eligible, I would like to be considered for programs administered by Sandoz.

Patient Name (Print) _____

Patient or Patient Representative Sign Here _____ Date _____

Relationship to Paitent _____

SANDOZ