ASCENIV PROGRAM ENROLLMENT FORM

ADvantage Ig Patient Support Program
PO Box 503227, San Diego, CA 92150

Phone: (833) 236-2246 **Fax:** (833) 216-0441
Hours: Monday through Friday, 9:00 am – 6:00 pm Eastern Time

SERVICE(S) REQUESTED

Check all that apply: ☐ Benefits Verification ☐ Prior Authorization/Appeals Assistance ☐ Claim Support

☐ Cost Share Program ☐ Triage Support (Assistance with locating a provider for ASCENIV)

APPLICATION CHECKLIST (Research may be delayed if all information is not received)

Confirm all are completed: ☐ All required sections ☐ Prescriber Signature OR ☐ Patient Signature

PRESCRIBER INFORMATION (required)

Physician Name:		Specialty:	
Physician Address:	City:	State:	Zip:
Physician Tax ID # :	Physician NPI #:		
Medicare PTAN #:	Medicaid Provider #:		

FACILITY INFORMATION (required)

Facility Name:	Facility NPI:	Facility Tax ID #:
Facility Address:		
City:	State:	Zip:

Facility Setting: ☐ Hospital Inpatient (21) ☐ Hospital Outpatient (22) ☐ Physician's Office (11) ☐ Home Infusion (12)
☐ Other, Please Specify:

How do you intend to supply the medication? ☐ Buy and Bill ☐ Specialty Pharmacy – Please specify name and phone #:

What is your preferred method to receive Program Result Forms only (information required below)? ☐ Fax ☐ Email
Please note: All other communication is sent via fax**

Contact Name:		Contact Email:
Contact Phone #:	(Extension)	Contact Fax #:

PATIENT INFORMATION (required)

Patient Name:	Date of Birth:	SSN/ID # (last 4 digits):	
Phone #:	US Resident? ☐ Yes ☐ No	Gender ☐ M ☐ F	
Patient Address:	City:	State :	Zip:

PATIENT INSURANCE INFORMATION (required) (Attach a copy of insurance cards, if available).

Primary Insurance:	Policy#:	Group #:
Policy Holder's Name:	Policy Holder's Date of Birth:	Payer Phone #:
Secondary Insurance:	Policy#:	Group #:
Policy Holder's Name:	Policy Holder's Date of Birth:	Payer Phone #:

TREATMENT INFORMATION (required)

Primary Diagnosis Code (ICD-10):		**CPT Code(s):**	☐ 96365 ☐ 96366 ☐ Other, Please Specify:
Secondary Diagnosis Code (ICD-10):		**Dosage and Patient Weight:**	

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COST SHARE PROGRAM: Who qualifies?

Eligibility, Terms and Conditions and Program Limitations

- Patient must be a US resident
- Must have private commercial insurance
- ASCENIV must be covered by insurance
- Cost Share Program provides deductible, copay or coinsurance and administration support for ASCENIV only*
- Program covers up to $15,000 of out-of-pocket costs per calendar year for eligible patients, after the patient has paid the first $75 of their required ASCENIV deductible, copay or coinsurance and administration amount
- The Program does not cover office/facility co-pays not directly associated with ASCENIV treatment or any other costs excluded by the Program guidelines not specifically mentioned here, which are subject to change.

*This offer is valid only in the United States. Patient must be prescribed ASCENIV by a licensed prescriber. Eligible patients must have private commercial insurance that covers medication costs for ASCENIV, and acceptance of this offer must be consistent with the terms of that insurer's drug benefit. Patients who pay cash or who are enrolled in or participate in any type of government insurance or reimbursement programs, including but not limited to Medicare, Medicare Advantage, Medicare Part D, Medicaid, Medigap, TRICARE, Veterans Affairs (VA), the Department of Defense (DoD) or other federally funded or state funded healthcare programs are not eligible. Patients who move from commercial to federally funded or state-funded insurance will no longer be eligible for the Program. Proof required for receiving payment for out-of-pocket drug costs must be a valid Explanation of Benefits(EOB) or specialty pharmacy invoice, which must be submitted within 120 days after each treatment. As a condition precedent of the cost share support provided under this program, e.g., copay or coinsurance amounts paid to administering providers, participating patients and administering providers are obligated to inform insurance companies and third-party payers of any benefits they receive and the value of this program, as required by contract or otherwise. Patient/Guardian may not seek reimbursement for value received from the Cost Share Program from any third-party payers, including flexible spending accounts or healthcare savings accounts. Void where prohibited by law, taxed, or restricted. Additional terms and conditions may apply. ADMA Biologics, Inc. may determine eligibility, monitor participation, and modify or discontinue any aspect of this program at any time.

COST SHARE PROGRAM INFORMATION (required)

Billing Address: Same as facility address? ☐ Yes ☐ No

Payee Name:

Payee Address:

City: State: Zip:

Payee Email:

Payee Phone #: (Extension) Payee Fax #:

Payee Tax ID #:

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PRESCRIBING CLINICIAN CERTIFICATION AND CONSENT (required)

By signing below, I am certifying that the information contained in this form is complete and accurate to the best of my knowledge. My signature certifies that I am a licensed practitioner eligible under state law to prescribe, receive, and administer the requested medication(s) listed on this enrollment form. I understand that ADMA Biologics, Inc. reserves the right to modify or terminate ASCENIV at any time and without notice. I understand that ADMA Biologics is not responsible for filing claims and that the information provided by ASCENIV is advisory in nature. All final decisions on diagnosis, the need for treatment, and the appropriateness of ASCENIV (immune globulin intravenous, human) for a particular patient rest with me as the patient's provider. I understand that I am under no obligation to prescribe any ADMA Biologics drug and I have not received and will not receive any benefit from ADMA Biologics for prescribing a ADMA Biologics drug. I further verify that I have the required authorizations, including a valid and completed HIPAA Authorization form, from my patient to release the referenced medical and/or other patient information relating to my patient's treatment to ASCENIV.

Prescribing Clinician Name (print):

Prescribing Clinician Signature (no stamped signatures):

Date:

PATIENT CERTIFICATION AND CONSENT (required for cost share program only)

I understand that ADvantage Ig Patient Support Program offers eligible patients services relating to benefits verification, claims support, prior authorization/appeals and cost share assistance. I attest that the information in this form is true, correct, and complete, and understand that that ASCENIV ("the Program") assistance will terminate if the Program becomes aware of any fraud or if ASCENIV (immune globulin intravenous, human) is no longer prescribed to me. I understand that in order for the Program to provide me with assistance, it will need to obtain, review, use, and disclose information related to my personal health, including information related to my medications, medical conditions and the personal information on my enrollment form. By signing this form, I authorize my treating doctor, my employer, and my health insurer to give people who work for and with ADMA Biologics, including its business partners and agents ("ADMA Biologics"), information about my insurance and my health. ADMA Biologics may use my information to help verify or coordinate insurance coverage or to obtain payment or other support for my treatment. In carrying out these activities, ADMA Biologics may share information about me with my doctor, my employer, my health insurer, and independent third-party patient assistance foundations. Third parties may receive payment from ADMA Biologics to provide the services associated with the Program. I understand that my consent is valid for one (1) year from the date of signature.

I understand that ADMA Biologics has the right to change or end the Program at any time without prior notification to me. I understand that I may refuse to sign this form and that doing so will not affect my doctor's treatment of me or my eligibility for insurance benefits. I further understand that I may revoke this Authorization at any time by contacting the Program in writing that includes my name, date of birth, address and date of revocation. The revocation will not apply to any information already used or disclosed pursuant to this Authorization. I permit ADMA Biologics, Inc. to speak with the Patient Representative named below about the information on this form and the status of my request. This includes discussing insurance and financial questions, any missing documentation and other issues related to my enrollment.

Patient/Guardian may not seek reimbursement for value received from the Cost Share Program from any third-party payers, including flexible spending accounts or healthcare savings accounts. If at any time patient begins receiving coverage under any federal, state, or government-funded healthcare program, Patient is no longer eligible to participate in the Program and must call (833) 236-2246 (833 ADMA BIO) between 9am-6pm ET to stop participation. Restrictions may apply. This is not health insurance. Patient/Guardian and pharmacist are responsible for notifying insurance carriers or any other third party who pays for or reimburses any part of the prescription filled using the Program as may be required by the insurance carrier's terms and conditions and applicable law. Enrollment in the Program will be reviewed on an annual basis to determine continued eligibility. This offer may not be combined with any other coupon, discount, prescription savings card, free trial, or other offer for ASCENIV. This is a limited time offer, and ADMA Biologics reserves the right to rescind, revoke, amend, or terminate this offer, or the program in its entirety, at any time without notice.

Signature certifies that patient/Guardian have received, understand, accept, and will comply with all eligibility requirements, terms, and conditions of the ADvantage Ig Patient Support Program as stated above, and that patient/Guardian consent to share patient's personal health information included in this Application with ADMA Biologics as stated above.

Patient Name (print): Date of Birth:

Patient Signature:

Date:

Patient Representative Name (print): Relationship to Patient:

Patient Representative Signature: Date: