BIOGEN

BIOSIMILAR SUPPORT SERVICES FOR PATIENTS

Questions?
Contact a Support Coordinator at 1-877-422-8360

Fax 1-240-696-8830

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?

1. 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?

1. 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 biosimilarsupportservices@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.

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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 INFORMATION

1 For which of the following indications are you prescribing BYOOVIZ to treat this patient?

- ☐ Neovascular (Wet) Age-Related Macular Degeneration (AMD)
- ☐ Macular Edema Following Retinal Vein Occlusion (RVO)
- ☐ Myopic Choroidal Neovascularization (mCNV)

2 Are you a US-licensed physician that will be administering BYOOVIZ at a US administration site?

- ☐ Yes
- ☐ No

III. COPAY SCREENING QUESTIONNAIRE—HCP ATTESTATION

My signature below certifies that the person named on this form is my patient, the information provided on this application, to the best of my knowledge, is complete and accurate, and that the BYOOVIZ received in response to this application is only for the use of BYOOVIZ for the patient named on this form.

My signature below certifies that the BYOOVIZ received in response to this application is only for the use of BYOOVIZ for the patient named on this form. With regard to any patient eligible for patient assistance through the Biogen Biosimilar Support Services program, I acknowledge that this medication will not be offered for sale, trade, or barter and EITHER no claim for reimbursement of either BYOOVIZ or related medical procedures and services will be submitted to Medicare, Medicaid, or any third-party payer OR I will provide appropriate denial and appeals documentation to support requests for patients who are deemed uninsured after a claim was submitted.

I consent to Biogen Inc. and its affiliates, representatives, agents, and contractors contacting me by fax, phone, mail, or email to confirm receipt of BYOOVIZ or to provide additional information about BYOOVIZ or the Biogen Biosimilar Support Services program. I acknowledge that Biogen Inc. may revise, change, or terminate any program services at any time without notice to me.

Signature of Healthcare Provider | Date

THE FOLLOWING SECTIONS SHOULD BE FILLED OUT BY THE PATIENT

All fields are mandatory.

IV. COPAY SCREENING QUESTIONNAIRE—PATIENT

1. Do you consent to enrollment in the **BYOOVIZ Drug Copay and/or Administration Copay Program(s)** for drug and/or administration assistance?
   - ☐ Yes ☐ No
2. What state do you live in?
3. Are you currently a US citizen or US resident?
   - ☐ Yes ☐ No
4. 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
5. Does your current source of healthcare insurance cover BYOOVIZ?
   - ☐ Yes ☐ No ☐ I don't know
6. Do you currently have an out-of-pocket financial responsibility for your BYOOVIZ treatment?
   - ☐ Yes ☐ No ☐ I don't know

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V. PATIENT ATTESTATIONS

Please initial each statement below and attest to in writing your agreement with the following:

☐ I understand that if the claim for BYOOVIZ and/or its administration (for which I am seeking copay assistance) is reimbursed, either in whole or in part, by a federally funded insurance plan, then I am not eligible for copay assistance on such claim.

☐ I attest that I (i) currently do not have federally funded health insurance, (ii) will not use my federally funded health insurance to cover BYOOVIZ and/or its administration, and (iii) agree to notify Biogen immediately if I obtain a federally funded health insurance plan during my enrollment in the copay program(s) and choose to use it to cover any portion of the costs of BYOOVIZ and/or its administration so that I may be removed from the copay program(s).

☐ I understand that the BYOOVIZ Drug Copay Program covers only the cost of the drug and does not cover other services and fees associated with treatment, such as office visits, administration costs, additional fees, or penalties (in some plans referred to as "network penalties") assessed by my insurance company.

☐ **For BYOOVIZ Administration Copay Program Only:** I understand that if I am a resident of Massachusetts, Minnesota, or Rhode Island, this program is not available to me. I understand that if I am enrolled in the BYOOVIZ Administration Copay Program, this program only covers out-of-pocket costs (such as a copayment or coinsurance) for the administration of BYOOVIZ. Other services and fees associated with treatment, such as office visits, and other fees or penalties (in some plans referred to as "network penalties") assessed by my insurance company are not included. I understand that drug costs may be covered by the Drug Copay Program, which I understand I must enroll in separately.

☐ I understand that if enrolled in the BYOOVIZ Administration Copay Program, I am responsible for knowing when I will meet my $1,000 administration assistance cap. Furthermore, I understand that if I meet the cap, I am responsible for 100% of the costs.

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:

- do not agree to the terms outlined above
- are unable to answer any of the questions above
- are unable to attest that you do not have federally funded health insurance that will be used to pay for BYOOVIZ and/or its administration

Please call 1-877-422-8360 to notify us — do not sign and date the form.

Signature of Patient or Patient's Legal Representative

Date

Biogen

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