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.

Co-pay Screening Form

Commercially insured eligible patients may lower their out-of-pocket costs to as little as $0 with the **TOFIDENCE™ (tocilizumab-bavi) injection, for intravenous use, Drug Co-pay Program**. There is an annual cap on the amount of drug co-pay assistance that patients can receive over a one-year period. By completing this form, you will be screened to determine your eligibility for the **TOFIDENCE Drug Co-pay Program**

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 **TOFIDENCE Drug Co-pay Program** for as long as it is offered and they are treated with TOFIDENCE, provided they meet the eligibility criteria.

Organon 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 an Organon Access Program Coordinator at 1-855-635-9581.

INSTRUCTIONS FOR HEALTH CARE PROVIDERS

In order for your patient to be screened for Co-pay Assistance, **they must be enrolled in The Organon Access Program and have provided their consent via signature**, using the enrollment form accessed via **www.organonaccessprogram-tofidence.com**

How do I complete this form?

1. Read, fill out, and sign, as indicated in Sections I, II, and III of this Co-pay Screening Form. This will enable you patient to be screened for the **TOFIDENCE Drug Co-pay Program**

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 Co-pay Screening Form. This will enable you to be screened for the **TOFIDENCE Drug Co-pay Program**

What happens next?

Once we receive the completed form, The Organon Access Program may contact you to discuss your eligibility. You can expect to receive several important notifications. You may receive a phone call from **The Organon Access Program**. Please be sure to answer when you see these calls so we can help you through your co-pay screening process.

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

All fields are mandatory.

I. PATIENT INFORMATION

First Name | M.I. | Last Name | Date of Birth (MM/DD/YYYY)

Phone Number | Email

II. CO-PAY SCREENING QUESTIONNAIRE—HCP INFORMATION

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

- ☐ Rheumatoid Arthritis (RA)
- ☐ Giant Cell Arteritis (GCA)
- ☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA)
- ☐ Systemic Juvenile Idiopathic Arthritis (SJIA)
- ☐ Coronavirus Disease 2019 (COVID-19)

2 Are you a US-licensed physician who will be administering TOFIDENCE at a US administration site?

☐ Yes ☐ No

III. CO-PAY SCREENING QUESTIONNAIRE—HCP ATTESTATION

My signature below certifies that the person named on this form is my patient, that I have obtained his/her written authorization in the Co-pay Screening Form to share this information, and that the information provided on this application, to the best of my knowledge, is complete and accurate, and that the TOFIDENCE received in response to this application is only for the use of the patient named on this form.

My signature below certifies that the TOFIDENCE received in response to this application is only for the use 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 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, and/or mail to confirm receipt of TOFIDENCE or to provide additional information about TOFIDENCE or the Co-pay Program. I also understand that my personal information collected in this enrollment form and during my interactions with Organon and third-party service providers working under its instructions ("Program Administrators") will be used to provide the services described in this form, comply with applicable laws and regulations, and conduct evaluations of the Program 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/. I acknowledge that Organon LLC may revise, change, or terminate any program services at any time without notice to me.

Name of Health Care Provider (please print)

Signature of Health Care Provider | Date

Please complete this form and return via our toll-free fax number: 1-240-752-6958.

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THE FOLLOWING SECTIONS SHOULD BE FILLED OUT BY THE PATIENT

All fields are mandatory.

IV. CO-PAY SCREENING QUESTIONNAIRE—PATIENT

1. Do you consent to enrollment in the **TOFIDENCE Drug Co-pay Program** for assistance with a co-pay for TOFIDENCE?
   - ☐ Yes ☐ No

2. Are you currently a US citizen or US resident?
   - ☐ Yes ☐ No

3. What is your current source of health care insurance and/or health care funding? Select all that apply.
   - ☐ Private insurance (includes employer or health care marketplace insurance)
   - ☐ Federal or state-funded program (includes, but is not limited to, Medicare, Medicaid, VA, DoD, and TRICARE®*)
   - ☐ No health care insurance or funding

4. Does your current source of health care insurance cover TOFIDENCE?
   - ☐ Yes ☐ No ☐ I don't know

5. Do you currently have an out-of-pocket financial responsibility for your TOFIDENCE treatment?
   - ☐ Yes ☐ No ☐ I don't know

*TRICARE® is a registered trademark of the Department of Defense, Defense Health Agency. All rights reserved.

V. PATIENT ATTESTATIONS

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

☐ I understand that if the claim for TOFIDENCE (for which I am seeking co-pay assistance) is reimbursed, either in whole or in part, by a federally funded insurance plan, then I am not eligible for co-pay 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 TOFIDENCE, and (iii) agree to notify Organon immediately if I obtain a federally funded health insurance plan during my enrollment in the co-pay program(s) and choose to use it to cover any portion of the costs of TOFIDENCE so that I may be removed from the co-pay program(s).

☐ I understand that the TOFIDENCE Drug Co-pay 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.

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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 and the assistance you receive will depend on your continuing to meet the following terms:**
  - You maintain coverage through a commercial insurance provider and notify Organon of any changes or additions to your coverage, including if you switch pharmacies or use out-of-network benefits.
  - You are taking TOFIDENCE in accordance with the Prescribing Information.
- There is an annual cap on the amount of assistance that you can receive as part of the **TOFIDENCE Drug Co-pay Program**. 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 program, you will be responsible for paying all out-of-pocket expenses for the remainder of the calendar year. As you are nearing the cap for the **TOFIDENCE Drug Co-pay Program**, you will be notified by mail. The **TOFIDENCE Drug Co-pay Program** cap will reset every January 1st.
- Organon will not provide the co-pay assistance directly to you but instead will pay it directly to your pharmacy or the administration site on your behalf. Your pharmacy or administration site will be responsible for sending in claims for each individual date of service.
- The **TOFIDENCE Drug Co-pay Program** is not health insurance or a benefit plan. The program does not obligate the use of a specific provider.
- You are responsible for appropriately reporting enrollment into the **TOFIDENCE Drug Co-pay 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.
- Organon reserves the right to modify or discontinue the program with respect to any patient, or in its entirety, at any time. Your participation in the program 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 and agree to the terms and conditions of the program as stated above. If I fail to comply with the program, I understand that I may jeopardize my ongoing participation in the program and may be subject to the costs associated with TOFIDENCE. I further understand that the personal health information (PHI) I provided in this form will be processed by Organon and the third-party service providers working under its instructions (“Program Administrators”) in accordance with the authorizations I provided through the Patient Services Enrollment Form.

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 TOFIDENCE

Please call 1-855-635-9581 to notify us — do not sign and date the form.

Signature of Patient or Patient’s Legal Representative

Date

ORGANON

Please complete this form and return via our toll-free fax number: 1-240-752-6958.