Enrollment and Prescription Form

Adalimumab-fkjp Injection | My Biocon Biologics™

Patients can be enrolled into the MY BIOCON BIOLOGICS adalimumab-fkjp program in two ways:

1. Fax – Complete this Enrollment and Prescription Form in its entirety and fax it to 1-833-726-4848.
2. E-Prescription – Send an electronic prescription for adalimumab-fkjp through your EHR directly to Phyz (21134 Market Ridge, Ste. 101, San Antonio, Texas, 78258; NCPDP: 5928809).

Please make sure your patient's cell phone number* is on file in your Phyz so it is included with the e-prescription. MY BIOCON BIOLOGICS will text and call your patient as part of the enrollment process for this prescription.

By submitting this form or e-prescribing adalimumab-fkjp to Phyz (21134 Market Ridge, Ste. 101, San Antonio, Texas, 78258; NCPDP: 5928809), you are requesting support services on behalf of the patient named below. Services include: benefits verification, prior authorization assistance, copay assistance, prescription triage.

1. PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Date Of Birth (MM/DD/YYYY) _____ Gender ☐ Male ☐ Female

Address 1 _____

Address 2 _____ City _____ State _____ Zip _____

Home Phone Number* _____ Mobile Phone Number* _____ Email Address* _____

*By providing the patient's phone number, you represent that your patient is aware of the disclosure and has given consent to be contacted by Biocon Biologics Inc. regarding this prescription, as well as the pharmacy fulfilling the prescription.

2. INSURANCE INFORMATION

Fax both sides of your patient's medical and prescription benefit insurance card.

☐ Patient has no insurance

Beneficiary Name:

First Name _____ Middle Initial _____ Last Name _____

Medical Insurance: Provider _____ Policy Number _____ Group Number _____ Phone Number _____

Pharmacy Insurance: Provider _____ Member ID _____ PCN (If Applicable) _____

Group ID _____ BIN (If Applicable) _____

3. PRESCRIPTION INFORMATION

Check the box for prescription required.

☐ Adalimumab-fkjp Pen injection 40 mg/0.8mL ☐ Adalimumab-fkjp PFS injection 20 mg/0.4mL ☐ Adalimumab-fkjp PFS injection 40 mg/0.8mL

Starting therapy (if applicable):

Direction Quantity _____

Quantity of Boxes (2 doses per box) _____ No Refills _____

Primary ICD-10 Code (Required) _____

Ongoing therapy:

Inject _____ mg subcutaneously every _____ days

Direction _____

Quantity of Boxes (2 doses per box) _____ Refills _____

Secondary ICD-10 Code (Optional) _____

Patient's preferred specialty pharmacy _____ Phone Number _____ ☐ Check if sent to specialty pharmacy

Note: Payer-mandated pharmacies may take first precedence, followed by preferred by specialty pharmacy.

4. PRESCRIBER INFORMATION

First Name _____ Last Name _____ Facility Name _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Fax Number _____ NPI Number (required) _____ Office Contact Name _____

Prescriber's Signature: (Required) _____ Supervising Physician's Signature: (Where Required) _____ Date _____

In the absence of ERx, if required by applicable state law, please attach copy of prescription on official state prescription form. (Ex. Official NY State Prescription ONYSRx)

MY BIOCON BIOLOGICS PATIENT CONSENT FORM

By signing this Authorization, I authorize each of my "Healthcare Providers" (eg, my physicians, pharmacists, specialty pharmacies, other healthcare providers, and their staff) and "Insurers" (eg, my health insurance plans) to disclose my Protected Health Information as described on this Form. My "Protected Health Information" includes any and all information related to my medical condition, treatment, prescriptions, and health insurance coverage, my name, address, telephone number, Social security number, insurance plan and or group numbers (together, "Protected Health Information") to Biocon Biologics, its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Biocon Biologics") including service providers supporting My Biocon Biologics patient services.

Specifically, I authorize disclosure of my Protected Health Information in order to:

- Enroll me in, and contact me about My Biocon Biologics Patient services program
- Communicate with my Healthcare Providers and Insurers about benefits, coverage, and medical care, including compliance with Product treatments
- Facilitate dispensing of my prescription by a commercial pharmacy and non-commercial pharmacy
- Provide me with educational materials, information and services related to my treatment experience with my prescribed medication and my condition
- Verify, investigate, and coordinate with my Insurers regarding my prescribed medication
- Contact me as otherwise required or permitted by law

Biocon Biologics agrees to protect my Protected Health Information by using and disclosing it only for the purposes described in this Authorization or as permitted by law. I understand that I may refuse to sign this Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me, but I will not have access to the Biocon Biologics and the services provided by Biocon Biologics, under the Program. If I refuse to sign the Authorization, or revoke my Authorization later, I understand that this means I will not be able to participate or receive assistance from the Program.

I understand that my signed Authorization is valid for 10 years from date of signature, and that I may revoke this Authorization at any time in the future, except to the extent that actions have been taken in reliance on the Authorization. I understand that to revoke this Authorization I may mail a request to My Biocon Biologics, fax to 1-833-726-4848, or by calling 1-833-61-BIOCON. I understand that revoking this Authorization will end further uses and disclosure of my Protected Health Information by the parties identified above except to the extent those uses and disclosures have been made in reliance upon this Authorization as permitted by applicable law. I am entitled to receive a copy of this Authorization.

My signature certifies that I have read and understand the above statements and agree to the outlined terms.

Signature: _____ Date: _____

For privacy rights and choices specific to California residents, please see Biocon's California privacy notice available at https://www.bioconbiologics.com/privacy-policy-bbl/

Permission for text communications:

Yes, I would like to receive text messages ☐

Patient Name (Print): _____

_____
Date

_____
Patient or Patient Authorized Representative Signature

If Patient Representative, Print Name: _____

Relationship to Patient: _____

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