VALORUM PRO™ Patient Resource Optimization

ARMLUPEG ENROLLMENT FORM

Phone: 844-VALORUM | Fax: 833-282-7224 | Web: ValorumPRO.com | Monday-Friday, 8:30 am-5:00 pm ET

Request reimbursement or financial assistance by using the provided form or by visiting ValorumPRO.com. ValorumPRO provides a customized portal to streamline your enrollment. For fax enrollment, complete the sections applicable to the services you are requesting.

PROGRAM ENROLLMENT

ACCESS & REIMBURSEMENT SERVICES	FINANCIAL ASSISTANCE SERVICES
☐ Benefits Verification (BV) and (eBV) Support With Stedi (Portal Option) ☐ Prior Authorization (PA) Support (Additional PA Support Within SamaCare) ☐ Appeals Support ☐ Claims & Reimbursement Support ☐ Product Replacement (Please Contact ValorumPRO) ☐ ValorumPRO Commitment Program (Please Contact ValorumPRO)	☐ Co-Pay Assistance Medical Benefit (Commercial Only) ☐ Co-Pay Pharmacy Benefit (Please Contact ValorumPRO) ☐ Patient Assistance Program (PAP - Free Goods) ☐ Foundation Referral Assistance (If Available)

PRODUCT SELECTION & APPLICATION ROUTING

☐ ARMLUPEG (pegfilgrastim-unne)

Completed by: ☐ Patient ☐ Provider ☐ Authorized Representative

SECTION 1: PATIENT INFORMATION

First Name*	MI	Last Name*	DOB*
Address Line 1*		Address Line 2	Sex at birth: ☐ M ☐ F
City*	State*	ZIP*	Primary Phone*
Email*		Alternate Contact	Phone/Relationship
Diagnosis/ICD-10			

SECTION 2: INSURANCE & COVERAGE INFORMATION

☐ No insurance coverage	
Primary insurer/plan	Secondary insurer/plan
Subscriber/Policy ID	Subscriber/Policy ID
Group #/Insurer phone	Group #/Insurer phone
Coverage: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other	Coverage: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other

SECTION 3: CO-PAY AND DEDUCTIBLE ASSISTANCE - BUY & BILL (COMMERCIAL ONLY)

Eligible patients may pay as little as $0 out-of-pocket per treatment.

☐ I authorize ValorumPRO to verify my eligibility and administer co-pay assistance. I certify that I have commercial insurance and am not enrolled in Medicare, Medicaid, TRICARE, VA, or another government-funded healthcare program. I agree to report any change in coverage.

Signature (Patient or Authorized Rep)	Printed Name	Date
Authorized Rep Relationship to Patient:	Primary Phone	Email

Payments are issued to the practice listed on the prescription page on behalf of the patient and are tied to a specific claim and date of service.
Fax or submit the Explanation of Benefits (EOB) or Remittance Advice (RA) through the portal. Claims will be reviewed within 48 business hours.
Portal Link: www.ValorumPRO.com

ARMLUPEG	Up to $5,500 per treatment/$15,000 annually

This program is available only for commercially insured patients. It is not available to patients insured by Medicare, Medicaid, TRICARE, Veterans Affairs, or any other government-funded healthcare program.

PAP AND COPAY REMITTANCE ADDRESS

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THIS PAGE IS SELF-CONTAINED AND MAY BE SEPARATED AND FAXED DIRECTLY TO THE THIRD-PARTY DISPENSING PHARMACY. PAP applicants must complete all applicable sections. For Co-Pay only enrollment, complete practice information.

SECTION 4: PATIENT ASSISTANCE PROGRAM (PAP)

Income Eligibility

• ARMLUPEG: ≤500% FPL; uninsured or functionally uninsured

Program Requirements

• Patient must be a United States resident and physically reside in the U.S., Washington, D.C., Puerto Rico, or the U.S. Virgin Islands.
• Veterans Affairs beneficiaries are not eligible (eg, TRICARE for Life and CHAMPVA).
• Eligible patients will be enrolled for up to 12 months. Eligible Medicare Fee-for-Service and Medicare Advantage patients will be enrolled through the end of the calendar year. Patients must reapply annually.
• Medicaid-eligible patients must have received a Medicaid denial within the previous 12 months.
• Patients with Medicare Part A, B, or D may be eligible only when they meet financial-hardship criteria and are unable to afford therapy.

Supporting documentation may be required. ValorumPRO may request proof of income at any time for audit or verification.

Household Size	Annual Household Income

☐ I certify that I am the patient or the patient's legally authorized representative.
☐ I certify that the patient is a United States resident and physically resides in the U.S., Washington, D.C., Puerto Rico, or the U.S. Virgin Islands.
☐ I certify that the prescribed therapy is unaffordable.
☐ I agree to provide documentation, including proof of income, if requested for program verification.
☐ I certify that the information provided is accurate and complete to the best of my knowledge.
☐ I authorize ValorumPRO and its service providers to collect, use, and disclose information necessary to determine eligibility and administer requested services, including sharing information with providers, pharmacies, payers, vendors, charitable foundations, and third-party program auditors.
☐ I authorize contact by phone, text, and email. Participation is voluntary, and I may revoke this authorization in writing; revocation may affect continued participation.

Signature	Printed Name	Date
Relationship to Patient	Primary Phone	Email

PATIENT & CLINICAL INFORMATION (PAP)

Patient Name*	Date of Birth*	Rx Written Date
Allergies: ☐ NKDA Other:		Diagnosis/ICD-10
Other Medications (prescription and OTC)		
Relevant Health Conditions		

PRESCRIPTION (PAP)

☐ ARMLUPEG — 6 mg/0.6 mL single-dose prefilled syringe

Directions for Use		
Dosage Prescribed	Number of Refills	Refills Start Date

PRACTICE & PRESCRIBER INFORMATION (Needed for Copay Remittance and PAP Programs)

Practice Name		Practice Phone
Practice Address		Fax
City	State	Zip
Prescriber Name	Prescriber Phone	NPI/DEA/License #
Office Contact	Office Email	
Check Remittance Address (if different)		

PROVIDER CERTIFICATION & SIGNATURE (PAP)

I certify that the information on this page and the applicable attestations are accurate and complete to the best of my knowledge. The prescribing decision was made based on my independent clinical judgment and is not contingent on program availability. For product provided through the Patient Assistance Program, I attest that it will be provided at no cost and will not be billed, in whole or in part, to any third-party payer or the patient. I have obtained the patient's authorization to release information necessary to administer ValorumPRO services and will provide documentation of that authorization upon request.

Prescriber Signature	Printed Name	Date
Original signature required for PAP prescription fulfillment		