Patient Enrollment Form

Yesafili™ (aflibercept-jbvf) | My Biocon Biologics®

For assistance or additional information, please call 1-833-61-BIOCON, Monday – Friday, 8am – 8pm ET.

Patients can be enrolled into the My Biocon Biologics Yesafili™ (aflibercept-jbvf) patient support program by either:

1. Fax – Complete this Patient Enrollment Form in its entirety and fax it to 1-833-726-4848.
2. HCP Portal – Visit www.BioconHCPportal.com to submit online 24 hours a day, 7 days a week. Portal registration is required.

By submitting this form, I am requesting support services for YESAFILI (aflibercept-jbvf) 2mg (0.05 mL of 40mg/mL solution) single-dose PFS or YESAFILI (aflibercept-jbvf) 2mg (0.05 mL of 40mg/mL solution) single-dose vial on behalf of the patient indicated below. Services available include benefits verification, prior authorization support, commercial copay assistance, and support with claim denials and appeals. ☐ Check if requesting Copay Assistance Program only

PATIENT INFORMATION *Fields marked with an * 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 to Patient _____ Phone Number (___)____–_____

INSURANCE INFORMATION *Please fax a copy 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* _____

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

Practice Name* _____

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

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

Primary Contact Name* _____ Preferred Email* _____

MEDICATION AND CLINICAL INFORMATION Reset

Product: ☐ YESAFILI (aflibercept-jbvf) 2mg (0.05 mL of 40mg/mL solution) single-dose PFS ☐ YESAFILI (aflibercept-jbvf) 2mg (0.05 mL of 40mg/mL solution) single-dose vial

Primary Diagnosis (ICD-10-CM Code) _____ Secondary Diagnosis (ICD-10-CM Code) _____

Eye(s) Affected ☐ Left ☐ Right ☐ Bilateral Has patient started treatment? ☐ Yes ☐ No If no, list anticipated start date ___/___/___

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

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 ___/___/_____

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