Jobevne™ (bevacizumab-nwgd) Injection | My Biocon Biologics™

Patient Enrollment Form

Please complete and fax this form to 833.726.4848. For E-prescription through your EHR send to Phyz (21134 Market Ridge, Ste.101, San Antonio, TX-78258. Please make sure your patient's cell phone number* is on file in your EHR so it is included with the e-prescription. 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 Jobevne™ (bevacizumab-nwgd) injection 100 mg and 400 mg on behalf of the patient indicated below. Services include benefits verification and prior authorization assistance.
required field

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

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

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

Product: ☐ **JOBEVNE** (bevacizumab-nwgd)

Primary Diagnosis (ICD 10)* _____ Secondary Diagnosis _____

Site Of Care* _____

PRESCRIBER CERTIFICATION:

I certify that (a) the above-prescribed therapy is medically necessary and, (b) I have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for the above-prescribed therapy(ies), to manufacturer and its agents or contractors for the purpose of seeking information related to coverage for the therapy(ies) and/or assisting in initiating or continuing therapy

Prescriber Signature _____ Date _____

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 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: _____