REACH®
Resources for Expert Assistance and Care Helpline

1

PHYSICIAN FORM

Fax to **1.787.777.1426 (Puerto Rico)**

Complete to the fullest extent possible. If an item does not apply, please write "N/A" on that line.

Physician must complete and sign the **Prescription (Physician Form 1, page 1)**. In order for a patient to receive assistance or nursing support, the patient must enroll in the REACH Patient Support Program by completing and signing the accompanying forms: **Patient Support Program Form 2a (page 2)** and the **Protected Health Information Authorization Form 2b (page 3)**.

Please Note: Once this information is released to Bayer, it is no longer protected.

PHYSICIAN NAME		SITE/FACILITY NAME		
STREET ADDRESS		CITY	STATE	ZIP
OFFICE CONTACT		TELEPHONE		
FAX		OFFICE CONTACT EMAIL		
STATE LICENSE #	TAX ID #		NPI #	

Patient Contact Information (to be provided by patient)

PATIENT PHONE NUMBER	PATIENT CELL PHONE NUMBER
PATIENT EMAIL	PATIENT'S PRIMARY LANGUAGE
ALTERNATIVE CONTACT NAME	ALTERNATIVE CONTACT TELEPHONE

Patient Diagnosis Information

PATIENT DIAGNOSIS/ICD CODE

Upon confirmation of insurance coverage, medication will be shipped via a specialty pharmacy provider to the patient's home address unless otherwise indicated by practitioner. Please include copy of patients pharmacy benefit or

Rx

PATIENT NAME		DATE OF BIRTH
ADDRESS		DATE
◯ NEXAVAR® (sorafenib) TABLETS	◯ STIVARGA® (regorafenib) TABLETS	
STRENGTH	SIG	
QUANTITY	REFILLS	
SIGNATURE REQUIRED		

Physician Sign Here

PLEASE ENSURE EVERY FIELD IS COMPLETED AND THIS FORM IS SIGNED.

Please see Full Prescribing Information for NEXAVAR®, and Full Prescribing Information for STIVARGA®, including Boxed Warning.

REACH® Program • PO Box 2528, Guaynabo, PR 00970 • Phone: 1.787.520.6103 • Fax: 1.787.777.1426
This form was printed from one of the following websites: nexavar-us.com, stivarga-us.com, or reachpatientsupport.com.

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PATIENT SUPPORT PROGRAM FORM

2a

Fax to **1.787.777.1426 (Puerto Rico)**

If you choose to enroll in the Bayer Patient Support Programs, please complete to the fullest extent possible. If an item does not apply, please write "N/A" on that line.

Bayer provides Patient Support Services for NEXAVAR® (sorafenib) and STIVARGA® (regorafenib) patients that include:

(A) Nursing Support. This service provides nurses who will call patients to provide them with information, educational materials, and to answer any questions they may have; and,

(B) Financial Support which includes financial assistance or co-pay assistance to help pay for your medication. If you enroll in financial assistance, a representative may call to ask for documentation to verify financial information.

A patient may enroll in one or both of these programs. To enroll in the Patient Support Programs you will also need to provide permission to share your Protected Healthcare Information (PHI) with Bayer ("HIPAA Authorization" below). If you experience an adverse event, it will be shared with Bayer Pharmacovigilance. Bayer may contact you or your treating physician to learn more about the event. Enrollment in the programs will be for three years. You may, however, opt out of this program at any time by writing to the REACH Program, PO Box 2528, Guaynabo, PR 00970.

I would like to enroll in **one or both** of the following services: ◯ **Nursing and education** ◯ **Financial**

Patient Initial Here

PLEASE INITIAL TO CONFIRM YOUR ELECTIONS:

Patient Insurance Information

1	**PRIMARY Rx INSURER**	TELEPHONE	GROUP NUMBER
	POLICY ID NUMBER	SUBSCRIBER NAME/DATE OF BIRTH	
	DOES THIS PLAN COVER PRESCRIPTION DRUGS? ◯ YES ◯ NO		
2	**SECONDARY Rx INSURER**	TELEPHONE	GROUP NUMBER
	POLICY ID NUMBER	SUBSCRIBER NAME/DATE OF BIRTH	
	DOES THIS PLAN COVER PRESCRIPTION DRUGS? ◯ YES ◯ NO		

Patient Financial Information*

CURRENT ANNUAL HOUSEHOLD INCOME $
NUMBER OF HOUSEHOLD MEMBERS DEPENDENT ON INCOME STATED ABOVE (INCLUDE APPLICANT):
*Income documentation will be required in order to assess Patient Assistance Program eligibility (i.e., 1040 tax return, SSA-1099, W-2 Form, etc.).

A **REACH** Nurse Counselor may call to discuss this patient's questions or concerns with:

NAME	
TITLE (e.g., RN, BSN, MSN, PA)	AT

Complete Next Page Section 2b (HIPAA form)

PLEASE ENSURE EVERY FIELD IS COMPLETED, INCLUDING PATIENT INITIALS.

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2b

PROTECTED HEALTH INFORMATION AUTHORIZATION FORM

Fax to **1.787.777.1426 (Puerto Rico)**
Please read, date, and sign.

I authorize the use and disclosure of my Protected Health Information ("PHI") as defined by the Health Insurance Portability and Accountability Act of 1996, which was amended 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 reasonably be used to identify me and that this authorization to release my information is voluntary.

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

I allow the use and disclosure of my PHI for the following purposes: (1) To verify my insurance information; (2) to ensure the accuracy and completeness of the REACH enrollment form; (3) to help with my reimbursement questions; (4) to see if I qualify for patient assistance; (5) to determine my eligibility 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 health care 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 expires at the end of my participation of the program or three (3) years after I sign it. I can revoke at any time. I understand that if I revoke this authorization, it will not have any effect on any actions taken by my health care providers before receiving the revocation. I can revoke this authorization by writing to: Bayer, Attn: Medical Communications, 100 Bayer Boulevard, Whippany, NJ 07981.

I also understand that, under this authorization, entities that receive my PHI may not be required by law to keep the information private and it will no longer be protected by the privacy law. It may become available in the public domain. **I understand that I do not need to sign this form to receive medical treatment or medication.**

I have read and understand this authorization and had an opportunity to ask questions about the uses and disclosures of PHI described above. All of my questions have been answered to my satisfaction. I authorize the use and disclosure of my information as described in this form, and I am entitled to receive a signed copy of this authorization.

Patient Sign Here

PATIENT'S OR PATIENT REPRESENTATIVE'S SIGNATURE	
DATE	RELATIONSHIP TO PATIENT

If signed by the Patient's Representative, a description of the representative's relationship to the Patient and such person's authority to act for the Patient (e.g., parent, guardian, spouse, etc.) must be provided in the space above that follows the date.

You will be providing protected data that **REACH** intends to keep confidential.

◯ I DO NOT wish to receive additional information related to STIVARGA® (regorafenib)

◯ I DO NOT wish to receive additional information related to NEXAVAR® (sorafenib)

If you do not wish to receive information related to STIVARGA® or NEXAVAR® or any related products or services, or to be contacted for market research purposes, you may call the REACH Program toll-free number 1.787.520.6103 at any time.

PLEASE ENSURE EVERY FIELD IS COMPLETED, INCLUDING PATIENT OR REPRESENTATIVE SIGNATURE.

Please see Full Prescribing Information for NEXAVAR®, and Full Prescribing Information for STIVARGA®, including Boxed Warning.

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