Instructions for completing the REACH Patient Support Request Form

Benefits Investigation*
(complete steps 1-4)

- Check patient's insurance to determine coverage
- **Please note:** Benefits investigations cannot be performed by REACH without a valid prescription (Step 4)
- Eligible patients will be automatically enrolled in the NEXAVAR® or STIVARGA® $0 Co-pay Program

Bayer US Patient Assistance Foundation
(complete steps 1-3 and 5)

- For eligible patients who need additional financial assistance

Alternate contacts may include family members to whom the patient has given permission to speak with REACH on their behalf

Prescription Information

- Accurately completing this section is important because it functions as the prescription that is submitted to the specialty pharmacy

REACH PATIENT SUPPORT REQUEST FORM
Phone: 1-866-639-2827 Fax: 1-866-639-5181

SUPPORT REQUESTED*: ○ Benefits Investigation† ○ Bayer US Patient Assistance Foundation

STEP 1 Patient Information — Required fields (*)

Last Name*: First Name*: Date of Birth*: Gender: ○ M ○ F
Street*: City*: State*: ZIP*:
Phone*: Home: ( ) - Cell: ( ) - Preferred Contact: ○ Home ○ Cell
OK to Leave Detailed Message?: ○ Yes ○ No Email: Preferred Language:
Alternate Contact's First and Last Name: Alternate Contact's Phone: ( ) -
Relationship:

STEP 2 Patient Insurance Information (send in copy of insurance cards) — ○ No Insurance

Patient's Medical Insurance*: Phone: ( ) -
Group Number: Policy ID Number*:
Subscriber Name: Date of Birth: Does this plan cover prescription drugs? ○ Yes ○ No
Patient's Pharmacy Insurance: Phone: ( ) -
Group Number: Policy ID Number:
Subscriber Name: Date of Birth: Does this plan cover prescription drugs? ○ Yes ○ No
Collaborating Physician Name:

STEP 3 Prescriber Information — ○ In-Office Dispensing

Site/Facility Name: Prescriber Name*:
Street*: City*: State*: ZIP*:
Phone*: ( ) - Fax*: ( ) -
Office Contact Name: Email: Phone: ( ) -
Tax ID #: NPI #:
Collaborating Physician Name:

STEP 4 Prescription

Prescribers in the state of New York: Please submit prescriptions on official state prescription blanks in conjunction with this form.

○ NEXAVAR® (sorafenib) Tablets: ○ STIVARGA® (regorafenib) Tablets:
Dosage*: Frequency*: Allergies:
Quantity*: Refills*: Other medications taken:

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I appoint REACH, on my behalf, to convey this prescription to the dispensing pharmacy. I understand that I may not delegate signature authority.

PRESCRIBER TO SIGN AND DATE
Dispense as written*: Date* (mm/dd/yyyy):
Substitutions permitted: Date (mm/dd/yyyy):

†Results of Benefit Investigation are not a guarantee of coverage and should be verified by dispensing provider.
For additional important risk and use information, please see the Full Prescribing Information for NEXAVAR and Full Prescribing Information for STIVARGA, including Boxed Warning.

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Please also see page 4 of the form

STEP 5 Bayer US Patient Assistance Foundation

Bayer offers a patient assistance program for patients who have limited or no prescription coverage. If you are eligible, NEXAVAR® (sorafenib) and STIVARGA® (regorafenib) may be available for free.

How many people live in your household and are dependent on your household income (include yourself)?
For example: you (1) + your spouse (1) + your children (2) + your parents (2) = 6
What is your total household income? $
This includes all income made by you and your relatives living in your household. Please include income earned by work wages, Social Security retirement benefit, Social Security disability benefit, unemployment, any pensions, and any other income including alimony and child support. Adding all of these numbers together gives your total household income.
You may be required to submit proof of income, which includes any of the following:

- Recent 1040 or 1040EZ federal tax return
- 1099 tax form
- Proof of non-filing letter if you did not file a federal tax return
- Wage/tax statements (W2)

Patient Last Name*: Patient First Name*: Date of Birth*: Gender: ○ M ○ F
Street*: City*: State*: ZIP*:
○ NEXAVAR® (sorafenib) Tablets ○ STIVARGA® (regorafenib) Tablets
Dosage*: Quantity/Supply*: Number of Refills:
List or attach other current medications prescribed:
Known drug allergies: ○ No ○ Yes List:

COMPLETE ALL REQUIRED FIELDS, INCLUDING PATIENT SIGNATURES, TO AVOID DELAYS IN TREATMENT

Check this circle if the patient does not have health insurance. **Complete Step 5 on page 4.**

Please check this circle for **In-Office Dispensing**

Prescribers in NY must submit prescriptions on official state prescription blanks with this form

Missing signatures **WILL** cause a delay in processing

Financial information will help determine if your patient is eligible for additional financial assistance

*Results of Benefit Investigation are not a guarantee of coverage and should be verified by dispensing provider.
For additional important risk and use information, please see the Full Prescribing Information for NEXAVAR and Full Prescribing Information for STIVARGA, including Boxed Warning.

REACH PATIENT SUPPORT REQUEST FORM

Phone: 1-866-639-2827 Fax: 1-866-639-5181

SUPPORT REQUESTED* ◯ Benefits Investigation† ◯ Bayer US Patient Assistance Foundation

STEP 1 Patient Information

Required fields (*)

Last Name*: ________ First Name*: ________ Date of Birth*: ________ Gender: ◯ M ◯ F

Street*: ________ City*: ________ State*: ________ ZIP*: ________

Phone*: Home: (   )   - ________ Cell: (   )   - ________ Preferred Contact: ◯ Home ◯ Cell

OK to Leave Detailed Message?: ◯ Yes ◯ No Email: ________ Preferred Language: ________

Alternate Contact's First and Last Name: ________ Alternate Contact's Phone: (   )   - ________

Relationship: ________

STEP 2 Patient Insurance Information (send in copy of insurance cards)

◯ **No Insurance**

Patient's Medical Insurance*: ________ Phone: (   )   - ________

Group Number: ________ Policy ID Number*: ________

Subscriber Name: ________ Date of Birth: ________ Does this plan cover prescription drugs? ◯ Yes ◯ No

Patient's Pharmacy Insurance: ________ Phone: (   )   - ________

Group Number: ________ Policy ID Number: ________

Subscriber Name: ________ Date of Birth: ________ Does this plan cover prescription drugs? ◯ Yes ◯ No

Collaborating Physician Name: ________

STEP 3 Prescriber Information

◯ **In-Office Dispensing**

Site/Facility Name: ________ Prescriber Name*: ________

Street*: ________ City*: ________ State*: ________ ZIP*: ________

Phone*: (   )   - ________ Fax*: (   )   - ________

Office Contact Name: ________ Email: ________ Phone: (   )   - ________

Tax ID #: ________ NPI #: ________

Collaborating Physician Name: ________

STEP 4 Prescription

Prescribers in the state of New York: Please submit prescriptions on official state prescription blanks in conjunction with this form.

◯ NEXAVAR® (sorafenib) Tablets: ◯ STIVARGA® (regorafenib) Tablets:

Dosage*: ________ Frequency*: ________ Allergies: ________

Quantity*: ________ Refills*: ________ Other medications taken: ________

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I appoint REACH, on my behalf, to convey this prescription to the dispensing pharmacy. I understand that I may not delegate signature authority.

PRESCRIBER TO SIGN AND DATE

Dispense as written*: ________ Date* (mm/dd/yyyy): ________

Substitutions permitted: ________ Date (mm/dd/yyyy): ________

†Results of Benefit Investigation are not a guarantee of coverage and should be verified by dispensing provider.
For additional important risk and use information, please see the Full Prescribing Information for NEXAVAR and Full Prescribing Information for STIVARGA, including Boxed Warning.

REACH PATIENT SUPPORT REQUEST FORM

Phone: 1-866-639-2827 Fax: 1-866-639-5181

WRITTEN PERMISSION TO SHARE PROTECTED HEALTH INFORMATION

I authorize the use and sharing of my Protected Health Information ("PHI") as defined by the Health Insurance Portability and Accountability Act of 1996, which was updated by the Health Information Technology for Economic and Clinical Health Act (as amended, "HIPAA"). I understand that Protected Health Information is health information that identifies me or that could possibly be used to identify me and that the authorization I give is voluntary.

I authorize my healthcare provider, including my physician, pharmacies and my health plan, to share my name, address, and telephone number along with certain medical information related to my treatment, my qualification for assistance, the planning of my care, the receiving of my medication and my participation in the Patient Support Program, REACH to Bayer and its agents. I understand that certain healthcare providers, such as my pharmacies, may receive payment from Bayer in connection with the use and sharing of my PHI as described in this authorization.

I allow the use and sharing of my PHI for the following purposes: (1) To confirm my insurance information; (2) to ensure the accuracy and completeness of the REACH Enrollment Form; (3) to help with my payment questions; (4) to see if I qualify for patient assistance; (5) to determine my qualification for other sources of funding; (6) to provide education, training, and ongoing support on the use of my medication; (7) to send me information on related products and services related to my treatment; (8) to send me refill reminders for my prescription and to encourage appropriate use; (9) to communicate with me, my healthcare providers and health plan insurers about my medical care and treatment; (10) to contact me for market research feedback; (11) for sales support purposes and (12) to comply with applicable law.

This authorization ends at the end of my participation of the program or 5 years after I sign it. I can cancel this authorization at any time. I understand that if I cancel this authorization, it will not have any effect on any actions taken by my healthcare providers before receiving the cancellation. I can cancel this authorization by writing to: Bayer, Attn: Medical Communications, 100 Bayer Boulevard, Whippany, NJ 07981.

I also understand that persons or entities that receive my PHI under this authorization may not be required by privacy laws (such as the HIPAA Privacy Rule) to protect the information and may share it with others without my permission, if they are allowed to by law. I understand that I do not need to sign this form to receive medical treatment or medication. I also understand that once I release my PHI in this manner, it is no longer protected by privacy laws.

My healthcare providers and health plan insurer will not base my medical treatment or its payment, insurance enrollment, or eligibility for insurance benefits on my signing this form. However, the Program needs access to PHI to provide assistance to me. I understand that if I do not agree to the sharing of my PHI as described in this form, Bayer will not be able to provide assistance under the Program to me.

I have read this authorization and/or had its contents read to me. I have been able to ask questions about the use and sharing of my PHI and any questions I had have been fully answered. By submitting this form, I agree to receive communications from Bayer by mail, email, phone, and/or other electronic means. I authorize the use and sharing of my information as described in this form. I understand that I am entitled to receive a signed copy of this authorization.

○ I have read and agree to the NEXAVAR and STIVARGA $0 Co-Pay Program Terms and Conditions on page 3.

PATIENT TO SIGN AND DATE

Patient signature: ______________________ Date (mm/dd/yyyy): ____________

If signed by a legal representative: Print Name: ______________________ Relationship to patient: ____________

For additional important risk and use information, please see the Full Prescribing Information for NEXAVAR and Full Prescribing Information for STIVARGA, including Boxed Warning.

NEXAVAR AND STIVARGA $0 CO-PAY PROGRAM TERMS AND CONDITIONS

- Patient must meet the eligibility requirements of the NEXAVAR or STIVARGA $0 Co-pay Program; for example, only commercially insured patients are eligible
- Patient eligibility will be reassessed annually
- Offer is expressly contingent on the requirement that the patient understand, accept, and comply with all requirements of the Co-pay Program
- Use of the Co-pay Program must be consistent with and not prohibited by the requirements of the patient's health insurance
- Patient agrees not to submit any portion toward the product dispensed pursuant to this Co-pay Program to a federal or state healthcare program for purposes of counting it toward the patient's out-of-pocket expenses (such as Medicaid)
- Co-pay assistance is capped at $25,000 per year, per patient
- Use of $0 co-pay must be for NEXAVAR® (sorafenib) or STIVARGA® (regorafenib) use that is consistent with the FDA-approved indications
- The program does not cover costs associated with a patient visit including prescriber, staff, or administrative charges associated with administering the applicable Bayer product
- Offer valid only for patients treated in the USA, including Puerto Rico, Guam and US Territories
- Bayer reserves the right to determine eligibility, monitor participation, equitably distribute product and modify or discontinue the $0 Co-pay Program at any time with or without notice
- Patient agrees to provide necessary health information to the administrators of the NEXAVAR or STIVARGA $0 Co-pay Program
- **For questions about the NEXAVAR or STIVARGA Co-pay Program, call the $0 Co-pay Program support at 1-866-581-4992**

PATIENT SUPPORT REQUEST FORM

Phone: 1-866-639-2827   Fax: 1-866-639-5181

Complete Step 5 for additional financial assistance

STEP 5 Bayer US Patient Assistance Foundation

Bayer offers a patient assistance program for patients who have limited or no prescription coverage. If you are eligible, NEXAVAR® (sorafenib) and STIVARGA® (regorafenib) may be available for free.

How many people live in your household and are dependent on your household income (include yourself)? ______________________

For example: you (1) + your spouse (1) + your children (2) + your parents (2) = 6

What is your total household income? $ ______________________

This includes all income made by you and your relatives living in your household. Please include income earned by work wages, Social Security retirement benefit, Social Security disability benefit, unemployment, any pensions, and any other income including alimony and child support. Adding all of these numbers together gives your total household income.

You may be required to submit proof of income, which includes any of the following:

- Recent 1040 or 1040EZ federal tax return
- Proof of non-filing letter if you did not file a federal tax return
- 1099 tax form
- Wage/tax statements (W2)

Patient Last Name*: ______________ Patient First Name*: ______________ Date of Birth*: __________ Gender: ◯ M ◯ F

Street*: ______________ City*: ______________ State*: __________ ZIP*: __________

◯ NEXAVAR® (sorafenib) Tablets   ◯ STIVARGA® (regorafenib) Tablets

Dosage*: ______________ Quantity/Supply*: ______________ Number of Refills: __________

List or attach other current medications prescribed: ______________________

Known drug allergies: ◯ No ◯ Yes List: ______________________

Healthcare Professional Authorization

I certify that I am the healthcare professional who prescribed the medication requested in this application for the sole benefit of the named patient, and that my decision to prescribe was based on my independent professional judgment. I authorize the Bayer US Patient Assistance Foundation free drug program (the "Program"), and agents acting on its behalf to use my provider information, including National Provider ID, in the eligibility assessment process, and to forward this prescription, as necessary, to a dispensing pharmacy. In addition to the above, my signature below certifies the following: (i) I will not charge patients any fee for, or related to, their application, enrollment in the Program, any co-payment, or other cost-sharing amount related to free drug provided under the Program; (ii) no claim for payment for any product provided through the Program may be submitted to any third-party payer, including private insurers, Medicaid or Medicare; (iii) this medication provided by the Program will only be utilized by the patient named on this form, and will not be offered for sale, trade, barter, or returned for credit; (iv) the patient applying for assistance through the Program is being treated in an outpatient setting; (v) to the best of my knowledge, the information provided on this form is current, complete and accurate.

I understand and acknowledge that (i) submission of the application does not guarantee the patient's eligibility in the Program; (ii) the Program has the right to discontinue the Program at any time; and (iii) medication provided through the Program for enrolled patients is not contingent on any past, present or future prescriptions for this or any other Bayer product.

PRESCRIBER TO SIGN AND DATE

Prescriber's Signature (Required): ______________________ Date (mm/dd/yyyy): __________

For additional important risk and use information, please see the Full Prescribing Information for NEXAVAR and Full Prescribing Information for STIVARGA, including Boxed Warning.

PATIENT SUPPORT REQUEST FORM

Phone: 1-866-639-2827 Fax: 1-866-639-5181

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

I agree to allow my healthcare providers and health insurers to give the Bayer US Patient Assistance Foundation free drug program, Bayer and its agents, my personal and medical information, including healthcare condition, diagnosis and medicines, for the following purposes: (1) (i) Determine if I am eligible for the program, (ii) provide me with free medicine through the Bayer US Patient Assistance Foundation free drug program if I am eligible to participate, and (iii) comply with any laws that may require the use or disclosure of my information. (2) Contact me or my healthcare provider for additional information to evaluate any adverse event or product complaint that I report or that my provider reports on my behalf. (3) Contact me to ask for feedback on the quality or customer service of the program. (4) Proper management and administration of the program and as permitted or required by applicable law.

I UNDERSTAND:

(1) Application to Bayer US Patient Assistance Foundation is entirely voluntary and I may choose to not complete or sign this form. My decision will not change the way my healthcare providers or health insurers treat me. However, if I do not complete and sign this application, I will not be able to participate in the Bayer US Patient Assistance Foundation free drug program. (2) Privacy laws may not prevent further disclosure of my information after it has been provided to the program, Bayer, their agents, or third-party providers authorized to administer the program. (3) This consent to provide my personal and medical information will continue until I am no longer enrolled in the program or until I choose to cancel my consent, which I may do at any time. (4) I can cancel my authorization at any time by writing to the Bayer US Patient Assistance Foundation, PO Box 5670, Louisville, KY 40255. Cancelling my consent will not have any effect on information given to or used by the program or its agents before the program received my written notice to cancel the consent. (5) I should keep a copy of this form. I also can get a copy by contacting the program at 1-866-2BUSPAF (1-866-228-7723).

INCOME VERIFICATION CONSENT

By applying for the Bayer US Patient Assistance Foundation free drug program, I understand and agree that: (i) there is no charge to participate and my participation in the program is not contingent on any requirement to purchase or use any Bayer product; (ii) completing and signing the program application does not guarantee my eligibility; (iii) the program may change or end at any time; (iv) I will not sell or trade any medicine that I get through this program; (v) I will notify the program within thirty (30) days if there is any change in my income, health insurance, eligibility to enroll in Medicare Part D, or any other reason that may affect my eligibility; (vi) I will not seek to be reimbursed or receive credit from my insurance provider, including Medicare Part D plans, for medicine I receive through the program; (vii) I will not seek credit for medicine from the program toward my true out-of-pocket expenses under Medicare Part D; (viii) the information I provided in this application is correct and complete.

I am providing 'written instructions' under the Fair Credit Reporting Act to the program, including its agents, administrators, and service providers, authorizing the program to obtain information from my credit profile and/or other information from Experian Health. I authorize the Bayer US Patient Assistance Foundation, including its agents, administrators, and service providers, to obtain such information solely to determine my eligibility to participate in the program.

PATIENT TO SIGN AND DATE

Patient signature: ______________________ Date (mm/dd/yyyy): ____________

If signed by a legal representative: Print Name: ______________________ Relationship to patient: ____________

For additional important risk and use information, please see the Full Prescribing Information for NEXAVAR and Full Prescribing Information for STIVARGA, including Boxed Warning.

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