Patient Enrollment Form

Please complete and fax this form to 833.247.2756. For assistance or additional information, please call 833.695.2623, Monday – Friday, 9am – 8pm ET.

My Biocon Biologics™

By submitting this form, I am requesting support services for Fulphila® (pegfilgrastim-jmdb) injection 6 mg/0.6 mL in a single-dose prefilled syringe, and/or Ogivri® (trastuzumab-dkst) injection 420mg, 150mg on behalf of the patient indicated below. Services include, but are not limited to: benefits verification, copay assistance, prior authorization assistance and assistance with appeals.

***required field**

☐ **Check if requesting Copay Assistance Program only**

PATIENT INFORMATION

First Name* | Middle Initial ☐ | Last Name*

DOB (MM/DD/YYYY)* | Gender M ☐ F ☐ | Email

Address* | City* | State* | Zip*

Primary Phone Number | Secondary Phone Number | Language

OK to Contact Patient for Additional Information? YES ☐ NO ☐

Alternate Contact Name | Relationship | Phone Number

INSURANCE INFORMATION

☐ Check if patient does not have insurance

Primary Insurance Name* | Insurance Phone*

Policy #* | Group #*

Policyholder Name | Relationship to Patient

Secondary Insurance Name* | Insurance Phone*

Policy #* | Group #*

Policyholder Name | Relationship To Patient

PRESCRIBER INFORMATION

First Name* | Last Name*

Tax ID # | NPI #* | Group NPI #

Payer Specific Provider #

Practice Name*

Address* | City* | State* | Zip*

Practice Phone Number* | Practice Fax Number*

Primary Contact Name* | Primary Contact Email*

MEDICATION AND CLINICAL INFORMATION** (Check the medication(s) the patient has been prescribed)

Product: ☐ **FULPHILA®** (pegfilgrastim-jmdb)

Primary Diagnosis (ICD-10)*

Secondary Diagnosis

Site Of Care*

Product: ☐ **OGIVRI®** (trastuzumab-dkst)

Primary Diagnosis (ICD-10)*

Secondary Diagnosis

Site Of Care*

PRESCRIBER CERTIFICATION:

By completing and transmitting this form, I am certifying that I have received from my patient and have on file the patient's HIPAA consent and all other necessary permissions from my patient authorizing the release of the patient's identification and insurance information, including the information I have provided above, to Biocon Biologics™ Inc. (d/b/a My Biocon Biologics™), its affiliates, its program administrator, and their respective agents and service providers (collectively, "My Biocon Biologics") for them to use in providing the patient with benefit verification and support services as described herein.

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