CIMERLI® (ranibizumab-eqrn) Product Replacement Program

Phone 1-844-472-6369 **Fax** 1-833-966-3043
Hours Monday through Friday 8 AM–8 PM ET

CIMERLI® (ranibizumab-eqrn) injection | SANDOZ one source®

Please print clearly. *Required field.

PRODUCT REQUEST FORM

The Sandoz One Source for CIMERLI Product Replacement program allows physician offices or hospital outpatient departments to receive CIMERLI replacement product if all eligibility criteria is met. (See Product Replacement Program Terms and Conditions on page 3). ***Please see Terms & Conditions for program revisions for your Medicare FFS patients.***

Please complete this form and submit all required documentation to Sandoz One Source via **Fax at 1-833-966-3043.**

1 Patient Information*

Patient's Name: Gender: ○ Male ○ Female ○ Other

DOB (MM/DD/YYYY): / / Patient's Phone #: ○ Home ○ Cell

Patient's Address:

City: State: ZIP:

Email:

Alternate contact name: Phone #:

Date: Date of service: Date of denial:

Please indicate the dose of CIMERLI administered to the patient:

○ 0.3 mg vial Quantity(# of vials) _____ ○ 0.5 mg vial Quantity(# of vials) _____

2 Provider Information*

Prescriber name:

Office contact name: Contact phone number:

Delivery address:

City: State: ZIP:

3 Product-specific Benefit Verification (BV) or Medicare and Medicap Cards*

For a patient to qualify for the Product Replacement Program, a product-specific benefit verification demonstrating active coverage must have been completed through Px Technology or Sandoz One Source and documented prior to treatment with CIMERLI.

Please complete the following:

The product-specific benefit verification was completed by

○ Px Technology ○ Sandoz One Source Date benefit verification completed:

○ I am attaching a copy of my patient's Medicare card ○ **AND** Medigap (Medicare Supplement Insurance Plan) Card

For which dose of CIMERLI did you complete a BV (if unsure, please select both)?

○ 0.3 mg vial Quantity(# of vials) _____ ○ 0.5 mg vial Quantity(# of vials) _____ ○ Both

Was a prior authorization (PA) required or a predetermination recommended?

○ Yes ○ No Date PA submitted:

If a PA was required or predetermination was recommended, please submit the PA or predetermination approval documentation with this request form. If PA was NOT required, please provide reference number _____.

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4 Appeal Information

Date of 1st appeal*: Date of 2nd appeal (If applicable):

All appeals must be completed within the appropriate payer timely filing limit. If appeals were conducted by the provider office, please provide the following documentation with this request form:

- ○ Initial denied claim (EOB)
- ○ Documentation of first appeal (Include second appeal documentation if applicable)
- ○ A copy of the claim form (CMS 1500 or UB-04 [CMS 1450]) must be submitted to confirm that therapy was used for an on-label indication

If only one level of appeal has been completed, please contact Sandoz One Source to determine if a second appeal is required.

5 To Be Completed by Office*

I certify that my patient is aware of the disclosure of their personal health information to Sandoz and its business partners for Sandoz's patient support services, including reimbursement and verification services and the services provided by field reimbursement professionals in your office, as part of the patient's treatment with this product, and for Sandoz Patient Safety requirements. I certify that I have obtained any required patient authorization. I further certify that (a) any service provided through Sandoz One Source on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use CIMERLI or any other Sandoz product or service for anyone, and that (b) my decision to prescribe CIMERLI was based solely on my determination of medical necessity as set forth herein, and that (c) I will not seek reimbursement for any medication or service provided by or through Sandoz One Source for any government program or third-party insurer. I also attest that I did not or will not receive payment for the product in which I am requesting a replacement nor do I belong to a physician practice that receives an all-inclusive payment for patients covered under the insurance plan. I understand the program only provides a replacement product and does not cover any costs related to the office visit or administration of the product.

I acknowledge that this product replacement will be returned if payment is recognized at any time in the future.

Office Contact (Name) Date:

Office Contact Signature:

6 To Be Completed by Field Reimbursement Manager (FRM)*

I, (FRM), hereby attest that I:

1. performed a thorough review of necessary documentation pertaining to the included claim(s)
2. certify that the dose of CIMERLI requested is:
   - ○ 0.3 mg vial Quantity(# of vials) _____
   - ○ 0.5 mg vial Quantity(# of vials) _____

FRM's Signature Date:

CIMERLI® (ranibizumab-eqrn) Product Replacement Program

PRODUCT REPLACEMENT PROGRAM DESCRIPTION

PROGRAM OVERVIEW

- This program allows physician offices or hospital outpatient departments to receive CIMERLI replacement product if all eligibility criteria are met
- This program requires providers to utilize Sandoz One Source or Px Technology to perform benefit verifications for the patient prior to therapy
- Providers *may* register claims for product replacement after an initial claim for CIMERLI is denied by a payer
- Sandoz One Source will honor the Product Replacement Program for Medicare Fee For Service (FFS) patients with a valid Medicare card and Medicare Supplemental enrollment without a prior benefit verification. Please see *Program Eligibility and Terms and Conditions* for additional details

PHYSICIAN OFFICES AND HOSPITAL OUTPATIENT DEPARTMENTS ARE ELIGIBLE:

- If CIMERLI is administered for a medically appropriate use, as determined by the specific payer's policies and coverage guidelines
- If the office used Px Technology or Sandoz One Source services to conduct the benefit verification
- If the patient has a valid Medicare card along with a current year Medicare Supplement Insurance Coverage (Medigap) Plans A through N. Medicare Supplement Insurance card must show current year in which patient is being treated as well as which plan type (A through N). Provider must be prepared to provide copies of the patient's Medicare and Medigap plan cards
- If CIMERLI is not reimbursed after all eligibility criteria are met

HOW THE PROGRAM WORKS*

1. Identify the denied claim
2. Report the denied claim to Sandoz One Source
   - Providers can register denied claims/appeals for CIMERLI with Sandoz One Source
   - At registration, the provider receives a product replacement request form (See pages 1-2)
   - The provider is required to submit the following documentation:
     - » Signed product replacement request form
     - » Identify the dose and quantity of CIMERLI administered
     - » Proof of benefit verification (Copy of Summary of Benefits); or Medicare and Medigap plan cards
     - » When appropriate, prior authorization (PA) results
     - » Explanation of Benefits (EOB)
     - » Denied appeals
     - » Provider letter of appeal
   - If the provider meets eligibility requirements for product replacement, Sandoz One Source can support the remaining appeals process
3. Coordinate with Sandoz One Source on the appeal(s)
   - Providers work with Sandoz One Source on the appeal process to attempt to have the claim paid. If the claim remains unpaid after one unsuccessful appeal, the CIMERLI Field Reimbursement Manager (FRM) should be contacted to help determine if a second appeal is required before the provider is eligible for product replacement
4. Your FRM will review all necessary documentation and sign the product replacement program request form before final submission to Sandoz One Source
5. If approved, Sandoz One Source ships the product to the provider's office

***Providers must adhere to all program terms and conditions. Provider must submit appeals in the appropriate payer timely filing limit.**

PROGRAM TERMS AND CONDITIONS

For each claim, prior to initiation of CIMERLI therapy, providers must perform a product-specific benefit verification to confirm that CIMERLI will be covered by the payer for the intended use. If required, the provider must also obtain PA approval from the payer.

For patients with valid Medicare and Medigap coverage (Medicare Supplement Insurance Plans (A through N), the provider is not required to have performed a product-specific benefit verification. Sandoz One Source will accept valid and current year copies of these insurance cards as a substitute for a Benefit Verification (BV). If a BV or Prior Authorization (PA) has been performed, Sandoz One Source will request copies of these. PLEASE NOTE THAT THIS DOES NOT APPLY FOR MEDICARE ADVANTAGE PLANS OR COMMERCIAL SUPPLEMENTAL PLANS. FOR MEDICARE ADVANTAGE OR COMMERCIAL SUPPLEMENTAL PLANS (NOT A MEDICARE SUPPLEMENT INSURANCE PLAN (A THRU N)) THE PROVIDER MUST PRESENT THE PRODUCT-SPECIFIC BV AND/OR PA IN ACCORDANCE WITH THE PAYER'S GUIDELINES FOR USE OF THE THERAPY.

The provider must keep a record of the benefit verification/PA results as well as current year Medicare and Medigap cards in the patient's record. This should include: the dates of these interactions and written information from the payer. Whether the patient's primary insurer is Medicare, Medicaid, or a private commercial payer, the patient's claim must meet the specific payer's guidelines for use of the therapy. If providers need assistance identifying the Medicare guidelines or Medicaid guidelines for their respective state, they may contact Sandoz One Source.

Once a provider receives a denial for a properly verified claim and contacts Sandoz One Source, Patient Access Specialists will confirm that the office is registered in the Sandoz One Source Product Replacement Program and will request copies of the relevant information, including but not limited to:

- The initial submitted claim
- The EOB (denial)
- Current Medicare and Medigap cards
- A Field Reimbursement Manager (FRM) will review all materials and documentation. A request form must have a FRM signature

Once these materials are received, Sandoz One Source will: confirm appropriate benefit verification and review the denied claim, help determine the reason for the denial, and provide support to appeal the claim. If Sandoz One Source confirms that the patient's coverage was verified prior to treatment, and the original claim was submitted appropriately, Sandoz One Source will register the claim in the Product Replacement Program.

Sandoz One Source can assist the provider with the first and/or second appeal. However, if a second appeal is unsuccessful, the provider must promptly notify Sandoz One Source to request enrollment in the Product Replacement Program for the registered claim. Sandoz will provide replacement product(s) to the provider for CIMERLI if all the above eligibility criteria are met.

The Product Replacement Program is available for outpatient use only and does not cover any costs related to office visits or administration of CIMERLI. The Product Replacement Program does not cover any costs associated with underpayments. Sandoz may modify or terminate this program at any time without notice. Nothing in this program is intended to induce or reward referrals of product.

Providers should not bill the patient for any product that was replaced under this program. If providers receive any payments for products replaced under this program, they agree to return or pay Sandoz for the cost of the product.

Providers that are reimbursed under a fully capitated rate for drug products or practices that account for drug products as part of their negotiated rates, the practice assumes full risk and cannot participate in the product replacement program.

SANDOZ

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