HEMA Biologics Patient Assistance Program Application

HEMA Biologics recognizes that some people may not have health insurance and may not be able to pay for SEVENFACT® [coagulation factor VIIa (recombinant)-jncw] on their own. As we want every patient who needs SEVENFACT to have access to it, we have developed the HEMA Biologics Patient Assistance Program (HBPAP), which provides SEVENFACT at no cost to the patient, for those who meet certain eligibility and income criteria.

PATIENT ELIGIBILITY CRITERIA:

- Must be prescribed SEVENFACT for an indicated condition.
- Must not have insurance coverage, neither private nor public.
  - Medicare Part D Applicants: If Part D does not allow or pay for any part of your medication, you will be viewed as having no insurance. Being in the donut hole does not qualify.
- Must be under the care of a licensed Healthcare Provider who is authorized to prescribe, dispense and administer medicine in the U.S.
- Must have a total household income at or below 400% of the federal poverty level (FPL).
  - For more information on FPL in your state, please visit the US Department of Health and Human Services website, https://aspe.hhs.gov/2020-poverty-guidelines.
- Must provide documentation of ANNUAL household income. Acceptable forms of documentation include one of the following:
  - Copy of most recently filed Income Tax Return (IRS Form 1040) or W-2
  - Copy of transcript received through submission of IRS 4506-T
  - Copy of most recent Social Security/Disability monthly check, award letter, benefit statement of 1099
  - Copy of Unemployment Determination letter

HEALTHCARE PROVIDER Instructions for completing this application:

1. **Complete and sign page 2.**
   - The completed Patient Prescription Information section will be accepted as a legal prescription.
2. **Ensure the patient completes and signs page 3.**
3. **Include one acceptable form of annual household income documentation as listed in the Patient Eligibility Criteria section above.**
4. **Submit the completed application by utilizing one of the following methods:**
   - **MAIL:** HEMA Biologics Cares, 270 Cramer Creek Court, Dublin, OH 43017
   - **FAX:** (833) 390-1379

What to expect after submitting the HBPAP application?

Applicants will be notified upon the completed review of their applications. If a patient's application is accepted, medication will be mailed directly to the patient's address. Please note, program rules are subject to change without notice. If you have questions or need further assistance, please call (855) 718-4362 between 9:00AM and 7:00PM Eastern Standard Time, Monday - Friday.

FAX/MAIL this page

HEMA Biologics Patient Assistance Program (HBPAP) Application
270 Cramer Creek Court, Dublin, OH 43017
Phone: (855) 718-4362 / Fax: (833) 390-1379

HEMA Biologics®

TO BE COMPLETED BY HEALTHCARE PROVIDER

Prescriber Information

First Name: _____ Last Name: _____ ☐ MD ☐ PA ☐ NP ☐ DO

State License #: _____ Expiration Date: MM / DD / YYYY NPI #: _____

Facility Name: _____

Facility Address: _____ City: _____ State: _____ Zip: _____

Office Contact: _____ Email: _____

Office Phone: _____ Office Fax: _____

SEVENFACT® [coagulation factor VIIa (recombinant)-jncw] Prescription and Dosing Information

Patient Name: _____ Patient DOB: MM / DD / YYYY Weight: _____ kg

Primary Diagnosis: ☐ Hemophilia A or B with Inhibitors ☐ Other: _____

IV Access: ☐ Peripheral IV ☐ Other _____

SEVENFACT Prescription

Dosing Instructions (select one):

☐ **Mild and Moderate Bleeds:** 75 mcg/kg repeated every 3 hours PRN until hemostasis is achieved.

☐ **Mild and Moderate Bleeds:** Initial dose of 225 mcg/kg. If hemostasis is not achieved within 9 hours, administer additional 75 mcg/kg every 3 hours PRN until achieved.

☐ **Severe Bleeds:** 225 mcg/kg, followed if necessary 6 hours later with 75 mcg/kg every 2 hours PRN until hemostasis is achieved.

☐ Other: _____

Dispense: ____ dose(s) **75 mcg/kg;** ____ dose(s) **225 mcg/kg;** ____ dose(s) _____ **mcg/kg**

Refills: _____

☐ HEPARIN 5 mL Flush UAD: ☐ 100 units/mL ☐ 10 units/mL
Dispense: _____ **Refills** _____

☐ Sodium Chloride 0.9% 10 mL Flush UAD
Dispense: _____ **Refills** _____

☐ All necessary ancillary infusion supplies required

Prescriber Declaration

My signature below certifies that the person named on this form is my patient, and I represent that information I have provided about this patient is complete, accurate and consistent with applicable privacy laws and regulations. I also certify that any medication received from HBPAP is medically necessary for the patient named on this form and will be used only for this patient. I further certify that the dose requested for this patient is appropriate for this patient's medical condition. To the best of my knowledge, this patient has no prescription insurance coverage, including Medicaid, Medicare or other public or private programs. This medication will not be offered for sale, trade, or barter. I certify that no claim for reimbursement for any medication furnished under the HBPAP will be submitted to the Medicare program, any state Medicaid program, any other healthcare benefit plan, or returned for credit. I understand that HBPAP reserves the right to modify or terminate this program at any time. I understand that HBPAP reserves the right to recall or discontinue product at any time without notice.

SIGN HERE **Prescriber Signature:** _____ **Date:** _____

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Phone: (855) 718-4362 / Fax: (833) 390-1379

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TO BE COMPLETED BY PATIENT OR LEGAL REPRESENTATIVE

Patient Information

First Name: _____ MI: _____ Last Name: _____

Social Security #: _____ – _____ –_____ Sex: ☐ M ☐ F DOB: MM / DD / YYYY

Mailing Address: _____

City: _____ State: _____ Zip: _____

Legal Representative (if applicable): _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Drug Allergies: _____

Current Medications: _____

Patient Income Eligibility Information – Attach proof of annual household income *(Required)*

TOTAL ANNUAL HOUSEHOLD INCOME: $_____ *(Include all annual income, wages, social security, pension, disability, interest earned on savings, etc.)*

Household Size (number of persons living in the home): _____

Are you currently enrolled in a Medicare Part D Prescription Drug Plan? ☐ Yes ☐ No

Do you have any public or private prescription drug coverage or are you in any benefit program that helps pay for your prescription drugs? ☐ Yes ☐ No

Do you have private prescription insurance coverage? ☐ Yes ☐ No

Are you currently enrolled in Medicaid? ☐ Yes ☐ No

Have you received a final denial from Medicaid, including exhausting all appeals? ☐ Yes ☐ No

Are you currently enrolled in a Department of Veterans Affairs (VA) plan? ☐ Yes ☐ No

Have you received a final denial from the VA for prescription benefits, including exhausting all appeals? ☐ Yes ☐ No

Patient Certification

By my signature, I attest that the above information is complete and accurate. I attest that I have insufficient financial resources to pay for the prescribed therapy and that I have no other health insurance coverage for prescription drugs including but not limited to Medicare, Medicaid, employer/retiree-sponsored coverage, state pharmacy assistance program. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payer (private or government) for the medication. My signature certifies that the medication received from the HEMA Biologics Patient Assistance Program (HBPAP) will not be resold nor offered for sale, trade or barter and will not be returned for credit. Additionally, I agree that at any time during my enrollment, the HBPAP may contact me to request additional documentation to authenticate the statements made on my application. I also agree to notify the HBPAP in the event my health insurance and prescription drug coverages change at any time during my enrollment. I understand and acknowledge that my eligibility to participate in the HBPAP is subject to the discretion of HEMA Biologics and this program may be changed or discontinued at any time without notice. I understand that product through the HBPAP is provided to me free of charge and I have no obligation to purchase product due to my participation in the HBPAP.

SIGN HERE **Patient's Signature (or Legal Representative):** _____ **Date:** _____

Patient Authorization

By my signature I authorize my healthcare provider, my health insurance company, and my pharmacy providers ("Healthcare Entities") to disclose to HEMA Biologics and companies working with HEMA Biologics, which may be branded as HEMA Biologics Cares (collectively, "HEMA Biologics"), my contact information, prescription information, health information relating to my medical condition which may also include the identification and/or evaluation of any potential drug interactions and allergies and insurance coverage for HEMA Biologics, as well as sensitive health information, including information related to the treatment of alcohol/drug abuse, HIV/AIDS, sexually transmitted diseases, mental health and genetic information. I authorize HEMA Biologics to use and disclose such information for the assessment of my eligibility for and enrollment into HBPAP and administration of HBPAP, which may include contacting my insurer, pharmacist, public funding programs, advocacy organizations, healthcare providers, or other persons or entities HBPAP may deem appropriate to release all medical records or requested information bearing on my eligibility to and benefits under the program. I understand that my pharmacy provider may receive remuneration from HEMA Biologics in exchange for sharing information concerning any services that the pharmacy may provide to me. HEMA Biologics agrees not to disclose any information to any third party except as authorized by me or as required by law. This Authorization expires one (1) year after I cease to participate in the Program, or the maximum period permitted by state law. This Authorization is voluntary, and Healthcare Entities will not condition treatment, payment, eligibility or enrollment benefits on execution of the Authorization. However, such refusal would cause me to be ineligible to participate in the HBPAP. I may also revoke this Authorization at any time by calling (855) 718-4362 and mailing a written revocation, signed by me or on my behalf, to HEMA Biologics Cares at 270 Cramer Creek Court, Dublin, OH 43017. Revocation of this Authorization will end my consent to further disclose health information to HEMA Biologics by my Healthcare Entities after they are notified of my cancellation but will not affect previous disclosures by them pursuant to this Authorization. Revocation of the Authorization would cause me to be ineligible for further participation in the HBPAP. I have a right to receive a copy of this Authorization and may request a copy by calling (855) 718-4362 or mailing a written request to HEMA Biologics Cares at 270 Cramer Creek Court, Dublin, OH 43017.

SIGN HERE **Patient's Signature (or Legal Representative):** _____ **Date:** _____