CIMERLI Solutions™

Patient Assistance Program Product Request Form

CIMERLI® (ranibizumab-eqrn) injection

All fields are required unless otherwise indicated.

Date ____/____/____

PATIENT

First Name _____ Last Name _____ DOB ____/____/____

TREATING PROVIDER

First Name _____ Last Name _____ Title _____

Office Contact _____ Name _____

Phone _____ Email _____ (not required)

Delivery Location _____

PLEASE COMPLETE AND RETURN TODAY TO AVOID PRODUCT SHIPMENT DELAY

FAX Number: 1-877-226-6370

1. **Is the patient in need of PAP replenishment?** ☐ YES ☐ NO
2. **Providers requesting more than six (6) PAP fills of CIMERLI™ (ranibizumab-eqrn) injection for the same patient** will be required to provide written attestation reaffirming continued PAP necessity (DX, patient therapy log, hardship, etc.)
3. **Has there been a change in the patient's insurance coverage since the last treatment?** ☐ YES ☐ NO
   a. If YES, please provide the following information:

      Insurance Name: _____

      Insurance ID: _____ Insurance Phone: _____
4. **When is the patient's next treatment date?** ____/____/____
5. **Please provide any additional comments below:**

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If you have any questions, please call CIMERLI Solutions™ at 1-844-483-3692, Monday through Friday, 8AM to 8PM ET.

Coherus Solutions™