Patient Enrollment Form

Jobevne™ (bevacizumab-nwgd) Injection

My Biocon Biologics®

Patients can be enrolled into the My Biocon Biologics patient support program for Jobevne™ (bevacizumab-nwgd) by:
1. Fax – Complete this Patient Enrollment Form in its entirety and fax it to 1-833-726-4848.
Have questions? Please call 1-833-61-BIOCON Monday to Friday, 8am to 8 pm ET.

By submitting this form, you are requesting patient 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.

PATIENT INFORMATION *Fields marked with a * are required.* Reset

First Name* _____ Middle Initial _____ Last Name* _____

DOB (MM/DD/YYYY)* ___/___/_____ Gender Assigned at Birth* M ☐ F ☐ Email _____

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

Preferred Phone* Cell ☐ Home ☐ (___)____–_____

Alternate Contact Name _____ Relationship _____ Phone Number (___)____–_____

INSURANCE INFORMATION *Please fax copies of the front and back of the patient's insurance card(s).* Reset

Primary Insurance Name* _____ Secondary Insurance Name _____

Member ID* _____ Member ID _____

Insurance Phone* (___)_____–_____ Insurance Phone (___)_____–_____

Group Number _____ Group Number _____

Policyholder Name _____ Policyholder Name _____

Relationship to Patient _____ Relationship to Patient _____

PRESCRIBER INFORMATION Reset

First Name* _____ Last Name* _____

NPI #* _____ Group NPI # _____ Tax ID # _____

Practice Name* _____

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

Practice Phone Number* (___)_____–_____ Practice Fax Number* (___)_____–_____

Primary Office Contact* _____ Preferred Email* _____

MEDICATION AND CLINICAL INFORMATION *Please select 1 dosage size.* Reset

Product: ☐ JOBEVNE (bevacizumab-nwgd) 100 mg/4 mL ☐ JOBEVNE (bevacizumab-nwgd) 400 mg/16 mL

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

Site of Care: ☐ Physician Office ☐ Hospital ☐ Outpatient Infusion Center ☐ Other _____

Has patient started treatment? ☐ Yes ☐ No If no, list anticipated start date ___/___/_____

PRESCRIBER CERTIFICATION Reset

By completing 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: ___/___/_____

BEV-2025-00036-US V2