Nexavar® (sorafenib) tablets

The REACH® Program
RESOURCES FOR EXPERT ASSISTANCE AND CARE HELPLINE

NexConnect™
Your link to knowledge and support

ENROLLMENT FORMS

Nexavar will **not** be filled through a retail pharmacy.
Nexavar can be obtained directly from a specialty pharmacy or through the REACH Program.
Use the forms attached to enroll your patients in REACH.

- Fill out the enrollment form, **including writing the prescription on the form**. See instructions below.
- Sign the form in the space provided under "Physician Declaration."
- Have your patient sign the form in the space provided under "Patient Declaration."
- Fax the form to **1.866.639.5181**.

1 This section requests basic contact information. The physician's state license number is needed for product shipment.

2 For physicians dispensing from the office, provider numbers for both the primary and secondary insurance company and tax identification number should be listed. When a REACH Program Counselor calls the insurance plans to check on a patient's benefits for Nexavar, these numbers are usually requested before the insurance plan will release patient benefit information.

3 Indicate the patient's diagnosis and respective ICD-9 code. This is often requested by an insurance plan when verifying a patient's benefits.

4 The physician should write the prescription for Nexavar here on the enrollment form, and sign the Physician Declaration. The REACH Program Counselor will forward the Rx information to the appropriate specialty pharmacy to coordinate product shipment.

Nexavar® (sorafenib) tablets | The REACH® Program – RESOURCES FOR EXPERT ASSISTANCE AND CARE HELPLINE | NexConnect™ *Your link to knowledge and support*

Nexavar REACH Program
PO Box 220765
Charlotte, NC 28222-0765
Phone: **1.866.NEXAVAR (1.866.639.2827)**
Fax: **1.866.639.5181**

Enrollment Form
Please complete each section to the fullest extent possible and return this confidential enrollment form to REACH. If an item does not apply, please note "N/A" on that line.

1 Physician Information
Physician Name: ______
Site/Facility Name: ______
Street Address: ______
City: ______ State: ______ Zip: ______
Office Contact: ______ Telephone: ______
Fax: ______ Best Time to Call: ______
Office Contact E-mail: ______
State License #: ______
Tax ID #: ______ **NPI #:** ______

2 In Office Physician Dispensing Information*
(*Complete this section only if the physician is dispensing in the office)
Payer-Specific Provider # (Primary Insurance): ______
Payer-Specific Provider # (Secondary Insurance): ______
Tax ID #: ______

3 Patient Diagnosis Information
Patient Diagnosis/ICD-9 Code: ______

4 Prescription
☐ Benefit verification only
Upon confirmation of insurance coverage (or the patient's approval for assistance through the Nexavar REACH Program), medication will be shipped via a specialty pharmacy provider to the patient's home address (listed above right) unless otherwise indicated by practitioner: ______
Patient Name: ______
Product Name: NEXAVAR 200-mg tablets
Supplied as: 120 tablets per bottle (30-day supply)
(Recommended dosage: 400 mg po bid)
Dosage: ______ Sig: ______
Quantity: ______
Refill(s): ______ DEA #: ______ Date: ______

Physician Declaration
I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Nexavar based on my professional judgment of medical necessity. I authorize Bayer and Onyx, its affiliated companies or subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient.

I appoint the Nexavar REACH Program solely to convey on my behalf to the pharmacy chosen by or for the above-named patient, the prescription described herein.

I authorize the Nexavar REACH Program to perform a preliminary assessment of insurance verification for the above-named patient, and I further authorize and request that the Nexavar REACH Program provide to me any and all information necessary for completing a Letter of Medical Necessity as may be required as a result of such insurance verification assessment.

Physician Signature: ______
Date: ______

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5 Patient Information
Patient Name: ______
Street Address: ______
City: ______ State: ______ Zip: ______
Date of Birth: ______ SSN: ______
Daytime Telephone: ______
Evening Telephone: ______ Best Time to Call: ______
Cell Phone: ______
E-mail: ______
Patient's Primary Language: ______
Alternative Contact Name: ______
Alternative Contact Telephone: ______

6 Patient Insurance Information
Primary Insurer: ______
Telephone: ______
Policy ID Number: ______ Group Number: ______
Subscriber Name/Date of Birth: ______
Does this plan cover prescription drugs? ☐YES ☐NO
Secondary Insurer: ______
Telephone: ______
Policy ID Number: ______ Group Number: ______
Subscriber Name/Date of Birth: ______
Does this plan cover prescription drugs? ☐YES ☐NO

7 Patient Financial Information*
Current annual household income: $ ______
Number of household members dependent on income stated above (include applicant): ______
Source of income:
☐ Job ☐ Family ☐ Public Assistance ☐ SSI/SSDI
☐ Other (please explain): ______
***Income documentation will be required in order to assess Patient Assistance Program eligibility** (ie, 1040 tax return, SSA-1099, W-2 Form, etc).

Patient Authorization
I verify that the information provided in this enrollment form is current, complete, and accurate. I further understand that the Nexavar REACH Program may request documentation from me, my employer, my health care provider, or my insurance company to verify my financial or insurance information. I understand that any patient assistance provided to me by Bayer and Onyx through the Nexavar REACH Program is contingent upon my ability to meet the eligibility criteria for the program and that the Nexavar REACH Program reserves the right to make an independent determination of my financial and medical need. I also understand Bayer and Onyx reserve the right at any time, and without notice, to modify or discontinue the Nexavar REACH Program and any assistance provided with respect to any patient (including me), or to modify or discontinue the program entirely. I authorize the Nexavar REACH Program to use and obtain medical, financial, or provider information from my prescribing physician, insurance company, specialty pharmacy, and other sources as deemed necessary to ensure the accuracy and completeness of this enrollment form, to provide services to me, and to otherwise administer the Nexavar REACH Program. I understand that the Nexavar REACH Program will use and give out my information to help me with my reimbursement questions, to see if I qualify for patient assistance, or to refer me to, or to determine my eligibility for, other programs, foundations, or alternative sources of funding or coverage to help me with the costs of obtaining my Nexavar treatment. I understand that information I provide may be subject to re-disclosure, in which case it may no longer be protected under federal privacy rules. I acknowledge that I am a legal resident of the United States. I authorize my health care providers, insurance companies, and specialty pharmacies to use and disclose to Bayer, Onyx, the Nexavar REACH Program, and their authorized agents and assignees, all medical records and financial information with respect to my treatment, my eligibility for assistance, the coordination of my treatment of Nexavar (and the receipt of my medication), and my participation in the Nexavar REACH Program for the purposes of providing services to me and otherwise administering the program. I understand that my health care providers and insurance company will not condition my medical treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits on my signing of this authorization. I understand, however, that if I do not sign this authorization, I will not be eligible to receive assistance through the REACH Program. This authorization will terminate one year from the signature date below, unless revoked by my written notice. I understand that my revocation will not affect any action taken before it is received by the REACH Program. I am entitled to a copy of this authorization.

Patient/Legal Guardian or Representative* Signature: ______
*a description of such guardian's or representative's authority to act for the patient must be provided.
Date: ______

I further authorize the Nexavar REACH Program to release information provided in this enrollment form to the Nexavar *NexConnect* Program for the provision of education, training, and ongoing support on the use of Nexavar. The Nexavar *NexConnect* Program may provide me with educational or product-related informational materials. The Nexavar *NexConnect* Program provider may receive compensation from Bayer for providing such services. I authorize Bayer, Onyx, the Nexavar REACH Program and the Nexavar *NexConnect* Program to use and give out my information to send me information or materials related to Nexavar (or any other related products or services in which I might be interested), to contact me occasionally to get my feedback (for market research purposes) about Nexavar or the Nexavar REACH Program, to operate (and improve the quality of) the Nexavar REACH Program, or otherwise as required or permitted by law. If you do not wish to receive information related to Nexavar (or any related products or services) or to be contacted occasionally for market research purposes, you may call the Nexavar REACH Program's toll-free number 1-866-NEXAVAR (1-866-639-2827) at any time.
Patient/Legal Guardian or Representatives Signature: ______
Date: ______

☐ I DO NOT wish to receive additional information related to Nexavar. 8/09

5 Complete patient contact information is needed.

6 The patient's primary and secondary insurer information and whether the insurer covers prescription drugs are needed to determine coverage for Nexavar.

7 To determine if patients are eligible for any financial assistance, this section must be completed. Proof of income will be required in order to assess REACH patient assistance program eligibility.

Additional forms can be obtained via REACH
or at **www.NEXAVAR.com**

Essential Support Is Within REACH®
1.866.NEXAVAR (1.866.639.2827)
Monday through Friday—9 AM to 8 PM ET

Bayer HealthCare Pharmaceuticals
6 West Belt, Wayne, NJ 07470 USA

Onyx Pharmaceuticals
2100 Powell Street, Emeryville, CA 94608 USA

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Charlotte, NC 28222-0765
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Enrollment Form

Please complete each section to the fullest extent possible and return this confidential enrollment form to REACH. If an item does not apply, please note "N/A" on that line.

Physician Information

Physician Name: ____________________
Site/Facility Name: ____________________
Street Address: ____________________
City: __________ State: ______ Zip: __________
Office Contact: __________ Telephone: __________
Fax: __________ Best Time to Call: __________
Office Contact E-mail: ____________________
State License #: ____________________
Tax ID #: __________ **NPI #:** __________

In Office Physician Dispensing Information*

(*Complete this section only if the physician is dispensing in the office)
Payer-Specific Provider # (Primary Insurance): __________
Payer-Specific Provider # (Secondary Insurance): __________
Tax ID #: ____________________

Patient Diagnosis Information

Patient Diagnosis/ICD-9 Code: ____________________

Prescription

☐ Benefit verification only

Upon confirmation of insurance coverage (or the patient's approval for assistance through the Nexavar REACH Program), medication will be shipped via a specialty pharmacy provider to the patient's home address (listed above right) unless otherwise indicated by practitioner: __________
Patient Name: ____________________
Product Name: NEXAVAR 200-mg tablets
Supplied as: 120 tablets per bottle (30-day supply)
(Recommended dosage: 400 mg po bid)
Dosage: __________ Sig: __________
Quantity: ____________________
Refill(s): ______ DEA #: ______ Date: __________

Physician Declaration

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Nexavar based on my professional judgment of medical necessity. I authorize Bayer and Onyx, its affiliated companies or subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient.

I appoint the Nexavar REACH Program solely to convey on my behalf to the pharmacy chosen by or for the above-named patient, the prescription described herein.

I authorize the Nexavar REACH Program to perform a preliminary assessment of insurance verification for the above-named patient, and I further authorize and request that the Nexavar REACH Program provide to me any and all information necessary for completing a Letter of Medical Necessity as may be required as a result of such insurance verification assessment.

Physician Signature: ____________________
Date: ____________________

Patient Information

Patient Name: ____________________
Street Address: ____________________
City: __________ State: ______ Zip: __________
Date of Birth: __________ SSN: __________
Daytime Telephone: ____________________
Evening Telephone: __________ Best Time to Call: __________
Cell Phone: ____________________
E-mail: ____________________
Patient's Primary Language: ____________________
Alternative Contact Name: ____________________
Alternative Contact Telephone: ____________________

Patient Insurance Information

Primary Insurer: ____________________
Telephone: ____________________
Policy ID Number: __________ Group Number: __________
Subscriber Name/Date of Birth: ____________________
Does this plan cover prescription drugs? ☐YES ☐NO
Secondary Insurer: ____________________
Telephone: ____________________
Policy ID Number: __________ Group 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): ______
Source of income:
☐Job ☐Family ☐Public Assistance ☐SSI/SSDI
☐Other (please explain): ____________________
***Income documentation will be required in order to assess Patient Assistance Program eligibility** (ie, 1040 tax return, SSA-1099, W-2 Form, etc).

Patient Authorization

I verify that the information provided in this enrollment form is current, complete, and accurate. I further understand that the Nexavar REACH Program may request documentation from me, my employer, my health care provider, or my insurance company to verify my financial or insurance information. I understand that any patient assistance provided to me by Bayer and Onyx through the Nexavar REACH Program is contingent upon my ability to meet the eligibility criteria for the program and that the Nexavar REACH Program reserves the right to make an independent determination of my financial and medical need. I also understand Bayer and Onyx reserve the right at any time, and without notice, to modify or discontinue the Nexavar REACH Program and any assistance provided with respect to any patient (including me), or to modify or discontinue the program entirely. I authorize the Nexavar REACH Program to use and obtain medical, financial, or provider information from my prescribing physician, insurance company, specialty pharmacy, and other sources as deemed necessary to ensure the accuracy and completeness of this enrollment form, to provide services to me, and to otherwise administer the Nexavar REACH Program. I understand that the Nexavar REACH Program will use and give out my information to help me with my reimbursement questions, to see if I qualify for patient assistance, or to refer me to, or to determine my eligibility for, other programs, foundations, or alternative sources of funding or coverage to help me with the costs of obtaining my Nexavar treatment. I understand that information I provide may be subject to re-disclosure, in which case it may no longer be protected under federal privacy rules. I acknowledge that I am a legal resident of the United States. I authorize my health care providers, insurance companies, and specialty pharmacies to use and disclose to Bayer, Onyx, the Nexavar REACH Program, and their authorized agents and assignees, all medical records and financial information with respect to my treatment, my eligibility for assistance, the coordination of my treatment of Nexavar (and the receipt of my medication), and my participation in the Nexavar REACH Program for the purposes of providing services to me and otherwise administering the program. I understand that my health care providers and insurance company will not condition my medical treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits on my signing of this authorization. I understand, however, that if I do not sign this authorization, I will not be eligible to receive assistance through the REACH Program. This authorization will terminate one year from the signature date below, unless revoked by my written notice. I understand that my revocation will not affect any action taken before it is received by the REACH Program. I am entitled to a copy of this authorization.

Patient/Legal Guardian or Representative* Signature: ____________________
*a description of such guardian's or representative's authority to act for the patient must be provided.
Date: ____________________

I further authorize the Nexavar REACH Program to release information provided in this enrollment form to the Nexavar *NexConnect* Program for the provision of education, training, and ongoing support on the use of Nexavar. The Nexavar *NexConnect* Program may provide me with educational or product-related informational materials. The Nexavar *NexConnect* Program provider may receive compensation from Bayer for providing such services. I authorize Bayer, Onyx, the Nexavar REACH Program and the Nexavar *NexConnect* Program to use and give out my information to send me information or materials related to Nexavar (or any other related products or services in which I might be interested), to contact me occasionally to get my feedback (for market research purposes) about Nexavar or the Nexavar REACH Program, to operate (and improve the quality of) the Nexavar REACH Program, or otherwise as required or permitted by law. If you do not wish to receive information related to Nexavar (or any related products or services) or to be contacted occasionally for market research purposes, you may call the Nexavar REACH Program's toll-free number 1-866-NEXAVAR (1-866-639-2827) at any time.
Patient/Legal Guardian or Representatives Signature: ____________________
Date: ____________________

☐ I DO NOT wish to receive additional information related to Nexavar.