THE ORGANON
ACCESS PROGRAM
FOR TOFIDENCE™
(tocilizumab-bavi) injection,
for intravenous use

Questions?
Contact a Support Coordinator
at 1-855-635-9581

Fax 1-240-752-6958

Before prescribing TOFIDENCE, please read the accompanying Prescribing Information, including the Boxed Warning about serious infections. The Medication Guide also is available.

The Organon Access Program Enrollment Form

INSTRUCTIONS FOR PATIENTS

The Organon Access Program offers eligible patients assistance to get started and stay on treatment. These services may include help understanding out-of-pocket costs and financial assistance for eligible patients.

To speak with a Support Coordinator about the resources that may be available to you, call **1-855-635-9581, Monday–Friday, 8:30AM–8:00PM ET.**

1. After discussing **The Organon Access Program** with your health care provider, read the Patient Consent Information on pages 2 and 3.
2. To get started, fill out the form on page 4. Your health care provider will send it to The Organon Access Program, which will help you throughout the process. A Support Coordinator will contact you soon via telephone if additional information is needed.

Organon takes patient confidentiality very seriously. Signing this consent form will allow Organon to provide support services that may require use of your personal health information.

INSTRUCTIONS FOR HEALTH CARE PROVIDERS

This form provides information to **The Organon Access Program**, enabling its representatives to contact your patients to provide support services. Please complete this form and return to our toll-free fax number: 1-240-752-6958.

1. To get started, have your patient read the Patient Consent Information on pages 2 and 3. If you collectively determine a need for **The Organon Access Program**, have them fill out and sign the patient section of the form on page 4.
2. Complete the Health Care Provider portion on pages 6-8. Copy both sides of the patient's medical insurance card and pharmacy benefit card.
3. Fax the completed form and copies of the insurance cards to 1-240-752-6958. Then give your patient the Instructions for Patients and Patient Consent Information pages. A Support Coordinator from **The Organon Access Program** will contact your patient, if information is needed, to help them throughout the process.

Visit **https://www.organonaccessprogram-tofidence.com/hcp/**
to learn more about The Organon Access Program

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PATIENT CONSENT INFORMATION

Please read the following. If you agree, complete, sign, and date the corresponding section on page 4.

I. Authorization to Share Health Information

I understand that before I may participate in The Organon Access Program, sponsored by Organon LLC, ("Organon"), or receive assistance from the Organon Patient Assistance Program ("Organon PAP"), sponsored by the Organon Patient Assistance Program Inc. (individually, "a Program"; collectively, "the Programs"), Organon and third-party service providers working under its instructions ("Program Administrators"), will need to obtain, review, use, and disclose my medical and health information.

By signing this Authorization, I authorize my health care provider, my health insurance company, and my pharmacy providers ("Health Care Entities") to disclose to the Program Administrators health information relating to my medical condition, treatment, and insurance coverage as well as information contained in this enrollment form ("Personal Health Information" or "PHI") for the Program Administrators to (i) verify my eligibility to enroll in the Programs and enroll me in the Programs for which I am eligible, (ii) provide me with the services described in this enrollment form, including but not limited to, communicate Program-related content with me by US postal mail, telephone, email or text, (iii) provide me with reimbursement support and to investigate my insurance coverage in connection with The Organon Access Program, (iv) ensure compliance with the rules of the Programs and compliance with applicable laws and regulations, and (v) conduct data analysis and prepare reports with de-identified and aggregated data that do not include my PHI. I understand that once I sign this Authorization, and my PHI is disclosed to the Program Administrators by the Health Care Entities, the Health Insurance Portability and Accountability Act (HIPAA) will no longer apply to my information because the Program Administrators are not covered by HIPAA. However, the Program Administrators are committed to protecting my PHI by using and disclosing it only for purposes informed in this Authorization or as required by law or regulations. I understand that the Program Administrators may disclose my personal information, including my PHI, to a third party relating to a corporate reorganization, merger, sale, joint venture, assignment, transfer, or other disposition of all or any portion of our business, assets, or stock, including regarding any bankruptcy or similar proceedings.

I understand that I may refuse to sign this Authorization. I further understand that my treatment (including with an Organon product), payment for treatment, insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization; but if I do not sign it or later cancel it, I will not be able to receive support in the context of the Programs.

I may cancel this Authorization at any time by calling 1-855-635-9581. Canceling this Authorization will end my consent to further disclosure of my health information to the Program Administrators by my Health Care Entities after they are notified of my cancellation but will not affect previous disclosures by them pursuant to this Authorization. Canceling this authorization will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance.

This Authorization expires three (3) years, or such shorter timeframe required by applicable law, from the day I sign it as indicated by the date next to my signature unless otherwise canceled earlier as set forth above.

I understand that I can learn more about Organon's privacy practices, including how to exercise my rights under applicable privacy laws, by visiting https://www.organon.com/privacy/.

Please sign in the space provided in Section A on page 4 to authorize your consent.

II. Patient Services Authorization

By checking the "Agree to terms" box and signing this authorization, I authorize Organon and third-party service providers working under its instructions ("Program Administrators"), to provide me with the services described in this enrollment form, including but not limited to, communicate Program-related content with me by US postal mail, telephone, email or text messages (including calls and text messages made with an automatic telephone dialing system or a prerecorded voice), and provide me with reimbursement support and to investigate my insurance coverage in connection with The Organon Access Program. I understand and agree that personnel, including but not limited to nurses, providing such support services on behalf of Organon are not employed by my health care professional.

I also authorize the Program Administrators to use and disclose my medical and health information in connection with providing the services, including but not limited to, disclosing my information to vendors, processors, and service providers for business purposes associated with providing the services, sharing such information with my health care provider, insurance provider, pharmacy, or Medicare or disclosing my information where required by applicable laws or regulations. I also authorize the disclosure of my health information to specific individuals that I have designated.

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PATIENT CONSENT INFORMATION

Please read the following. If you agree, complete, sign, and date the corresponding section on page 4.

I may cancel this Authorization at any time by calling 1-855-635-9581. Canceling this Authorization will end my consent to further disclosure of my health information to the Program Administrators by my Health Care Entities after they are notified of my cancellation but will not affect previous disclosures by them pursuant to this Authorization. Canceling this authorization will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance.
I understand that I can learn more about Organon's privacy practices, including how to exercise my rights under applicable privacy laws, by visiting https://www.organon.com/privacy/.

Please sign in the space in Section B on page 4 to authorize your consent.

I understand that I have the right to receive a copy of the terms and conditions of my agreement with Organon, and that I may request that copy at the time of signing or at a later date by contacting the Program Administrators at: 1-855-635-9581.

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PLEASE ENSURE PAGES 4-7 ARE COMPLETED

THE FOLLOWING SECTION SHOULD BE FILLED OUT BY THE PATIENT

*denotes a required field

I. Authorization to Share Health Information

Ⓐ I have read and understand the Authorization to Share Health Information and agree to the terms.

☐ I understand that before I may participate in The Organon Access Program, sponsored by Organon LLC, ("Organon"), or receive assistance from the Organon Patient Assistance Program ("Organon PAP"), sponsored by the Organon Patient Assistance Program Inc. (individually, "a Program"; collectively, "the Programs"), Organon and third-party service providers working under its instructions ("Program Administrators"), will need to obtain, review, use, and disclose my medical and health information.

By signing this Authorization, I authorize my health care provider, my health insurance company, and my pharmacy providers ("Health Care Entities") to disclose to the Program Administrators health information relating to my medical condition, treatment, and insurance coverage as well as information contained in this enrollment form ("Personal Health Information" or "PHI") for the Program Administrators to (i) verify my eligibility to enroll in the Programs and enroll me in the Programs for which I am eligible, (ii) provide me with the services described in this enrollment form, including but not limited to, communicate Program-related content with me by US postal mail, telephone, email or text, (iii) provide me with reimbursement support and to investigate my insurance coverage in connection with The Organon Access Program, (iv) ensure compliance with the rules of the Programs and compliance with applicable laws and regulations, and (v) conduct data analysis and prepare reports with de-identified and aggregated data that do not include my PHI. I understand that once I sign this Authorization, and my PHI is disclosed to the Program Administrators by the Health Care Entities, the Health Insurance Portability and Accountability Act (HIPAA) will no longer apply to my information because the Program Administrators are not covered by HIPAA. However, the Program Administrators are committed to protecting my PHI by using and disclosing it only for purposes informed in this Authorization or as required by law or regulations. I understand that the Program Administrators may disclose my personal information, including my PHI, to a third party relating to a corporate reorganization, merger, sale, joint venture, assignment, transfer, or other disposition of all or any portion of our business, assets, or stock, including regarding any bankruptcy or similar proceedings.

I understand that I may refuse to sign this Authorization. I further understand that my treatment (including with an Organon product), payment for treatment, insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization; but if I do not sign it or later cancel it, I will not be able to receive support in the context of the Programs.

I may cancel this Authorization at any time by calling 1-855-635-9581. Canceling this Authorization will end my consent to further disclosure of my health information to the Program Administrators by my Health Care Entities after they are notified of my cancellation, but will not affect previous disclosures by them pursuant to this Authorization. Canceling this authorization will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance.

This Authorization expires three (3) years, or such shorter timeframe required by applicable law, from the day I sign it as indicated by the date next to my signature unless otherwise canceled earlier as set forth above.

I understand that I can learn more about Organon's privacy practices, including how to exercise my rights under applicable privacy laws, by

Signature of Patient or Patient's Legal Representative* Date*

If signed by Legal Representative, by my signature above, I represent and warrant that I have current legal authority to execute on behalf of the patient.

Please Explain Authority to Act on Behalf of the Patient

Ⓑ II. Patient Services Authorization

I have read and understand the *Patient Services Authorization* and agree to the terms.

☐ I consent to receive autodialed and prerecorded marketing calls and text messages from the Program Administrators at the telephone number(s) that I provide. I understand that I do not need to provide this consent in order to purchase any Organon products. I understand that text message and data rates may apply. Frequency may vary. Reply STOP to cancel, HELP for help.

Signature of Patient or Patient's Legal Representative* Date*

If signed by Legal Representative, by my signature above I represent and warrant that I have current legal authority to execute on behalf of the patient.

Authorizing a Caregiver (optional)

By providing caregiver information below, I authorize the disclosure of my health information to the following designated individual (optional).

☐ I also authorize this individual to take action on my behalf for the purposes of assessing my eligibility and enrolling me in The Organon Access Program services. I attest that the individual designated below has my permission and the knowledge and ability to accurately provide information about my insurance plans as well as provide details regarding my financial status.

If you authorize a caregiver above, please fill out the fields below:

Caregiver First Name | Caregiver Last Name | Relationship

Address

City | State | Zip Code

Caregiver Email | Caregiver Phone

By providing the caregiver information above, I confirm that I have received permission from the designated individual listed above to share their contact information with Organon.

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PATIENT INFORMATION

First Name* | M.I. | Last Name*

Date of Birth (MM/DD/YYYY)*

Gender* (Check one) ☐ M ☐ F

Email

Phone Number

Address Type (Check one) ☐ Mailing ☐ Home ☐ Work ☐ Other

Address Line 1 (address/street)*

Address Line 2 (apt/suite #)

City* | State* | Zip Code*

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PLEASE ENSURE PAGES 4-7 ARE COMPLETED

THE FOLLOWING SECTION SHOULD BE FILLED OUT BY A HEALTH CARE PROVIDER

*denotes a required field

SUPPORT REQUESTED (check all that apply)

- ☐ Medical Benefits Verification
- ☐ Other Financial Assistance
- ☐ Authorization Assistance (Medical Benefit)
- ☐ Appeals Support
- ☐ Drug Co-pay Assistance
- ☐ Claims Support

HEALTH CARE PROVIDER

First Name* | Last Name*

NPI* | Tax ID*

DEA Number* | Provider State License Number*

Licensing State* | HIN

ADMINISTRATION SITE

Name*

Tax ID* | NPI*

Address Line 1 (address/street)*

Address Line 2 (suite #/floor)

City* | State* | Zip Code*

Office Contact First Name | Office Contact Last Name

Office Contact Phone Number* | Office Contact Email*

Fax number*

☐ Check here if HCP practice address is the same as the administration site.

Procurement Method (Check one)

☐ Specialty Pharmacy ☐ Buy and Bill ☐ Other

Preferred Specialty Pharmacy

PATIENT PRIMARY MEDICAL INSURANCE

Insurance Name* | Plan Name*

Policy Number* | Group Number

Plan Type (Check one)*

☐ Commercial/ Private ☐ Medicare ☐ TRICARE® ☐ VA/Military

☐ Managed Medicaid ☐ Traditional Medicaid ☐ Other

Phone Number*

Cardholder Relationship to Subscriber (Check one)

☐ Dependent ☐ Self ☐ Spouse

Subscriber Name* | Cardholder DOB (MM/DD/YYYY)*

PRIMARY MEDICAL PHARMACY INSURANCE

Pharmacy Insurance Name*

Pharmacy Insurance Cardholder Identification*

Pharmacy Insurance Group Number

Benefit Identification Number (BIN)

Processor Control Number (PCN)

Phone Number*

Therapy History

☐ Switching from another therapy ☐ Naive to therapy

Therapy Switching From

Is prior authorization in place? (Check one) ☐ Yes ☐ No

Authorization Number

If patient is uninsured, please call 1-855-635-9581 for assistance.

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*denotes a required field

PATIENT SECONDARY MEDICAL INSURANCE

Medical Insurance Name*

Plan Name*

Medical Insurance Policy Number*

Medical Insurance Group Number

Medical Insurance Plan Type (Check one)

☐ Commercial/ Private ☐ Medicare ☐ TRICARE® ☐ VA/Military

☐ Managed Medicaid ☐ Traditional Medicaid ☐ Other

Medical Insurance Phone Number

Cardholder Relationship to Subscriber (Check one)

☐ Dependent ☐ Self ☐ Spouse

Subscriber Name*

Cardholder DOB (MM/DD/YYYY)*

Pharmacy Insurance Name*

Pharmacy Insurance Cardholder Member ID*

Pharmacy Insurance Group Number

Benefit Identification Number (BIN)

Processor Control Number (PCN)

Phone Number*

DRUG INFORMATION

Drug Name*: ☐ TOFIDENCE™ (tocilizumab-bavi) injection, for intravenous use

HCPCS II Code*: ☐ Q5133, Injection, tocilizumab-bavi (TOFIDENCE) biosimilar, 1 mg

NDC Code (check all that apply)*:

☐ 80 mg/4 mL (NDC 64406-024-01)

☐ 200 mg/10 mL (NDC 64406-022-01)

☐ 400 mg/20 mL (NDC 64406-023-01)

SIG

Infuse (mg)

☐ Once every 2 weeks ☐ Once every 4 weeks

☐ Other:

Dispense TOFIDENCE vials:

☐ 80-mg vial ☐ 200-mg vial ☐ 400-mg vial

Patient weight (lbs)

Refills

DIAGNOSIS AND CLINICAL INFORMATION

To the highest level of specificity, provide:

Primary diagnosis code*

Secondary diagnosis code

Anticipated date of treatment (MM/DD/YYYY)

Has the patient started therapy? ☐ Yes ☐ No

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HCP ATTESTATION

My signature certifies the following: (i) that the person named on this Enrollment Form is my patient, (ii) that I have obtained his/her written authorization and certification under the Authorization to Share Health Information section of this form, (iii) that to the best of my knowledge the information, if applicable, under Section 6.2 of this form is accurate and complete, (iv) that I will retain in my files the complete patient-executed Enrollment Form, (v) that upon request, I will promptly provide a copy of this patient-executed Enrollment Form on file to **The Organon Access Program**, and (vi) I understand that my personal information collected in this enrollment form and during my interactions with the Program Administrators will be used to provide the services described in this form, comply with applicable laws and regulations, and conduct evaluations of the Programs with de-identified and aggregated information, and that I can learn more about Organon's privacy practices, including how to exercise my rights under applicable privacy laws, by visiting https://www.organon.com/privacy/. 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 TOFIDENCE™ (tocilizumab-bavi) injection, for intravenous use received in response to this application is only for the use of TOFIDENCE for the patient named on this form. With regard to any patient eligible for patient assistance through **The Organon Access Program**, I acknowledge that this medication will be prescribed for an indication consistent with the product's label and will not be offered for sale, trade, or barter and EITHER no claim for reimbursement of either TOFIDENCE 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 Organon LLC and its affiliates, representatives, agents, and contractors contacting me by fax, phone, mail, or email to confirm receipt of TOFIDENCE or provide additional information about TOFIDENCE or **The Organon Access Program** and that Organon LLC may revise, change, or terminate any program services at any time without notice to me. I authorize Organon LLC and its representatives and contractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient, and I appoint **The Organon Access Program** solely to convey the prescription herein on my behalf to the pharmacy chosen by or for the above-named patient.

Provider Signature*	Date*

ORGANON