Phone: 1-833-61-BIOCON (1-833-612-4626) Fax: 833-726-4848

Copay Program Enrollment and Reimbursement Request Form

My Biocon Biologics - YESINTEK & Ustekinumab-kfce Copay Assistance Program

This form can be used to enroll into the copay program. In case you are utilizing this form only for copay enrollment, you do not have to submit proof of purchase.

If you are an eligible patient whose pharmacy does not accept your copay savings card, or if your information was not available at the time of purchase, you can receive reimbursement for your copay payment by mailing in the required details*. Eligibility restrictions apply. Not valid for uninsured patients or patients who are covered by a state or federally funded healthcare program.

If you are seeking to be enrolled into the copay program, please complete this form and return via FAX or MAIL. If you are determined to be eligible for the My Biocon Biologics Copay Program you will receive a notification which will include your unique Savings Card Member ID # details. Please retain this important information for future reimbursement requests using this form.

If you are seeking reimbursement, please complete this form and FAX or MAIL along with your pharmacy receipt or proof of purchase. Once we receive your completed claim request form, your request will be processed within 6 to 8 weeks**.

Print out and complete this form, and mail or fax it with the following items:
Failure to include any of the following will result in claim rejection.

1. The original pharmacy receipt/invoice received from your pharmacy with your Rx (see below sample receipt) which must include the following information:
   - ✓ Patient name and address
   - ✓ Pharmacy name, address, and phone number
   - ✓ Doctor or health care provider name, address, and phone number
   - ✓ Prescription # (RX #), fill date, drug name, strength, NDC #, and quantity
   - ✓ Overall prescription price and Copay amount/out of pocket expense paid
2. Copy of your explanation of benefits (EOB) if prescription was filled via mail order or specialty pharmacy
3. Copy of your primary insurance card (including both front and back of the card)


RECEIPT
ANY PHARMACY, INC
100 Main St.
Anytown, NY 12345
Rx:100053 Filled:03/31/05
SMITH, JOHN Q (CC)
123 MOTORPARK WAY
HAUPPAUGE,NY 11788 OR
MYDRUG 120 MG
Qty:30 NDC:00000000000
No Refills
NO AUTHORIZATION REQUIRED
DR.JONES, TOM
1324 MOTOR PARKWAY, HAUPPAUGE,NY 11788
AA0000000 (631)582-6787
RxPrice:$XXX.XX
THIS IS YOUR RECEIPT. PLEASE RETAIN FOR YOUR TAX OR INSURANCE.

** For full terms and conditions on copay assistance, visit www.Yesintek.com/copay*

***Savings card reimbursement check amounts will vary according to quantity filled and personal healthcare insurance coverage. Payment of the reimbursement is subject to verification and pursuant to the terms and conditions of the savings card program. See savings card for details.*

610 Crescent Executive Ct. #200 Lake Mary, FL 32746

PATIENT INFORMATION – *Please print*

Patient First Name:	**Middle Name:**	**Last Name:**
Date of Birth:	**Gender at Birth** ☐ Male ☐ Female	**Phone:**
Address 1:	**Address 2:**	
City:	**State:**	**Zip:**

PRESCRIBER INFORMATION – *Please print*

Provider First Name:	**Provider Last Name:**	
Phone:	**Organization Name:**	
Address 1:	**Address 2:**	
City:	**State:**	**Zip:**

If you have not been issued a unique Savings Card Member ID for the My Biocon Biologics Copay Program, please complete the following section:

Copay Screening Questionnaire (Required)		
1. Do you consent to enrollment in the YESINTEK (Ustekinumab-kfce) Copay Assistance Program for drug and/or administration assistance?	☐ YES	☐ NO
2. Is the patient's prescription covered in part or in full under any state or federally funded programs such as Medicare (including Medicare Part D and Medicare Advantage), Medicaid, Medigap, VA, DoD, State Pharmacy Assistance, Tricare, etc?	☐ YES	☐ NO
3. Is the patient a resident of the United States or Puerto Rico?	☐ YES	☐ NO
5. Does the patient have a valid prescription for the drug?	☐ YES	☐ NO
6. What clinical indication are you being treated for? ☐ Crohn's Disease / Ulcerative Colitis and 18 years or older ☐ Crohn's Disease / Ulcerative Colitis and under the age of 18 ☐ Psoriasis / Psoriatic Arthritis and 6 years or older ☐ Psoriasis / Psoriatic Arthritis and under the age of 6		

If you have already been enrolled into the copay program, please fill out your My Biocon Biologics Copay Program Savings Member ID information below:

Savings Card Group Number (if available): _____
Savings Card Member ID # (if available): _____

Please return this form to:

My Biocon Biologics
610 Crescent Executive Ct. #200 Lake Mary, FL 32746
OR by Fax: 1-833-726-4848

To receive reimbursement, your completed reimbursement form must be accompanied by a dated Pharmacy Invoice with product information (proof of purchase) with the amount.

Yesintek and Ustekinumab-kfce Copay Assistance Program Terms and Conditions

With this Yesintek or Ustekinumab-kfce Copay Assistance Program, eligible patients may Pay As Little As (PALA) $0 for each monthly fill of Yesintek (ustekinumab-kfce) injection or ustekinumab-kfce injection, while this program remains in effect. Subject to all other terms and conditions, this copay assistance program may be used to reduce the amount of an eligible patient's out-of-pocket costs for Yesintek or ustekinumab-kfce up to the full amount of the patient's out-of-pocket cost per prescription, subject to a maximum aggregate amount while this copay assistance program remains in effect. Whether a patient is eligible to receive the maximum aggregate amount is determined by the type of commercial insurance plan coverage the patient has and may vary among individual patients covered by different plans. Additional information on the program and whether your particular insurance coverage is likely to result in your reaching the maximum aggregate amount can be obtained by calling 1-833-61-BIOCON (1-833-61-246-26). Valid prescription is required. No other purchase is necessary. Biocon Biologics reserves the right to amend or end this copay assistance program at any time without notice.

- Eligibility Requirements: This copay assistance can be redeemed only by patients age 6 or older and who are residents of the U.S. or Puerto Rico. For patients under the age of 18, authorization is required from legal guardian. Patients must have commercial prescription drug insurance with coverage for Yesintek or ustekinumab-kfce . This copay assistance program is not valid for uninsured patients or commercially insured patients without coverage for Yesintek or ustekinumab-kfce ; not valid for patients who are covered in whole or in part by any state or federally funded healthcare program, including, but not limited to, any state pharmaceutical assistance program, (Medicare Part D or otherwise), Medicaid, Medigap, VA or DOD, or TRICARE (regardless of whether Yesintek or ustekinumab-kfce injection is covered by such government program); not valid if the patient is Medicare eligible and enrolled in an employer-sponsored health plan or prescription benefit program for retirees; and not valid if the patient's insurance plan is paying the entire cost of this prescription. This copay assistance program is void outside the U.S. or Puerto Rico or in any state or jurisdiction where prohibited by law, taxed or restricted. Absent a change in Massachusetts law, this copay assistance program will no longer be valid for Massachusetts residents as of January 1, 2026.
- This copay assistance program is not health insurance. The copay assistance program is not transferable, and the amount of the savings cannot exceed the patient's out-of-pocket costs. Cannot be combined with any other rebate/coupon, cash discount card, free trial, or similar offer for the specified prescription. This copay assistance is not redeemable for cash. This copay assistance is not valid for product dispensed by a 340B covered entity that purchased the product at discounted pricing under the 340B drug pricing program.
- The value of this copay assistance program is exclusively for the benefit of patients and is intended to be credited solely towards patient out-of-pocket costs, including applicable co-payments, coinsurance, deductibles and one time administration charges for the IV induction dose up to a maximum of $100. This copay assistance is not available if the patient's commercial insurance plan, pharmacy benefit manager, or

other plan agent uses a copay adjustment program that restricts program payments from being applied to satisfy the patient's out-of-pocket costs or counted toward the patient's out-of-pocket maximum limits. This copay assistance program also is not available to patients who are members of insurance plans that adjust, reduce, or waive their patients. Out-of-pocket costs based on the availability of, or a member's participation in, manufacturer-sponsored copay assistance. These programs are often referred to as accumulator adjustment or maximizer programs. Patients with these plan terms may not use this copay assistance program but may be eligible for other needs-based assistance provided by Biocon Biologics. If you believe your commercial insurance plan may have such terms, please contact 1-833-61-BIOCON (1-833-61-246-26). Biocon Biologics, in its sole discretion, may reduce or eliminate program benefits for any patient whose plan requires enrollment in the program as a condition of participation in any plan or plan benefit, coverage, or program or otherwise imposes different or additional requirements on patients who receive this copay assistance.
NOTICE. Data related to your use of this copay assistance program may be collected, analyzed and shared with Biocon Biologics for market research and other purposes related to assessing its copay assistance programs. Data shared with Biocon Biologics will be aggregated and de-identified, meaning it will be combined with data related to other copay assistance program redemptions and will not identify you.

- Use of this copay assistance program must be consistent with the terms of any drug benefit provided by a commercial health insurer, health plan or private third-party payer. Patients must have not submitted and will not submit a claim for reimbursement under any federal, state or other governmental programs for this prescription. Patients are responsible for reporting the receipt of copay assistance to any commercial insurer, health plan, or third-party payer who pays for or reimburses any part of the prescription filled, as may be required. Patients should not use this copay assistance program if their health plan prohibits use of manufacturer copay assistance programs. Patients should withdraw from this copay assistance program should they begin to receive prescription benefits from any government funded program by calling 1-833-61-BIOCON (1-833-61-246-26).
- By utilizing this copay assistance program, you hereby accept and agree to abide by these terms and conditions. Any individual or entity who enrolls or assists in the enrollment of a patient in the copay assistance program represents that the patient meets the eligibility criteria and other requirements described herein. Health plans, specialty pharmacies, pharmacy benefit managers, and vendors or agents of any of the foregoing, are prohibited from enrolling or assisting in the enrollment of patients in this copay assistance program. Further, you agree that you currently meet the eligibility criteria and other requirements described herein every time you use this copay assistance program.

CERTIFICATION STATEMENT

I, _____, certify that the information provided for this reimbursement request is accurate to the best of my
knowledge, and the copayment or out-of-pocket expenses requested for reimbursement were incurred. I also certify that I am not enrolled in any state or federally funded healthcare program, including but not limited to, Medicare, Medigap, Medicaid, VA, DOD, TRICARE, Puerto Rico Government Health Insurance Plan, nor am I a Medicare-eligible patient enrolled in an employer-sponsored health plan or prescription drug benefit program for retirees.

Patient or Legal Guardian signature _____ Date_____

For additional questions, please call the My Biocon Biologics Program at 1-833-61-BIOCON (833-612-4626) between 8 AM – 8 PM ET, Monday to Friday.

610 Crescent Executive Ct. #200 Lake Mary, FL 32746

Patient Name _____ Date Of Birth (MM/DD/YYYY) _____

MY BIOCON BIOLOGICS PATIENT SERVICES AUTHORIZATION 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 Yesintek Patient Services and 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): _____

_____

Patient or Patient Authorized Representative Signature

Date: _____

If Patient Representative, Print Name: _____

Relationship to Patient: _____