



# **Copay Screening Form**

Commercially insured eligible patients may lower their out-of-pocket costs to as little as \$0 with the BYOOVIZ™ (ranibizumab-nuna) Drug Copay and/or Administration Copay Program(s). There is an annual cap on the amount of drug copay assistance that patients can receive over a one-year period. In addition, there is an annual BYOOVIZ Administration Program cap. By completing this form, you will be screened to determine your eligibility for the BYOOVIZ Drug Copay and/or Administration Copay Program(s).

Federal and state laws and other factors may prevent or otherwise restrict eligibility. People covered by Medicare, Medicaid, Veterans Affairs (VA), the Department of Defense (DoD), or any other federal plans are not eligible to enroll. Patients are eligible to enroll in the BYOOVIZ Drug Copay and/or Administration Copay Program(s) for as long as they are offered and they are treated with BYOOVIZ, provided that they meet the eligibility criteria.

Biogen is committed to making access to therapy as easy as possible. If your situation ever changes, you have concerns about your ability to pay for your medication, or you have any concerns or questions about your medication, please call a Biogen Biosimilar Support Coordinator at 877-422-8360.

## INSTRUCTIONS FOR HEALTHCARE PROVIDERS



In order for your patient to be screened for Copay Assistance, they must be enrolled in Biogen Biosimilar Support Services and have provided their consent via signature, either using the enrollment form or the HCP Portal, both of which can be accessed via **ByoovizHCP.com/Support**.

#### How do I complete this form?

Read, fill out, and sign as indicated in Sections I, II, and III of this Copay Screening Form. This will enable your patient to be screened for the BYOOVIZ Drug Copay and/or Administration Copay Program(s).

## **INSTRUCTIONS FOR PATIENTS**

#### How do I complete this form?

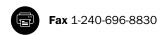
Read, fill out, and sign as indicated in Sections IV, V, and VI of this Copay Screening Form. This will enable you to be screened for the BYOOVIZ Drug Copay and/or Administration Copay Program(s).

#### What happens next?

Once we receive the completed form, Biogen Biosimilar Support Services, brought to you by CareMetx, may contact you to discuss your eligibility. You can expect to receive several important notifications. You may receive a phone call from Biogen Biosimilar Support Services or receive an email from biosimilar support services@biogen.com. Please be sure to answer when you see these calls and respond to any emails requesting your attention. They are intended to help you through your copay screening process.





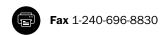


## THE FOLLOWING SECTIONS SHOULD BE FILLED OUT BY A HEALTHCARE PROVIDER

| All fields are mandatory.   |                   |   |  |
|---|-------------------|---|--|
| I. PATIENT INFORMATION  |                   |   |  |
|   |                   |   |  |
| First Name M.I.   | Last Name         |   | Date of Birth (MM/DD/YYYY)                               |
|   |                   |   |  |
| Phone Number  | Email             |   |  |
| II. COPAY SCREENING QUESTIONNAIRE-  | -HCP INFORI       | MATION                                      |  |
| For which of the following indications are y prescribing BYOOVIZ to treat this patient?               | ′ou               | Are you a US-licensed administering BYOOVIZ | physician that will be<br>Z at a US administration site? |
| Neovascular (Wet) Age-Related Macula  | ar                | Yes   |  |
| Degeneration (AMD)  |                   | ☐ No  |  |
| <ul><li>Macular Edema Following Retinal Vein (RVO)</li></ul>  | Occlusion         |   |  |
| Myopic Choroidal Neovascularization (   | mCNV)             |   |  |
|   |                   |   |  |
|   |                   |   |  |
| III. COPAY SCREENING QUESTIONNAIRE  |                   |   |  |
| My signature below certifies that the person na   |                   |   | -  |
| application, to the best of my knowledge, is cor<br>application is only for the use of BYOOVIZ for th | -                 |   | eceived in response to this                              |
| My signature below certifies that the BYOOVIZ r   | •                 |   | ly for the use of BYOOVIZ for                            |
| the patient named on this form. With regard to  |                   |   |  |
| Support Services program, I acknowledge that  |                   |   |  |
| claim for reimbursement of either BYOOVIZ or r<br>Medicaid, or any third-party payer OR I will prov   |                   | •   |  |
| patients who are deemed uninsured after a cla   |                   |   | ntation to support roquests for                          |
| I consent to Biogen Inc. and its affiliates, repres   | sentatives, ager  | nts, and contractors contacti               | ng me by fax, phone, mail, or                            |
| email to confirm receipt of BYOOVIZ or to provid  |                   |   | _  |
| Services program. I acknowledge that Biogen Ir without notice to me.                                  | ic. may revise, c | change, or terminate any prog               | gram services at any time                                |
|   |                   |   |  |
|   |                   |   |  |
|   |                   |   |  |
|   |                   |   | _  |
| Signature of Healthcare Provider  |                   |   | Date   |







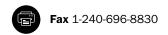
## THE FOLLOWING SECTIONS SHOULD BE FILLED OUT BY THE PATIENT

All fields are mandatory.

| IV. COPAY SCREENING QUESTIONNAIRE—PATIENT   |  |
|---|--|
| Do you consent to enrollment in the BYOOVIZ Drug Copay and/or Administration Copay Program(s) for drug and/or administration assistance?  Yes No What state do you live in?   | What is your current source of healthcare insurance and/or healthcare funding? Select all that apply.  Private insurance (includes employer or Healthcare Marketplace insurance)  Federal or state-funded program (includes, but not limited to, Medicare, Medicaid, VA, DoD, and TRICARE®*)  No healthcare insurance or funding                                   |
| Are you currently a US citizen or US resident?  No  | Does your current source of healthcare insurance cover BYOOVIZ?  No Idon't know  |
|   | Do you currently have an out-of-pocket financial responsibility for your BYOOVIZ treatment?  Yes  I don't know   |
| *TRICARE® is a registered trademark of the Department of Defense, Defense He  | ealth Agency. All rights reserved.   |
| is reimbursed, either in whole or in part, by a federa assistance on such claim.  I attest that I (i) currently do not have federally fund health insurance to cover BYOOVIZ and/or its admit obtain a federally funded health insurance plan dur | s administration (for which I am seeking copay assistance) ally funded insurance plan, then I am not eligible for copay led health insurance, (ii) will not use my federally funded nistration, and (iii) agree to notify Biogen immediately if I ring my enrollment in the copay program(s) and choose to and/or its administration so that I may be removed from |
|   | a covers only the cost of the drug and does not cover other as office visits, administration costs, additional fees, or enalties") assessed by my insurance company.   |
| Minnesota, or Rhode Island, this program is not ava<br>BYOOVIZ Administration Copay Program, this progra<br>or coinsurance) for the administration of BYOOVIZ.<br>as office visits, and other fees or penalties (in some                          | I understand that if I am a resident of Massachusetts, allable to me. I understand that if I am enrolled in the am only covers out-of-pocket costs (such as a copayment Other services and fees associated with treatment, such a plans referred to as "network penalties") assessed by my that drug costs may be covered by the Drug Copay Program,               |
|   | stration Copay Program, I am responsible for knowing when p. Furthermore, I understand that if I meet the cap, I am  |







### THE FOLLOWING SECTION SHOULD BE FILLED OUT BY THE PATIENT

All fields are mandatory.

#### VI. PATIENT ADDITIONAL TERMS AND CONDITIONS

Please read and acknowledge that you understand and agree to the additional terms and conditions listed below.

- If you are found eligible, your participation in the program(s) and the assistance you receive will depend on you continuing to meet the following terms:
  - You maintain coverage through an insurance provider and notify Biogen of any changes or additions to your coverage, including if you switch pharmacies or use out-of-network benefits.
  - You are taking BYOOVIZ in accordance with the Prescribing Information.
- There is an annual cap on the amount of assistance that you can receive as part of the BYOOVIZ Drug Copay and the BYOOVIZ Administration Copay Programs. Individuals may reach this cap at different times based on a variety of factors, including but not limited to insurance coverage, claims details, and/or participation in other insurance plan-sponsored programs. Once you have reached the cap on the relevant program, you will be responsible for paying all out-of-pocket expenses for the remainder of the calendar year. As you are nearing the caps for the BYOOVIZ Drug Copay Program and/or the BYOOVIZ Administration Copay Program, you will be notified via your preferred method of communication (letter or email). The BYOOVIZ Drug Copay Program cap and/or the BYOOVIZ Administration Copay Program cap will reset every January 1st.
- Biogen will not provide the copay assistance directly to you but instead will pay directly to your pharmacy or administration site on your behalf. Your pharmacy or administration site will be responsible for sending in claims for each individual date of service.
- The **BYOOVIZ Drug Copay Program** and the **BYOOVIZ Administration Copay Program** are not health insurance or benefit plans. The programs do not obligate the use of a specific provider.
- You are responsible for appropriately reporting enrollment into the BYOOVIZ Drug Copay Program and/or the BYOOVIZ
   Administration Copay Program as required by your insurer. It is your responsibility to ensure compliance with all terms of your insurance as outlined by your insurance plan.
- To be eligible for the BYOOVIZ Administration Copay Program, you need to be personally responsible for your
  administration costs, such as coinsurance or copay. This program works in conjunction with determined administration
  sites accepting this assistance.
- Biogen reserves the right to modify or discontinue these program(s) with respect to any patient, or in its entirety, at any time. Your participation in these program(s) does not mean that you will be entitled to receive program assistance indefinitely.

By signing below, I acknowledge that I understand the eligibility criteria for the program(s) and agree to the terms and conditions of the program(s) as stated above. If I fail to comply with the program(s), I understand that I may jeopardize my ongoing participation in the program(s) and may be subject to the costs associated with BYOOVIZ and/or its administration.

| If you meet any of the following criteria:   |  |
|--|--|
| <ul><li>do not agree to the terms outlined above</li><li>are unable to answer any of the questions above</li></ul> | <ul> <li>are unable to attest that you do not have federally<br/>funded health insurance that will be used to pay for<br/>BYOOVIZ and/or its administration</li> </ul> |
| Please call 1-877-422-8360 to notify us — do not significantly $\mathbf{u}$  | gn and date the form.  |
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