Patient Enrollment Form

Bosaya™ (denosumab-kyqq) | Aukelso™ (denosumab-kyqq) | My Biocon Biologics™

Please complete and fax this form to 833.726.4848. For assistance or additional information, please call 833.61-BIOCON, Monday – Friday, 8am – 8pm ET.

By submitting this form, I am requesting support services for Bosaya™ (denosumab-kyqq) 60 mg/mL single-dose PFS or Aukelso™ (denosumab-kyqq) 120 mg/1.7 mL single-dose vial on behalf of the patient indicated below. Services include Benefits Verification, Prior Authorization Support and Copay Assistance. ***required field***

PATIENT INFORMATION

Reset

First Name* _____ Middle Initial _____ Last Name* _____

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

Address* _____ City* _____ State* _____ Zip* _____

Preferred Phone* Cell ☐ _____ Home ☐ _____ Language _____

Alternate Contact Name _____ Relationship _____ Phone Number _____

INSURANCE INFORMATION

Reset

Primary Insurance Name* _____ Insurance Phone* _____

Policy #* _____ Group #* _____

Policyholder Name _____ Relationship with patient _____

Secondary Insurance _____ Insurance Phone _____

Name of the Policy # _____ Group # _____

Policyholder Name _____ Relationship with patient _____

PRESCRIBER INFORMATION

Reset

First Name* _____ Last Name* _____

NPI #* _____ Practice NPI # _____ Tax ID # _____

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

Reset

Product: ☐ Bosaya™ (denosumab-kyqq) 60 mg/mL single-dose PFS ☐ Aukelso™ (denosumab-kyqq) 120 mg/1.7 mL single-dose vial

Primary Diagnosis (ICD 10) _____ Secondary Diagnosis (ICD 10) _____

☐ Physician Office ☐ Hospital Outpatient ☐ Infusion Center ☐ Other

PRESCRIBER CERTIFICATION

Reset

By completing and faxing this form, you certify that you have on file, your patient's request and authorization that permits the disclosure of their protected health information to Biocon Biologics, and its agents, for Biocon Biologics to provide the patient support services described in this paragraph. You represent that you have explained to the patient, and the patient indicated they understand and have consented to, the following: 1) Biocon Biologics and its agents will use the patient's name, date of birth, contact information, prescriptions, and other necessary health information listed in this form for reimbursement services related to this prescription, including to verify their insurance benefits, and to contact the patient directly for the administration of these patient support services; 2) Biocon Biologics will then disclose the patient's personal information to the insurer(s) listed on this form for the same purposes; 3) The patient can withdraw their consent by contacting My Biocon Biologics at 1(833) 612 4626. If the patient does not agree to, or withdraws consent for, these uses or disclosures, the patient cannot receive these patient support services for this medication which necessarily requires Biocon Biologics to process the patient's personal information; 4) the patient can view more details about Biocon Biologics privacy policy at www.bioconbiologics.com/privacy-policy-bbl/

Prescriber Signature _____ Date _____

DEN-2025-00017-US