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Patient Assistance Program Product Refill Request Form

Coherus COMPLETE™
The clear choice for patient support

Date _____

PATIENT

First Name _____ Last Name _____ DOB _____

TREATING PROVIDER

First Name _____ Last Name _____ Title _____

The patient referenced above is scheduled to have their next shipment of UDENYCA® (pegfilgrastim-cbqv) sent on or about _____ from the Coherus COMPLETE™ program.

PLEASE COMPLETE AND RETURN TODAY TO AVOID PRODUCT SHIPMENT DELAY
FAX Number: 1-877-226-6370

1. Is the patient in need of PAP replenishment? ○ YES ○ NO

a. If NO, please indicate when you would like another reminder:

○ 1 week ○ 2 weeks ○ 3 weeks ○ 4 weeks

○ No longer needs assistance ○ Other: _____

2. Has there been a change in the patient's insurance coverage since the last treatment? ○ YES ○ NO

a. If YES, please provide the following information:

Insurance Name: _____

Insurance ID: _____ Insurance Phone: _____

3. When is the patient's next treatment date? _____

a. How many replenishments remain? ____

4. Please provide any additional comments below:

_____

_____

_____

_____

_____

_____

If we do not receive this completed form within seven (7) days of the scheduled shipment date above, we will assume that the patient is no longer in need of product assistance. If you have any questions, please call Coherus COMPLETE™ at 1-844-4-UDENYCA (1-844-483-3692), Monday through Friday, 8AM to 8PM ET.

Coherus BIOSCIENCES